# Health Protection Legislation (England) Guidance 2010

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# Health Protection Legislation (England) Guidance 2010

This guidance is intended to explain the notification requirements on registered medical practitioners and laboratories testing human samples, as well as the health protection powers available to local authorities and justices of the peace. These duties and powers are contained within the Public Health (Control of Disease) Act 1984, as amended by the Health and Social Care Act 2008, and the regulations made under it.

While this guidance attempts to describe and explain those duties and powers, it is not a substitute for consulting the legislation itself or for taking legal advice.

## Acknowledgements

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# Contents

# Foreword from the Chartered Institute of Environmental Health

I am pleased to write the foreword to this guidance. The Chartered Institute of Environmental Health has been happy to work with the Department of Health, the Health Protection Agency (HPA) and other partners to produce it.

Infectious diseases and contamination, such as with chemicals or radiation, can threaten health in circumstances that range from small-scale incidents to national emergencies. Local authorities, as Category 1 responders under the Civil Contingencies Act 2004, are often among the first on the scene when events such as a food poisoning outbreak, an anthrax poisoning or a chemical leak occur. Other emergencies involve previously unknown threats, such as the spread of radioactive polonium 210 or the emergence of a new communicable disease.

The updated health protection legislation provides local authorities with wider, more flexible powers so that they can respond to public health hazards more effectively. In using these powers, local authorities will work closely with other organisations, including the NHS and the HPA. The modernised legal framework will assist environmental health practitioners, who in their daily role of investigating incidents, enforcing public health standards and removing hazardous materials, sometimes encounter lack of cooperation which endangers the health of others.

This document provides guidance on how the legal measures can be put into action and details the safeguards in place to protect people who might be subject to those measures. The guidance also explains the requirements on registered medical practitioners to notify cases of infectious disease or contamination that present a significant risk to human health and the requirements on diagnostic laboratories to notify the HPA of specified causative agents.

We believe this is an important opportunity for public authorities to deal more decisively with modern-day threats to health. In this context, we would encourage local authorities to take the opportunity to review their arrangements for implementing this guidance and particularly to ensure that their environmental health practitioners are appropriately authorised and trained to carry out these important duties.

**Graham Jukes, Chief Executive, Chartered Institute of Environmental Health**

# Executive summary

Health protection legislation in England has been updated from 6 April 2010[1] to give public authorities modernised powers and duties to prevent and control risks to human health from infection or contamination, including by chemicals and radiation.

The main features of the legislation are to:

- extend the long-standing requirement on registered medical practitioners (RMPs) to notify the proper officer of a local authority of individual cases of specified infectious diseases (notifiable diseases) by also requiring them to notify cases of other infections or of contamination which they believe present, or could present, a significant risk to human health;
- require diagnostic laboratories to notify the Health Protection Agency (HPA) of specified causative agents they identify in tests on human samples;
- provide local authorities with wider, more flexible powers to deal with incidents or emergencies where infection or contamination presents, or could present, a significant risk to human health. Some powers, relating to specific circumstances, can be exercised directly by local authorities. In other circumstances, local authorities can apply to a justice of the peace (JP) for a Part 2A Order to impose restrictions or requirements to protect human health.

Earlier legislation, much of it dating from the 19th century, applied only to specified infectious diseases and was based on outdated assumptions about risks to health and how society operated.

The updated legislation adopts an “all hazards” approach, encompassing infection and contamination of any kind. This is consistent with the International Health Regulations 2005 through which the World Health Organization (WHO) and its member states aim to prevent the international spread of infectious diseases and contamination.

The revised measures are contained within the Public Health (Control of Disease) Act 1984 (as amended) and accompanying regulations. The legislation helps public authorities respond to modern-day health hazards more effectively. It means that appropriate steps can be taken in response to previously unknown threats, such as SARS or polonium 210, as well as known infections and contamination that could result in significant harm to human health.

The first section of the guidance explains the notification requirements on RMPs and diagnostic laboratories; the second explains the health protection powers available to local authorities. Both are illustrated by examples of how the legislation might be applied and include algorithms to help practitioners follow the required processes.

[1] Except for provisions relating to diagnostic laboratories, which come into force on 1 October 2010.

## Section A: Guidance on the Health Protection (Notification) Regulations 2010

The statutory notification of infectious diseases has been a crucial health protection measure in this country since the late 19th century. The purpose of notification is to enable the prompt investigation, risk assessment and response to cases of infectious disease and contamination that present a significant risk to human health. Notification has the secondary benefit of providing data for use in the epidemiological surveillance of infection and contamination.

### Notification duties of registered medical practitioners

RMPs attending a patient are required to notify the proper officer of the local authority in which the patient resides when they have "reasonable grounds for suspecting" that the patient:

- has a notifiable disease as listed in Schedule 1 of the Notification Regulations; or
- has an infection not included in Schedule 1 which in the view of the RMP presents, or could present, significant harm to human health (e.g. emerging or new infections); or
- is contaminated (such as with chemicals or radiation) in a manner which, in the view of the doctor presents, or could present, significant harm to human health; or
- has died with, but not necessarily because of, a notifiable disease, or other infectious disease or contamination that presents or could present, or that presented or could have presented significant harm to human health.

Notification of cases of infection not included in Schedule 1 and of contamination are expected to be exceptional occurrences.

RMPs should not wait for laboratory confirmation or results of other investigations in order to notify a case. This will ensure prompt notification so that health protection interventions and control measures can be initiated as soon as possible. The guidance describes how such notifications should be made and the time limits for making them, including provision for urgent oral reporting.

### Notification duties of diagnostic laboratories

Diagnostic laboratories now have a duty to notify the HPA when they identify evidence of infection caused by specified causative agents that are listed in Schedule 2 to the Regulations.

Identification of a causative agent includes:

- direct identification of organisms – such as by direct microscopy, culture, or detection of nucleic acids or antigens, **or**
- finding other evidence of infection by that agent – such as an antibody response to the agent or histological findings that are considered diagnostic of a specific agent.

The guidance describes how such notifications should be made as well as the relevant timescales for making them, including provision for urgent oral reporting.

The vast majority of NHS laboratories across England already voluntarily report a wide range of laboratory diagnoses of causative agents to the HPA for epidemiological surveillance, usually by electronic extraction of data using the CoSurv system. In general, the notification requirements on laboratories can be met by continuing to use CoSurv.

Voluntary reporting includes a more comprehensive list of causative agents than that in the Notification Regulations, and notification under these Regulations does not replace voluntary reporting to the HPA, which will continue.

## Section B: Guidance on the use of public health protection powers

Generally, there is no need to compel people to take action to protect other people's health. Occasionally, however, voluntary measures are insufficient and legal powers are needed to deal with infections or contamination that present a significant risk to human health.

The powers now available to local authorities include powers that can be exercised without judicial oversight and other powers that involve an application to a JP for a Part 2A Order. The powers will usually be exercised in consultation with other organisations, such as the HPA, the NHS or the emergency services.

The health protection powers are for use where voluntary cooperation to avert a health risk cannot be secured and where other methods of control are ineffective, unsuitable or disproportionate to the risk involved. The guidance describes how these powers should be used.

Powers that impose restrictions or requirements are conditional on strict criteria being met. Before making use of one of these powers, the local authority or JP must be satisfied that the criteria relating to a particular threat to health are met. The criteria cover evidence of infection or contamination, assessment of the potential for significant harm to human health, risk of spread to others and necessity for action to be taken in order to reduce or remove that risk. The legislation also contains safeguards for people who might be subject to the legal measures.

The measures are contained in the Public Health (Control of Disease) Act 1984 (as amended) together with the Health Protection (Local Authority Powers) Regulations 2010 and the Health Protection (Part 2A Orders) Regulations 2010.

### Local authority powers

These powers enable a local authority to request or require action to be taken to prevent, protect against or control a significant risk to human health. They allow local authorities to:

- require that a child is kept away from school;
- require a headteacher to provide a list of contact details of pupils attending their school;
- disinfect/decontaminate premises or articles on request;

- request (but not require) individuals or groups to co-operate for health protection purposes;
- restrict contact with, or relocate, a dead body for health protection purposes.

**Part 2A Orders**

In other circumstances, a local authority can apply to a JP for an order that imposes restrictions or requirements on a person(s) or in relation to a thing(s), a body or human remains, or premises. Provided the JP is satisfied that relevant criteria are met, an order can be made for the purposes of protecting against infection or contamination that presents, or could present, significant harm to human health. There are safeguards to protect the interests of individuals who may be the subject of an application for an order.

A JP can make a Part 2A Order requiring a **person(s)** to:

- undergo medical examination (NOT treatment or vaccination);
- be taken to hospital or other suitable establishment;
- be detained in hospital or other suitable establishment;
- be kept in isolation or quarantine;
- be disinfected or decontaminated;
- wear protective clothing;
- provide information or answer questions about their health or other circumstances;
- have their health monitored and the results reported;
- attend training or advice sessions on how to reduce the risk of infecting or contaminating others;
- be subject to restrictions on where they go or who they have contact with;
- abstain from working or trading.

In addition, a JP can make a Part 2A Order requiring that:

- **a thing(s)** is seized or retained; kept in isolation or quarantine; disinfected or decontaminated; or destroyed or disposed of;
- **a body or human remains** be buried or cremated, or that human remains are otherwise disposed of;
- **premises** are closed; premises are disinfected or decontaminated; a conveyance or movable structure is detained, or a building, conveyance or structure is destroyed.

There are a few special considerations in relation to sexually transmitted diseases and HIV. The guidance provides advice on these issues.

# Glossary of terms

***as used in this guidance***

**Child:** a person under the age of 18 years.

**Contamination:** contamination covers all kinds of contamination, including with chemicals or radiation, with or without signs and symptoms of disease.

**Relevant contamination:** where a patient(s) is contaminated in a manner which, in the view of the registered medical practitioner (RMP) presents, or could present, significant harm to human health.

**Other relevant infection:** where a patient(s) has an infection (not listed as a notifiable disease in Schedule 1) which, in the view of the RMP presents, or could present, a significant harm to human health.

**Diagnostic laboratory:** an institution (or facility within an institution) which is equipped with apparatus and reagents for the performance of diagnostic tests for human infection. This includes any type of laboratory performing the above specified function, including microbiology, virology, histopathology and haematology laboratories.

**Health protection professional:** a person suitably qualified in the field of health protection and registered with an appropriate body such as the Faculty of Public Health, the Chartered Institute of Environmental Health and/or the Nursing & Midwifery Council or the General Medical Council.

**HPA:** Health Protection Agency.

**JP:** Justice of the peace (magistrate).

**Operator of diagnostic laboratory:** the corporate body that operates the diagnostic laboratory or, if there is no such body, the director of the diagnostic laboratory.

**Parent:** includes any person who in respect of a child has parental responsibility for that child, or who has care of that child. “Parental responsibility” has the same meaning as in the Children Act 1989. Note that in determining whether an individual has care of a child, any absence of that child at a hospital or boarding school – or any other temporary absence – should be disregarded.

**Part 2A Order:** An order made by a JP, on application from a local authority, under the 1984 Act, imposing restrictions or requirements for the purposes of protecting human health.

**Proper officer:** an officer appointed by a local authority to carry out a particular function (section 74 of the 1984 Act). In relation to the notification obligations, it will be the proper officer appointed to receive the notifications.

**Registered medical practitioner (RMP):** a medical doctor – a fully registered person within the meaning of the Medical Act 1983 who holds a licence to practice under that Act.

**Schedule 1:** Schedule 1 to the Health Protection (Notification) Regulations 2010, which lists the infectious diseases that must be notified by an RMP.

**Schedule 2:** Schedule 2 to the Health Protection (Notification) Regulations 2010, which lists the causative agents that must be notified by a diagnostic laboratory.

**1984 Act:** the Public Health (Control of Disease) Act 1984, as amended by the Health and Social Care Act 2008

# SECTION A
# Guidance on the Health Protection (Notification) Regulations 2010

## 1. Introduction to notification

The statutory notification of infectious diseases has been a crucial health protection measure in this country since the late 19th century. Many countries have statutory notification systems in place for doctors, laboratories or hospitals to report specific infectious diseases. These countries include France, Germany, the Netherlands, Sweden, USA, Canada, Australia and New Zealand.

The purpose of notification is to enable the prompt investigation, risk assessment and response to cases of infectious disease and contamination (such as with chemicals or radiation) that present, or could present, a significant risk to human health. Notification has to be timely if public health interventions are to be effective in controlling the further spread of infection or contamination. Notification has the secondary benefit of providing data for use in the epidemiological surveillance of infection and contamination. These data can help, for example, in monitoring the effect of existing interventions (e.g. immunisation), identifying the need for new interventions (e.g. outreach services for specific groups) and informing the planning of healthcare services.

The Health Protection (Notification) Regulations 2010 ("the Notification Regulations") modernise the requirements for notification in England.

The longstanding requirement for registered medical practitioners (RMPs) to report notifiable diseases continues. A revised list of notifiable diseases is included in Schedule 1 to the Regulations. In addition, RMPs have a duty to notify other infections, not listed in Schedule 1, which they believe present, or could present, a significant risk to human health. In line with the "all hazards" approach of the updated Public Health (Control of Disease) Act 1984, RMPs are also required to notify cases of contamination that present, or could present, a significant risk to human health.

The Notification Regulations place a new duty on diagnostic laboratories to notify the Health Protection Agency (HPA) when they identify evidence of infection caused by specified causative agents. These causative agents are listed in Schedule 2 to the Regulations.

In future, it will be possible to amend the lists of notifiable diseases and causative agents as necessary by further regulations.

## 2. Main features of the Notification Regulations

The Notification Regulations relating to RMPs come into effect on 6 April 2010 and those relating to diagnostic laboratories come into effect on 1 October 2010. The main features are:

**RMPs** attending patients are required to notify the proper officer of the local authority, in which they attended the patient, of:

- cases of notifiable infectious diseases in Schedule 1 to the Notification Regulations;
- cases of other infections not included in Schedule 1 if they present, or could present, significant harm to human health (e.g. emerging or new infections);
- cases of contamination, such as with chemicals or radiation, that may present or could present significant harm to human health;
- cases of patients who die with, but not necessarily because of, a notifiable disease or other infectious disease or contamination that presents, or could present, or that presented or could have presented significant harm to human health.

**Diagnostic laboratories** that test human samples are required to notify the HPA when they identify specified causative agents of infectious disease.

There are clear **time limits** for notification by RMPs and diagnostic laboratories, including provision for urgent reporting.

## 3. Notification duties of registered medical practitioners

An RMP must notify the proper officer of the local authority in which they attended a patient when they have "reasonable grounds for suspecting" that the patient:

- has a notifiable disease as listed in Schedule 1 (see Table 1 at the end of this subsection);
- has an infection (not listed in Schedule 1) which, in the view of the RMP presents, or could present, a significant harm to human health ("**other relevant infection**"), or
- is contaminated in a manner which, in the view of the RMP, presents or could present significant harm to human health ("**relevant contamination**").

Notification of infections not included in Schedule 1 and contamination are expected to be exceptional occurrences. Factors the RMP may wish to consider in deciding whether to notify a case of infection that is not included in Schedule 1 or a case of contamination include:

- the risk of transmission or spread to others
  **and**
- the potential to cause significant harm to human health.

Illustrative examples of cases of infection or contamination that should be notified under this provision are provided below for guidance. If in any doubt, the RMP may seek advice from the proper officer, the local HPA office or another appropriate health protection professional, such as an environmental health practitioner. The HPA (www.hpa.org.uk) or local authority website will provide necessary contact details.

RMPs should **not** wait for laboratory confirmation of the suspected infection or contamination before notification. They must notify cases if they have reasonable clinical suspicion that their patient is suffering from a notifiable disease or other relevant infection or contamination. If an RMP has good reason to believe that another RMP has already notified the case, they are not required to notify. However, prior notification of the causative agent by a diagnostic laboratory does not remove the RMP's responsibility to notify a notifiable disease or relevant infection. Separate notification systems are in place for diagnostic laboratories, as outlined later in this guidance.

If laboratory test results refute the clinical diagnosis later, the RMP is not required to de-notify the case. However, they should contact the proper officer if they made administrative errors in the notification process. When a statutory notification is made, it is useful to mention the notification in the patient's records. This will help to avoid duplicate notifications.

When a patient is referred from one RMP to another, the first RMP who forms a clinical suspicion that a patient suffers from a notifiable disease or other infectious disease or contamination that presents, or could present, harm to human health should notify the case. This is to prevent unnecessary delay in advising or implementing public health measures.

### 3.1 Notifiable diseases

The list of notifiable disease is contained in Schedule 1 to the Notification Regulations[2]. See Table 1 at the end of this subsection for the list of notifiable diseases, explanatory notes and guidance on which ones are likely to need urgent notification.

### 3.2 Notification of other relevant infections

RMPs are required to notify cases of infection that are not listed in Schedule 1 if they consider that there is, or could be, a significant harm to human health. These infections could include new or emerging diseases or other known and/or common infections not included in Schedule 1.

There are separate mechanisms for notifying and responding to cases of healthcare associated infections, Human Immunodeficiency Virus (HIV)/Sexually Transmitted Infections (STIs) and Creutzfeldt-Jakob Disease (CJD) (see subsection 3.6 below). Therefore, cases of these diseases should **not** be reported routinely under this requirement. However, suspected acute infectious hepatitis should be notified even if it is considered to have been acquired through sexual activity (see 3.6).

These notification requirements should not replace the normal professional communications between RMPs and the HPA locally.

#### 3.2.1 New or emerging infections

A new or emerging disease may cause a serious public health threat. A new disease may be identified from its symptoms and epidemiology before it is fully described or the causative agent identified.

The patient's presentation and available epidemiological information, such as contact with similar cases, may suggest that the disease is likely to be transmitted from person to person. If not, there is likely to be a common source of infection, which may provide clues for basic control measures. The public health impact of such a disease may be, for example, due to the mode of transmission, the number of people affected, significant morbidity, high case fatality rates, community disruption due to sickness absence or severe pressure on health services.

An RMP is required to notify such new or emerging diseases when they suspect there is a risk of significant harm to human health. If in doubt, the RMP may seek advice from the proper officer, the HPA locally or another appropriate person.

[2] http://www.opsi.gov.uk/si/si2010/uksi_20100659_en_1

**Example 1: Severe Acute Respiratory Syndrome (SARS)**

SARS is a notifiable disease under Schedule 1 to the Notification Regulations. It was an unknown infection until the first cases were reported in November 2002. Under previous legislation, there was no requirement for notification of SARS or any other emerging infections. Under the 2010 Notification Regulations, if a similarly novel infection occurred which might present a significant risk to human health, RMPs would be required to notify cases to the proper officer of the local authority to enable investigation. Notification should take place even prior to the syndrome being named and the case definition being determined. This could be achieved by describing the signs and symptoms of the cases.

### 3.2.2 Known infections that are not listed as notifiable

An RMP should notify cases of known infections which are not listed as notifiable if they believe that in specific circumstances such infections present, or could present, a significant risk to human health. Two examples are given below.

**Example 2: Parvovirus B19 in a contact of a pregnant woman**

Parvovirus is highly infectious. In the first 20 weeks of pregnancy, Parvovirus infection can cause foetal loss (9%) and hydrops foetalis (3%). An RMP who knows that a patient with Parvovirus has been in contact with a pregnant woman should consider notifying the case.

**Example 3: Chickenpox in a healthcare worker**

An RMP who diagnoses chickenpox in a healthcare worker should consider notification. Although cases of chickenpox are not routinely notifiable, in the case of a healthcare worker, the attending RMP may decide that, based on the information available to them and because of the patient's occupation, there might be a risk to certain susceptible individuals (such as pregnant women or immuno-suppressed patients). Contact with such patients may result in serious illness.

### 3.3 Notification of contamination

There is now a requirement for RMPs to notify suspected cases of contamination, which they believe present, or could present, significant harm to human health. Notification will allow control measures to be considered and implemented as appropriate.

In deciding whether there could be significant harm to human health from the contaminated case, the attending RMP should consider morbidity and mortality already caused, or likely to be caused, by such contamination and the risk to public health from the spread of the contamination. In making a judgement, the RMP may consider the clinical presentation of the case(s) and/or available evidence on the effects of such contamination. If in doubt, the RMP may seek advice from the proper officer, the HPA locally or another appropriate person.

It is recommended that the RMP should also contact the proper officer or the local HPA office, if they become aware of a possible source of contamination associated with a suspected case that presents or could present a risk to others – even if there is no risk of spread of

contamination from the case. This will ensure that appropriate investigation and control measures can take place.

**Example 4: Carbon monoxide poisoning**

An RMP suspects that a patient has carbon monoxide (CO) poisoning and considers that the possible source of this contamination could present a risk to others. It is recommended that, although such a case is not notifiable, the RMP contacts the proper officer of the local authority or the local HPA office. The proper officer and partner organisations, such as the HPA, would assist with identification of the CO hazard, risk assessment, provision of advice and remedial measures.

### 3.3.1 Chemical contamination

The RMP may become aware of chemical contamination in a person in two ways: if they see a patient with signs and/or symptoms consistent with exposure to a specific chemical; or if a patient provides a history of recent exposure to a potentially harmful chemical substance, with or without signs or symptoms of a disease. If the attending RMP considers it likely that the contamination carried by the patient presents, or could present, a significant risk to others, they should notify the case to the proper officer of the local authority.

### 3.3.2 Contamination with radioactive material

The RMP may become aware of a case of radioactive contamination in two ways: if they see a patient with signs and/or symptoms consistent with exposure to a radiation; or if a patient provides a history of recent exposure to radiation, with or without signs or symptoms of a disease. If the RMP considers there is, or could be, a significant risk to others from radioactive contamination carried by the patient, they are required to notify the case to the proper officer of the local authority.

## 3.4 Reporting clusters of disease

The Notification Regulations set out requirements only in relation to individual cases. RMPs should continue to report, on a voluntary basis, suspected outbreaks or clusters of cases of infection or contamination to the proper officer of the local authority and the local HPA office, irrespective of the disease being notifiable or not. This reflects good professional practice.

**Example 5: Outbreak of PVL *Staphylococcus aureus* in a primary school**

PVL-positive *Staphylococcus aureus* is not a notifiable disease under the Notification Regulations. However, PVL-positive *Staphylococcus aureus* strains are usually associated with community-acquired infections and generally affect previously healthy young children and young adults. An RMP may be aware of a number of children with recurrent boils or abscesses in a school class. This may be an indicator of PVL infection. A risk assessment, contact screening and infection prevention and control measures are likely to be needed to prevent further spread. Even though the disease is not notifiable, the RMP should report the incident to the local HPA office.

**Example 6: Outbreak of scabies in a care home**

Scabies is not a notifiable disease under the Notification Regulations. However, outbreaks of scabies in care homes may require significant degrees of intervention to control them. Confirmation of diagnosis is important in this setting and a high level of diagnostic suspicion should be maintained. All patients and residents may need to be examined. Cases and contacts should be treated promptly and simultaneously and control measures implemented. Monitoring should be undertaken to identify treatment failures. Although scabies is not notifiable, reporting such incidents to the local HPA office will help in managing them effectively.

### 3.5 Notification of disease in patients who have died

An RMP must notify the proper officer of the local authority if they suspect that a patient they are attending has died with, but not necessarily from, a notifiable disease, or other relevant infection or relevant contamination. However, notification is not necessary if the RMP has good reason to believe that it has already been made by another RMP (e.g. when the patient was still alive).

**Example 7: A patient dies at home from suspected meningococcal disease**

An RMP attends a sudden death at home and makes the clinical diagnosis of probable meningococcal disease. The RMP notifies the proper officer of the local authority. A range of public health interventions would be required based on this probable diagnosis, including contact tracing and administration of chemoprophylaxis.

### 3.6 Infections that have not been included in the list of notifiable diseases

There are certain infections that may cause significant harm to human health but which have not been included in Schedule 1. This is because there are other effective systems in place to report, monitor and control the risk from such infections and it is unlikely that notification would reduce the public health impact of such conditions – although in exceptional circumstances notification of specific cases, as other relevant infections, might be necessary. These infections include:

- **Healthcare associated infections**: Mandatory reporting of healthcare associated infections has proved to be effective in providing real time surveillance data that infection control teams routinely use for control measures. Such surveillance systems include all laboratory reports of bacteraemia for a variety of microorganisms, some of which are associated with healthcare settings; *Staphylococcus aureus* (including MRSA); *Clostridium difficile*; Surgical Site Infection Surveillance Service (SSISS); and glycopeptide-resistant enterococcal bacteraemia.

- **HIV and STIs**: Genitourinary medicine (GUM)/sexual health clinics routinely follow up contacts of cases and take necessary public health actions. Clusters or outbreaks of disease are managed in collaboration with the HPA. Patient confidentiality is of vital

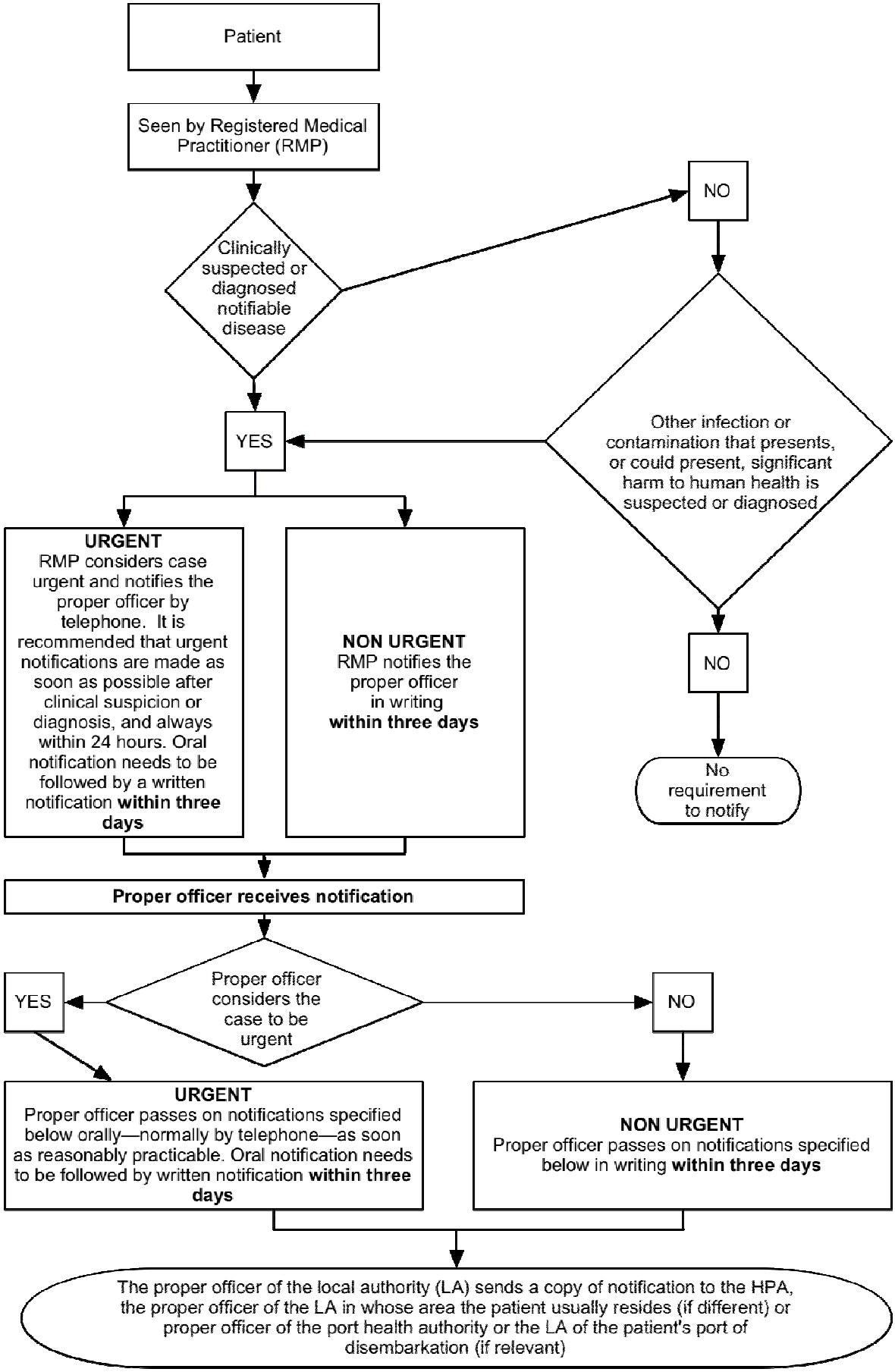
importance in HIV and STI settings to retain patients' trust in health services and to encourage access to clinics and services for information and advice, testing, diagnosis and treatment. However, notification is required if a patient attending a GUM clinic is diagnosed with acute infectious hepatitis. This disease is also spread by non-sexual means and so notification will ensure that contact tracing is undertaken and control measures offered to non-sexual contacts who could be at risk.

- **CJD:** The incidence of Creutzfeldt-Jakob Disease is monitored in the UK by the National CJD Surveillance Unit (NCJDSU) and all suspected cases should be reported to this unit. The unit assists clinicians with the investigation of this disease and works in collaboration with the HPA and the CJD Incidents Panel in the investigation and management of CJD incidents.

### 3.7 The notification process

The diagram below shows the process by which RMPs notify cases of infection or contamination that present, or could present, a significant risk to human health.

## Algorithm 1: The notification process



### 3.7.1 Time frame for notifications

The RMP should send a written notification to the proper officer of the local authority so that it is received within three days, beginning with the day on which the RMP forms the clinical suspicion or makes the clinical diagnosis.

However, if the RMP considers the case requires urgent notification, they need to notify it orally – usually by telephone – as soon as reasonably practicable and follow this up with written notification within three days. It is recommended that urgent notifications are made **as soon as possible after the RMP forms the clinical suspicion or makes the clinical diagnosis**, and **always within 24 hours**.

In determining whether a case is urgent or not, factors that should be considered include the:

- nature of the suspected notifiable disease, other relevant infection or relevant contamination including morbidity, case-fatality and epidemiology of the disease – a rare disease, or one that is re-emerging, is likely to need urgent notification.
- ease of spread of that disease or infection, route of transmission (for example, a highly infectious respiratory disease) or potential spread of contamination.
- ways in which the spread of the notifiable disease, other relevant infection or contamination can be prevented or controlled, for example by immunisation, disinfection, isolation or prophylactic treatment.
- specific circumstances of the case which might represent particular risks, such as occupation, age and sex. These details have a bearing if, for example, a patient is a healthcare worker, a child attending nursery or a woman of child-bearing age.

There may be other circumstances where urgent notification is necessary, for example, if a disease appears to be a cluster of cases rather than a single case. See Table 1 at the end of this subsection.

### 3.7.2 Paper-based and electronic notification

Written notifications to the proper officer of the local authority are either paper-based or, if the receiving local authority consents and facilities are available, may be made electronically by secure online reporting, by secure e-mail or by secure fax.

The details of notification arrangements will usually be available on the local authority's website. The local authority may indicate its consent to receiving electronic notification on their website.

Appendix 1 to this document contains a suggested template for RMP notifications. This form is also available on the HPA's website.

All parties should have utmost regard for security of data in compliance with the Data Protection Act 1998 and (for NHS practitioners) the Caldicott guidelines[3] and the NHS confidentiality code of practice.[4] If electronic notifications are to be accepted, the local authority must be confident that all the necessary requirements for secure electronic transmission of personal data have been met.

### 3.7.3 Providing relevant information

The notification by RMPs must include the following information about the patient in so far as it is known to them:

- name, date of birth and sex;
- home address including postcode;
- contact telephone number;
- current residence (if it is not the home address);
- NHS number;
- occupation (if the RMP considers it relevant);
- name, address and postcode of place of work or educational establishment (if the RMP considers it relevant);
- ethnicity;
- relevant overseas travel history;
- contact details of a parent (if the patient is a child);
- disease or infection which the patient has or is suspected of having or the nature of the patient's contamination or suspected contamination;
- date of onset of symptoms; and
- date of diagnosis.

The notification should also include the name, address and telephone number of the RMP making the notification.

The importance of certain data items is discussed below.

#### 3.7.3.1 Occupation

The RMP should include a patient's occupation in the data they send to the proper officer of the local authority when they consider this may be relevant to health protection investigations and/or control measures.

[3] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4068403

[4] http://www.dh.gov.uk/en/Managingyourorganisation/Informationpolicy/Patientconfidentialityandcaldicottguardians/DH_4100550

**Example 8: Food handler with a gastrointestinal infection**

For all individual cases of gastrointestinal infection (GI) one of the key priorities is to limit secondary spread to other people. Food handlers, whose work involves touching unwrapped foods to be consumed by others, are a group considered to be at increased risk of spreading GI infection. Therefore specific exclusions and in some cases clearance samples will be required before the individual can return to work.

#### 3.7.3.2 Address of a patient's workplace or educational establishment

This information is relevant if there is a risk to other people at the workplace or educational establishment. These places could also be the source of infection or contamination. The proper officer of the local authority therefore needs details to initiate further investigation.

**Example 9: Infectious bloody diarrhoea in a young child in a nursery**

Investigations will be required to ensure that there are no other cases of similar disease in this high risk setting. Advice on precautions to minimise any secondary spread should be given.

#### 3.7.3.3 Overseas travel history

This information is relevant if the patient has been abroad within the incubation period of the infectious disease, or if it is likely that the disease or contamination was acquired in another country. This information may exclude a source of disease in the UK. There may also be a need for action if there is a risk to other people who travelled with the patient or were passengers in the same vehicle.

**Example 10: Tuberculosis in an air passenger**

A risk assessment will need to be undertaken to determine whether contact tracing is necessary for other people on the flight. Contacts are managed according to national guidelines.

**Example 11: Typhoid fever**

Reports should be made to the proper officer on clinical suspicion of typhoid infection in order that health protection measures can be implemented promptly. Information on travel history is important to establish if the source is likely to be in the UK or overseas. Investigation of the potential source, if not travel related, is crucial in preventing further spread of the disease in the UK.

#### 3.7.3.4 Current address if different from permanent address

This information is very important because it may have significant bearing for health protection investigations, advice and interventions. For example, if a patient is currently in hospital while presenting signs and symptoms of the disease, they may put other patients at risk if not isolated. Other examples are patients in a care home, prison, boarding school or university halls of residence.

**Example 12: Meningococcal disease in a university student**

Public health action is required for all probable and confirmed cases of meningococcal disease. Chemoprophylaxis will need to be arranged for close contacts, the aim of which is to eradicate the infecting strain from the network of close contacts. In a university setting this may include students in a hall of residence.

#### 3.7.3.5 Ethnicity

This information should be provided by the RMP when available and should be based on the ethnic categories used by the NHS.[5] Ethnicity data are important for monitoring health inequalities.

### 3.8 Removal of fee for notification

Under the Notification Regulations, there are no provisions for RMPs to be paid fees for notifications. RMPs are expected to provide information that is a requirement of legislation is needed to protect public health as part of their professional duties.[6]

### 3.9 Removal of Offence for RMPs

There is no offence in the Notification Regulations for failure by an RMP to notify because there are other mechanisms for dealing with non-compliance with legal requirements. RMPs in England are regulated by the General Medical Council and RMPs in employment are also subject to the clinical governance requirements that safeguard standards of care in the NHS. Contracts for general medical services and personal medical services require adherence by providers to relevant legislative requirements such as those in the Notification Regulations 2010.

### 3.10 Reporting by other healthcare professionals

There are no legal requirements for other regulated healthcare professionals, such as registered nurses, to notify in respect of a patient suspected of having a notifiable disease, other relevant infection or relevant contamination. Most cases are seen and diagnosed by an RMP who is responsible for making the notification. If a patient is under the care of an advanced nurse practitioner or nurse, and they assess or suspect the patient to have a notifiable disease, other infection or contamination, they have a duty of care to initiate a referral to an RMP and work collaboratively with other healthcare professionals.

If a nurse believes that the patient may not be seen by an RMP, or there may be a delay in the patient being seen by the RMP, the nurse may – based on good professional practice principles – report the case to their local HPA office and seek advice. However, this action would not be regarded as notification under the requirements of these Regulations.

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[5] NHS Ethnic Category Code. http://www.datadictionary.nhs.uk/data_dictionary/attributes/e/enh/ethnic_category_code_de.asp

[6] General Medical Council guidance on confidentiality, see www.gmc-uk.org/guidance/ethical_guidance/confidentiality_17_23_disclosures_required_by_law.asp#statute

**Table 1: Notifiable diseases, with explanatory notes and guidance on the need for urgent notification**

NB: This table is only for guidance and each case should be considered individually.

| Notifiable diseases | Definition / comment | Likely to be urgent? |
|---|---|---|
| Acute encephalitis | | No |
| Acute meningitis | Viral and bacterial. | Yes, if suspected bacterial infection. |
| Acute poliomyelitis | | Yes |
| Acute infectious hepatitis | Close contacts of acute hepatitis A and hepatitis B cases need rapid prophylaxis. Urgent notification will facilitate prompt laboratory testing. Hepatitis C cases known to be acute need to be followed up rapidly as this may signify recent transmission from a source that could be controlled. | Yes |
| Anthrax | | Yes |
| Botulism | | Yes |
| Brucellosis | | No – unless thought to be UK-acquired |
| Cholera | | Yes |
| Diphtheria | | Yes |
| Enteric fever (typhoid or paratyphoid fever) | Clinical diagnosis of a case before microbiological confirmation (e.g. case with fever, constipation, rose spots and travel history) would be an appropriate trigger for initial public health measures, such as exclusion of cases and contacts in high risk groups (e.g. food handlers). | Yes |

| Notifiable diseases | Definition / comment | Likely to be urgent? |
|---|---|---|
| Food poisoning | Any disease of infectious or toxic nature caused by, or thought to be caused by consumption of food or water (definition of the Advisory Committee on the Microbiological Safety of Food). | Clusters and outbreaks, yes.<br>For specific organisms see Table 2. |
| Haemolytic uraemic syndrome (HUS) | | Yes |
| Infectious bloody diarrhoea | See also HUS in Schedule 1 and VTEC in Schedule 2. | Yes |
| Invasive group A streptococcal disease and scarlet fever | | Yes, if IGAS. No, if scarlet fever |
| Legionnaires' Disease | | Yes, |
| Leprosy | | No |
| Malaria | | No, unless thought to be UK-acquired |
| Measles | | Yes |
| Meningococcal septicaemia | | Yes |
| Mumps | Post-exposure immunization (MMR or HNIG) does not provide protection for contacts. | No |
| Plague | | Yes |
| Rabies | A person bitten by a suspected rabid animal should be reported and managed urgently, but if a patient is diagnosed with symptoms of rabies, they will not pose a risk to human health. | Yes |
| Rubella | Post-exposure immunisation (MMR or HNIG) does not provide protection for contacts. | No |
| SARS | | Yes |
| Smallpox | | Yes |

| Notifiable diseases | Definition / comment | Likely to be urgent? |
|---|---|---|
| Tetanus | | No, unless associated with injecting drug use |
| Tuberculosis | | No, unless healthcare worker or suspected cluster or multi drug resistance |
| Typhus | | No |
| Viral haemorrhagic fever (VHF) | | Yes |
| Whooping cough | | Yes, if diagnosed during acute phase |
| Yellow fever | | No, unless thought to be UK-acquired |

**NB:** RMPs are also required to notify suspected cases of other infections ("other relevant infection") or contamination ("relevant contamination") that present, or could present, significant harm to human health (see 3.2 and 3.3).

# 4. Notification duties of diagnostic laboratories

The statutory notification by diagnostic laboratories of specified causative agents of infectious disease to the HPA is a new aspect of health protection legislation introduced by the Health Protection (Notification) Regulations 2010 ("the Notification Regulations"). It recognises the crucial role that laboratories play in the diagnosis of infectious disease. This requirement comes into effect on 1 October 2010.

The vast majority of NHS laboratories across England are already voluntarily reporting a wide range of laboratory diagnoses of causative agents to the HPA for epidemiological surveillance, usually by electronic extraction of data from laboratory systems and submission via the CoSurv system.[7] Many HPA offices already have agreements with their local laboratories for urgent reporting of some infections. Voluntary reporting includes a more comprehensive list of causative agents than that in the Notification Regulations, and notification under these Regulations does not replace voluntary reporting to the HPA, which will continue.

Since health protection actions are taken at a local level, for the purposes of the Notification Regulations, the recipient of laboratory notifications is the local HPA office, even though the CoSurv system is capable of currently transmitting reports to local, regional and national parts of the HPA, and also to local authorities.

The legal responsibility to ensure that laboratory notification is carried out in accordance with the Notification Regulations rests with the corporate body that operates the laboratory or the director of the laboratory if there is not a corporate body.

## 4.1 Identification of causative agents in human samples

The Notification Regulations require diagnostic laboratories that test human samples (from live or deceased patients) to notify the HPA when they identify the specified causative agents that are listed in Schedule 2 to the Regulations. (See Table 2 at the end of this subsection for a list of notifiable causative agents, explanatory notes and guidance about urgent notification.)

Identification of a causative agent includes:

- identification of the causative agent: by direct identification of organisms, such as by direct microscopy, culture, or detection of nucleic acids or antigens,
  **or**
- finding other evidence of infection by that agent: such as an antibody response to the agent or histological findings that are considered diagnostic of a specific agent.

In both of the above situations, the case should be notified when there is a sufficient level of certainty to make a diagnosis of any of the agents listed in Schedule 2. In other words, if there

[7] CoSurv is a set of interconnected databases that form a national surveillance system.

is sufficient certainty to communicate a diagnosis to an RMP, either verbally or by a laboratory report, the case should be notified. It should not necessarily await further confirmatory tests.

Illustrative examples of when a diagnostic laboratory is required to notify the identification of a causative agent (or other evidence of infection by that agent), are provided below.

**Example 13: Tuberculosis found during a postmortem**

Histopathological changes such as caseation and necrosis observed in a postmortem sample taken from a patient's lung may suggest infection with tuberculosis in the deceased, even when acid-alcohol fast bacilli are not seen. Notification should be made so that contact tracing can be carried out.

### 4.2 Diagnostic laboratories testing human samples

The term "diagnostic laboratory" includes microbiology, virology, histopathology, haematology laboratories and any other laboratory that may identify the causative agents listed in Schedule 2 in a human sample.

**Example 14: Malaria**

Malaria is usually diagnosed either by microscopy of thick and thin blood films or by detection of *Plasmodium* spp. antigens in the patient's blood. This is often undertaken in haematology rather than microbiology laboratories. When this is the case, it is the responsibility of the operator of the haematology laboratory to ensure that the HPA is notified.

**Example 15: Hepatitis B in pregnancy**

Antenatal screening may be undertaken in different laboratories from those that normally undertake diagnostic microbiology testing. If the laboratory undertaking antenatal testing detects markers of hepatitis B in a sample, and has no reason to believe that the HPA has already been notified of this case by the operator of another diagnostic laboratory, the operator of the antenatal screening laboratory has a duty to ensure that the case is notified to the HPA.

### 4.3 How laboratories notify

#### 4.3.1 Time frame for notifications

The Regulations require that laboratory notifications of specified infections are provided in writing (on paper **or** electronically – see below) and received by the HPA **within seven days** of the causative agent being identified. Urgent cases should be notified **as soon as reasonably practicable** after the identification of the causative agent. This should be done orally, usually by telephone. It is recommended that this should always be done **within 24 hours**. Urgent oral notification should be followed up by written notification **within seven days**.

In determining whether a case is urgent, factors that should be considered include the:

- nature of the causative agent, for example a rare and/or re-emerging disease;

- ease of spread of that causative agent, including the infectiousness of cases and route of transmission – a highly infectious respiratory disease, for example, may require urgent notification;
- ways in which the spread of the causative agent can be prevented or controlled, taking into account, for example, immunisation, isolation and prophylactic treatment;
- nature of the disease it causes, including morbidity and case-fatality;
- specific circumstances of the case which might represent particular risks, such as occupation, age and sex. It may be relevant, for example, if a patient is a healthcare worker, a child attending nursery or a woman of child-bearing age.

Guidance as to when urgent notification is likely to be necessary is given for each causative agent in Table 2, but each case should be considered individually.

Overall, the key consideration will be the likelihood that an intervention is needed to protect human health and the urgency of such an intervention.

**Example 16: *Escherichia coli* O157**

Infection with *E. coli* O157 usually causes haemorrhagic colitis, but may have severe and potentially fatal complications, such as haemolytic uraemic syndrome. The infection is usually acquired by ingestion of food or water, or contact with animals or their environments. A number of people may have been exposed to the same sources of infection. The infectious dose is extremely low and secondary cases may therefore occur unless appropriate hygiene measures are taken. Specific clinical diagnosis is unlikely unless the case is associated with other laboratory-confirmed cases. Consequently, urgent laboratory notification of confirmed cases is essential to ensure that appropriate health protection measures are taken as soon as possible to detect and avoid further cases.

### 4.3.2 Paper-based and electronic notification

The Notification Regulations still allow for paper-based notification, but to reflect the significant changes in information technology, they now also allow electronic notification as a legitimate reporting mechanism, where the recipient (in this case, the HPA) consents.

Electronic notifications to the HPA are normally made via the CoSurv system, which meets the necessary requirements for secure electronic transmission of personal data. CoSurv is a set of interconnected database modules designed to collect and transmit both laboratory isolate and notification results from diagnostic laboratories. This system is the preferred mechanism for voluntary communicable disease reporting to the HPA in England. Laboratories using CoSurv are supported by a network of HPA staff that provide assistance with installation, maintenance and training. Guidance on laboratory reporting is published by the HPA on its website.[8]

The HPA will make the necessary changes to this system to ensure that the requirements of the Notification Regulations are supported so that CoSurv can be used for electronic

[8] http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1194944947381307

notification by laboratories. The HPA will also ensure that these requirements are appropriately reflected in the development of future applications intended to replace CoSurv and support laboratory reporting.

As with all notifications, electronic notification will comply with the Notification Regulations as long as it includes the data items listed in 4.3.4 below, as far as they are known to the operator of the laboratory (for example via the request form) and provided it occurs within the time frames specified in 4.3.1 above. However, urgent notification must initially be made orally.

If electronic notification is to be used, it is the responsibility of the operator of the laboratory to ensure that the information required to be reported by the Notification Regulations, as far as it is known to the laboratory, is available for transmission from its laboratory information management system.

In circumstances in which laboratories are unable or unwilling to notify causative agents electronically, paper-based notification may be used. A possible template for such notifications is provided in Appendix 2.

### 4.3.3 Cases already notified by a registered medical practitioner (RMP)

If a case has already been notified by an RMP on the basis of a clinical suspicion of a notifiable disease, the diagnostic laboratory is still required to notify the case if they identify any evidence of the infection caused by a notifiable causative agent. It is important to verify (or refute) a clinical diagnosis because it may have considerable impact on health protection actions in relation to the case, such as excluding someone from work, immunising contacts or other prophylactic measures.

### 4.3.4 Provision of relevant information

When making a notification, the operator of a laboratory must include the details listed below in so far as they are known. The laboratory is not expected to search for information that is not known to it (for example if the information is not on the request form).

Details should include the:

- name and address of the diagnostic laboratory;
- details of the causative agent identified;
- date of sample;
- nature of sample;
- name of the patient from whom the sample was taken;
- date of birth and sex of the patient;
- current home address, including postcode, of the patient;
- current residence (if not home address), including postcode if available;
- ethnicity of the patient;
- NHS number of the patient; and

- name, address and organisation of the person who solicited the test or tests that identified the causative agent.

The importance of certain data items above is discussed below.

#### 4.3.4.1 Details of the person who solicited the test

The HPA may need to investigate the case further and advise the RMP who requested the test and/or patient on specific control measures. It may be necessary to obtain more detailed information and further details of a case from the RMP. Contact details of the person who solicited the test(s) will enable the HPA to perform its function without unnecessary delay. When contacted by the HPA, the RMP who solicited the test is required to provide any information available that the laboratory would have been required to notify but was not known to it. The HPA may also wish to request other relevant information for health protection purposes.

Usually, this information should be provided in writing within three days of the request being made by the HPA. Should the HPA consider the case to be urgent then this information will need to be provided orally as soon as is reasonably possible. The HPA will determine whether the case is urgent based on the nature and ease of spread of the causative agent; the ways in which its spread can be prevented or controlled; the nature of the disease caused and the circumstances of the person (e.g. age, sex, occupation) from whom the sample was taken.

**Example 17: Hepatitis A in a food handler**

An RMP seeing a patient with acute jaundice may suspect a common cause such as gallstones and not notify the case, but still send a laboratory test to exclude viral hepatitis. If the laboratory identifies evidence of acute hepatitis A and notifies this to the HPA, this will only include the information listed in paragraph 4.3.4 above.[9] If the patient is a food handler, however, there may be a risk of transmission to others via food. Further health protection measures will be necessary, such as the identification and possibly the immunisation of those at risk. In order to identify such cases, it is important that the HPA is able to obtain all the information that would have been provided had the case been notified on the basis of clinical suspicion in the first place.

#### 4.3.4.2 Details of tests and results

The laboratory should report the date of sample, nature of sample (e.g. blood, cerebrospinal fluid (CSF), urine, lung biopsy) and details of causative agent identified by providing information on tests carried out and their results (e.g. blood culture, PCR, IgG/IgM). This information will allow the HPA to assess the accuracy and timeliness of the diagnosis and consider whether further testing is required.

[9] In this example, the RMP, on receipt of the laboratory report, would also be required to notify the case to the proper officer of the local authority.

#### 4.3.4.3 Current address if different from permanent address

This information is important because it may have significant bearing on health protection investigations, advice and interventions. For example, if a patient is currently in hospital while presenting signs and symptoms of the disease, they may put other patients at risk if not isolated. Other examples are patients in a care home, prison, boarding school or university halls of residence.

**Example 18: Salmonella in a boarding school**

A stool sample from a sixth form student in a boarding school grows *Salmonella* spp. The stool sample was submitted at the weekend by his family GP, who provided both the student's home address and school address on the request form. The probability that this case is part of an outbreak within the school is significant and it is likely that samples from other students will be sent to multiple geographically-spread laboratories. It is therefore important that the HPA is aware of both the patient's home and school addresses so that the potential common link with other cases is recognised and so that appropriate investigations may be initiated by the HPA office local to the school.

#### 4.3.4.4 Ethnicity

This information should be provided when available to the operator of a diagnostic laboratory because these data are important for monitoring health inequalities. The ethnic categories applied by the NHS should be used.[10]

### 4.4 Samples sent from one laboratory to another

Where a laboratory receives human samples and, under an agreement, sends them to another (secondary) laboratory, either a reference laboratory or a sub-commissioned laboratory, the operator of the first (primary) laboratory that receives the sample is legally responsible to ensure the causative agent is notified.

Notification may be made either by the primary laboratory, when they become aware of the results, or following formal arrangements, which are recommended to be agreed in writing, by the secondary laboratory, as the primary laboratory's agent.

However, the legal responsibility to ensure that the case is notified remains with the primary laboratory. In these cases, the day of identification for the notification purposes will be the day on which the primary diagnostic laboratory becomes aware of identification by the secondary laboratory.

### 4.5 Offences and penalties

It is an offence for the operator of the diagnostic laboratory to fail to comply with the requirements in the Regulations **unless there is a reasonable excuse as to why they were**

[10] NHS Ethnic Category Code.
http://www.datadictionary.nhs.uk/data_dictionary/attributes/e/enh/ethnic_category_code_de.asp

**unable to do so**. The offence is applicable to the corporate body that operates the laboratory. If there is not a corporate body responsible for operating the laboratory, then the offence would apply to the director of the laboratory. The penalty on summary conviction is a fine not exceeding level 5 on the standard scale (currently £5,000).

**Table 2: Causative agents, with explanatory notes and guidance on the need for urgent notification**

As regards urgency, the key consideration will be the likelihood that an intervention is needed to protect human health and the urgency of such an intervention. The likelihood of the diagnosis of an infection being considered urgent may also increase if it is part of a known or suspected cluster, or in someone with increased risk of transmission such as enteric infection in a food handler.

**NB:** This table is only for guidance and each case should be considered individually.

| Notifiable organisms | Definition / comment | Likely to be urgent? |
|---|---|---|
| *Bacillus anthracis* | | Yes |
| *Bacillus cereus* | Only if associated with food poisoning | No, unless part of a known cluster |
| *Bordetella pertussis* | | Yes if diagnosed during acute phase |
| *Borrelia* spp | | No |
| *Brucella* spp | | No, unless thought to be UK-acquired |
| *Burkholderia mallei* | | Yes |
| *Burkholderia pseudomallei* | | Yes |
| *Campylobacter* spp | | No, unless part of a known cluster |
| Chikungunya virus | | No, unless thought to be UK-acquired |
| *Chlamydophila psittaci* | | Yes if diagnosed during acute phase or part of a known cluster |
| *Clostridium botulinum* | | Yes |
| *Clostridium perfringens* | Only if associated with food poisoning | No, unless known to be part of a cluster |
| *Clostridium tetani* | | No, unless associated with injecting drug use |
| *Corynebacterium diphtheriae* | Notify without delay, before results of toxigenicity tests are known | Yes |

| Notifiable organisms | Definition / comment | Likely to be urgent? |
|---|---|---|
| *Corynebacterium ulcerans* | Notify without delay, before results of toxigenicity tests are known | Yes |
| *Coxiella burnetii* | | Yes if diagnosed during acute phase or part of a known cluster |
| Crimean-Congo haemorrhagic fever virus | | Yes |
| *Cryptosporidium* spp | | No, unless part of known cluster, known food handler or evidence of increase above expected numbers |
| Dengue virus | | No, unless thought to be UK-acquired |
| Ebola virus | | Yes |
| *Entamoeba histolytica* | | No, unless known to be part of a cluster or known food handler |
| *Francisella tularensis* | | Yes |
| *Giardia lamblia* | | No, unless part of known cluster, known food handler or evidence of increase above expected numbers |
| Guanarito virus | | Yes |
| *Haemophilus influenzae* | Invasive i.e. from blood, cerebrospinal fluid or other normally sterile site | Yes |
| Hanta virus | | No, unless thought to be UK-acquired |
| Hepatitis A, B, C, delta, and E viruses | All acute and chronic cases. | All acute cases and any chronic cases who might represent a high risk to others, such as healthcare workers who perform exposure-prone procedures |
| Influenza virus | | No, unless known to be a new sub-type of the virus or associated with known cluster or closed communities such as care homes |

| Notifiable organisms | Definition / comment | Likely to be urgent? |
|---|---|---|
| Junin virus | | Yes |
| Kyasanur Forest disease virus | | Yes |
| Lassa virus | | Yes |
| *Legionella* spp | | Yes |
| *Leptospira interrogans* | | No |
| *Listeria monocytogenes* | | Yes |
| Machupo virus | | Yes |
| Marburg virus | | Yes |
| Measles virus | | Yes |
| Mumps virus | | No |
| *Mycobacterium tuberculosis* complex | | No, unless healthcare worker or suspected cluster or multi-drug resistance |
| *Neisseria meningitidis* | Excluding asymptomatic cases (e.g. throat carriage) | Yes |
| Omsk haemorrhagic fever virus | | Yes |
| *Plasmodium falciparum, vivax, ovale, malariae, knowlesi* | | No, unless thought to be UK-acquired |
| Polio virus | Wild or vaccine types | Yes |
| Rabies virus | Classical rabies and rabies-related lyssaviruses | Yes |
| *Rickettsia* spp | | No, unless thought to be UK-acquired |
| Rift Valley fever virus | | Yes |
| Rubella virus | | No |
| Sabia virus | | Yes |

| Notifiable organisms | Definition / comment | Likely to be urgent? |
|---|---|---|
| *Salmonella* spp | Including *S.* Typhi and *S.* Paratyphi | Yes, if *S.* Typhi or *S.* Paratyphi or suspected outbreak or food handler or closed communities such as care homes<br>No, if sporadic case of other Salmonella species |
| SARS coronavirus | | Yes |
| *Shigella* spp | | Yes, except *Sh. sonnei* unless suspected outbreak or food handler or closed communities such as care homes |
| *Streptococcus pneumoniae* | Invasive i.e. from blood, cerebrospinal fluid or other normally sterile site | No, unless part of a known cluster |
| *Streptococcus pyogenes* | Invasive i.e. from blood, cerebrospinal fluid or other normally sterile site, or associated with necrotising soft tissue infection | Yes |
| Varicella zoster virus | | No |
| Variola virus | | Yes |
| Verocytotoxigenic *Escherichia coli* | Including *E. coli* O157 | Yes |
| *Vibrio cholerae* | | Yes |
| West Nile Virus | | No, unless thought to be UK-acquired |
| Yellow fever virus | | No, unless thought to be UK-acquired |
| *Yersinia pestis* | | Yes |

# 5. Role of local authorities in the notification process

## 5.1 Appointment of proper officer of the local authority

The local authority appoints a proper officer for the purpose of receiving and forwarding information about notifications within their area. In the majority of cases, local authorities have decided to appoint a consultant in communicable disease control/health protection based within the local HPA office as their proper officers, although some proper officers are, for example, senior environmental health practitioners.

## 5.2 Actions by local authorities

The primary aim of notification by RMPs is to enable the proper officer of the local authority to investigate promptly and take health protection measures to prevent further spread or transmission of infection or contamination and to reduce the public health impact.

## 5.3 Forwarding notifications

The proper officer of the local authority is required to disclose the content of notifications they receive from RMPs to:

- the HPA – however, if the proper officer of the local authority is an HPA employee, then notification by the proper officer to the HPA will be automatically effected;
- the proper officer of the local authority in which the patient usually resides, if different;
- the proper officer of the port health authority or the local authority in which the port is located, if the patient has disembarked from a ship, hovercraft, aircraft or international train, and this fact is known to the proper officer of the local authority who receives the notification, and they consider it relevant.

It is for the proper officer of the local authority to determine whether it is relevant to disclose information to the port health authority or the local authority for the port. Circumstances in which this might apply include, for example: when a patient was on a ship during the incubation period of the disease, when a patient was likely to have acquired the infection or contamination on the ship, or when there are implications for other passengers.

## 5.4 Time frame for forwarding notifications

The proper officer of the local authority is required to pass on information about a notification within three days of receiving the notification. Additionally, if the proper officer of the local authority considers the disease to be urgent, they must notify the case orally – usually by telephone – as soon as reasonably practicable.

In determining whether a case is urgent or not, factors that should be considered include the:

- nature of the suspected disease, including morbidity, case-fatality and epidemiology of the disease – for example, a rare disease, or one that is re-emerging, is likely to need urgent notification;

- ease of spread of that disease, route of transmission (for example, a highly infectious respiratory disease) or potential spread of contamination;
- ways in which the spread of disease or contamination can be prevented or controlled, for example by immunisation, disinfection, isolation or prophylactic treatment;
- patient's circumstances, including occupation, age and sex. These details have a bearing if, for example, a patient is a healthcare worker, a child attending nursery or a woman of child-bearing age.

There may be other circumstances where urgent notification is necessary, for example, if a disease appears to be a cluster of cases rather than individual cases.

# 6. Role of the HPA in the notification process

The HPA is responsible for protecting the community (or any part of the community) against infectious diseases and contamination. In relation to the notification process, it has four main roles:

## 6.1 Receiving and responding to notifications

When the proper officer informs the HPA about a notification, or when laboratories notify the HPA of cases of disease caused by notifiable causative agents, the HPA responds to these cases, often in collaboration with the local authority and other organisations.

This might involve:

- providing expert advice on prevention and control to individuals, local authorities, the NHS and other organisations
- undertaking further investigations of cases, incidents or outbreaks to understand the causes and what interventions might be needed to provide better control measures.

Sometimes, it might be necessary for the HPA to request further relevant information about a case from the RMP who made the clinical notification or from the RMP who solicited the test that led to the laboratory notification. Such information will be provided by the RMP on a voluntary basis. However, the RMP is required by the Notification Regulations to provide any information available that the laboratory would have been required to notify but was not known to it.

## 6.2 Surveillance reports

The primary purpose of notification is to enable the prompt investigation, risk assessment and response to cases of infectious disease and contamination that present, or could present, a significant risk to human health. However, the notification process also has an important secondary function of providing data for the epidemiological surveillance of disease and contamination. All data used for surveillance are anonymous and aggregated.

The HPA routinely publishes regular tabulations and analysis of RMP notifications on its HPA website and in other publications. It will also publish equivalent data on laboratory notifications.

## 6.3 Support for CoSurv and clinical notification reporting

Historically, microbiology reports from diagnostic laboratories and microbiologists, and notifications of infectious diseases (NOIDS) by RMPs, have been the foundation of communicable disease surveillance in England. The updated notification requirements will improve these functions.

Subsection 4.3.2 describes how laboratories can notify the HPA via the CoSurv system. It also explains that the HPA will ensure that the relevant requirements are reflected in the development of future applications intended to improve or replace CoSurv.

A new Information Standard is being developed by the HPA for submission to the NHS Information Standards Board. If accepted, this could be used by providers of GP information systems to facilitate clinical notifications by RMPs.

### 6.4 Providing proper officers

Most local authorities appoint local HPA staff (consultants in communicable disease control or health protection consultants) as proper officers for the purpose of the notification within their area.

# SECTION B
# Guidance on the use of health protection powers

## 7. Introduction to health protection powers

The aim of this section of the guidance is to assist all those with health protection responsibilities to understand health protection legislation. It explains what the law says and provides guidance on its practical application, setting out what actions should be taken, when, how and by whom.

The health protection powers are contained within the Public Health (Control of Disease) Act 1984 (as amended) together with the Health Protection (Local Authority Powers) Regulations 2010[11] and the Health Protection (Part 2A Orders) Regulations 2010.[12]

Subsection 7 provides an overview of the powers and the principles that underpin them. Subsections 8, 9 and 10 describe the powers and the processes in more detail.

### 7.1 Background

Legislation has long provided that local authorities and justices of the peace (JPs) can take certain actions to protect public health. Generally, there is no need to compel people to take action to protect others. Occasionally, however, voluntary measures are insufficient and legal powers are needed to deal with infections or contamination that present a significant risk to human health.

The reform of health protection legislation in England provides updated powers to JPs to make orders specifying actions to protect human health, and also provides specific health protection powers to local authorities where judicial oversight by a JP is not necessary.

The arrangements for controlling infectious diseases have been modernised and extended, and now also cover contamination, such as with chemicals or radiation.

Overall, powers are available to deal with a range of situations where an infection or contamination presents, or could present, significant harm to human health, and voluntary cooperation is not forthcoming. Where necessary and appropriate, the health protection powers enable restrictions or requirements to be imposed on people and in respect of things and/or premises to protect human health, provided strict criteria are met.

[11] http://www.opsi.gov.uk/si/si2010/uksi_20100657_en_1
[12] http://www.opsi.gov.uk/si/si2010/uksi_20100658_en_1

### 7.2 Authorities with a role in health protection

Local authorities (including port health authorities where appropriate), JPs and the Health Protection Agency (HPA) have statutory responsibilities for the protection of people against specific health threats. However, many other organisations may have responsibilities or be involved during a health protection incident, depending on the circumstances and scale. Locally, these include NHS primary care trusts, ambulance services, police constabularies and fire and rescue services.

At other levels, there may be involvement from the Environment Agency, the Food Standards Agency, the Nuclear Installation Inspectorate or from organisations from outside the public sector such as the Royal Society for the Prevention of Cruelty to Animals, the operator of a chemical installation site or staff based at a commercial port.

### 7.3 Types of health protection powers

Local authorities can employ two types of powers to deal with incidents or emergencies where an infection or contamination presents, or could present, a significant risk to human health. These powers are the local authority powers and the Part 2A Orders powers.

#### 7.3.1 Local authority powers

These powers provide local authorities with a range of measures that can be used to prevent, protect against, control or provide a health protection response to an incident or spread of infection or contamination that presents, or could present, significant harm to human health. They are specific powers that can be exercised directly by the local authority (i.e. without applying to a JP for a Part 2A Order as below).

These powers are explained more fully in subsection 8.

#### 7.3.2 Part 2A Orders

A local authority may apply to a JP for a Part 2A Order that imposes restrictions or requirements on a person (or persons), or relating to a thing (or things), a body or human remains, or premises. The order requires action to be taken to protect human health against infection or contamination that presents, or could present, significant harm to human health.

A Part 2A Order can impose restrictions or requirements to fit the circumstances – for example, a local authority could apply for an order to require that a person is detained in hospital; to restrict where a person goes or what contact they have with other people; to seize something, keep it in isolation, decontaminate it or have it destroyed; or to require that a premises is closed, decontaminated or destroyed.

The arrangements for Part 2A Orders contain safeguards to protect the interests of individuals who may be the subject of an application for an order. The requirement on local authorities to seek such orders through the judicial system is such a safeguard.

Part 2A Orders are explained more fully in subsections 9 and 10.

### 7.4 General concepts underpinning the legislation

This subsection describes general principles that apply to the powers.

#### 7.4.1 "All hazards" approach

The updated health protection powers are based on an "all hazards" approach that encompasses infection and contamination of any kind. This means that appropriate health protection action can be taken in response to new or unknown diseases or threats (for example, SARS or polonium 210) as well as known infections and contamination that could result in significant harm to human health. The "all hazards" approach is consistent with the International Health Regulations 2005, which aim to facilitate international responses to acute public health risks that have the potential to cross borders.[13]

#### 7.4.2 Risk assessment

The process of risk assessment is an essential part of determining whether and what health protection measures are necessary in relation to a particular set of circumstances.

A common approach to risk assessment is to identify the hazard – a hazard being anything that may cause harm to human health – and to assess:

- its impact if there were to be exposure to it, and
- the probability of the exposure occurring.

Any decision or advice about what to do will follow from the risk assessment.

In undertaking an assessment, consideration should be given to a range of factors, including who might be harmed, how the harm might happen and how serious it might be. The risk assessment should be updated as necessary, including after any interventions.[14]

Actions should be selected to prevent or mitigate the adverse human health consequences associated with a particular hazard, whether it is an unusual health threat from exceptional circumstances or a familiar disease.

There will be situations when there is insufficient information for a complete risk assessment to be done. For example, there may be scientific uncertainty about the health threat, the available evidence may be contradictory or the threat may be a new disease about which little is known. In these situations, explicit assumptions will have to be made regarding the potential magnitude of the health consequences and the likelihood of them occurring.

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[13] http://www.who.int/ihr/en/

[14] Health and Safety Executive, *Five Steps to Risk Assessment* http://www.hse.gov.uk/pubns/indg163.pdf

If the consequences for human health are assessed as very great, it could be proportionate to take measures to address the risk, even if the likelihood of the consequences occurring is relatively low or not fully known. This approach is known as the precautionary principle.

### 7.4.3 Proportionality and assessment of options

The vast majority of cases where the behaviour of a person, or group of people, is putting the health of others at risk can be effectively dealt with through advice and support to the person concerned or, where necessary, to those people who are responsible for that person's conduct or care. Most people will comply without the need for compulsion. Only when advice and support fail to alter the behaviour that puts the health of others at risk should legal health protection measures be considered.

Powers which impose restrictions or requirements must be used in a way that is proportionate to the risk to human health posed by a health threat in particular circumstances. They should only be used once a critical assessment of the available options to achieve the health protection outcome has concluded that other options can be discounted. This may be because voluntary cooperation is not forthcoming or has failed, because other options are not practical, or because there are good reasons to believe that they will not work. In effect, these health protection powers should be viewed as a last resort.

The Human Rights Act 1998[15] is relevant to this. Under this Act, public authorities are required to make decisions in a way that is compatible with the European Convention on Human Rights.[16] The health protection powers may have a bearing on a person's rights under the convention. These can only be restricted in certain circumstances. Where restrictions are imposed, they must be proportionate to the need. For example, a person's right to liberty (under Article 5) can only be restricted by a JP order, subject to the criteria laid down in the Act being satisfied, to prevent the spread of infection or contamination presenting significant harm to human health.

Other restrictions in the legislation may have a bearing on a person's "qualified" rights (e.g. under Article 8, the right to respect for private and family life). These require a balance to be struck between the rights of the individual and the needs of the wider community. These rights can be restricted in the interests of public safety, or for the protection of health, but restrictions should not be more onerous than they need to be to achieve the objective: in other words they must be proportionate.

### 7.4.4 The Regulators' Compliance Code

When exercising their powers as regulators, local authorities are required to have regard to the Regulators' Compliance Code and the principles of good regulation. The Local Authorities

[15] http://www.opsi.gov.uk/ACTS/acts1998/ukpga_19980042_en_1
[16] http://conventions.coe.int/Treaty/Commun/QueVoulezVous.asp?NT=005&CL=ENG

Coordinators of Regulatory Services (LACORS) has produced guidance for local authorities to help them understand the requirements of the code. This is available from LACORS.[17]
The purpose of the code is to promote efficient and effective approaches to regulation that improve regulatory outcomes without imposing unnecessary burdens on regulated entities.

### 7.5 Making use of the powers

This subsection sets out some considerations that should be borne in mind when considering the use of these powers.

Some of the powers are permissive in that they allow actions to be taken – such as the local authority power to request cooperation, and to disinfect and decontaminate on request.

Other powers require certain actions to be taken or impose certain restrictions. These powers are conditional on specific criteria being met. Before making use of one of these powers, local authorities and JPs must be satisfied that the criteria relevant to a particular threat to health are met. The criteria cover evidence of infection or contamination, assessment of the potential for significant harm to human health, risk of spread to others and necessity for action to be taken in order to reduce or remove that risk. These criteria are explained more fully in 10.1.3.
In assessing whether these criteria are (or in the case of an application for an order, appear to be) met, local authorities may, where relevant, find it helpful to consider:

- **Risk of transmission:** Are there ways in which the person concerned, and/or a potentially exposed person(s), are acting or are likely to act that would reduce, or increase, the risk of transmission? This addresses the specific risk of spread arising in the circumstances being considered.

- **Impact of transmission:** How serious would the harm to others be if transmission occurred? This includes the characteristics of the infection/contamination itself and any specific susceptibilities in others.

- **Necessity:** Have all other interventions been exhausted or discounted?

- **Proportionality:** Is the intervention proportionate to the risks?

- **Context:** Are there any other factors, including the impact of this case on the overall pattern of an outbreak/epidemic?

  For example, in an epidemic, an early case could be more significant in terms of relevant preventative action than a later one.

[17] LACORS, April 2008, *Guidance for Councils on the Regulators' Compliance Code.*

Some elements of the above will be required to be produced for the JP as part of the statutory evidential requirements applying to an application for an order about a person – see subsection 10.1.4.

In assessing which health protection powers are appropriate, local authorities should take account of the consequences of non-compliance.

### 7.6 Transitional issues

To ensure a smooth transition to the updated health protection system in April 2010, specific legal arrangements are in place. These transitional provisions are summarised in Appendix 3.

# 8. Local authority powers

## 8.1 General points

Local authorities have powers to require, request or take action for the purposes of preventing, protecting against, controlling or providing a public health response to the incidence or spread of infection or contamination which presents, or could present, significant harm to human health.

These powers are similar in some respects to those available to local authorities before April 2010, but redundant powers have been removed and the remainder updated.

Without applying to a JP for a Part 2A Order, local authorities have the power to:

- require that a child is kept away from school;
- require a headteacher to provide a list of contact details of pupils attending their school;
- disinfect/decontaminate premises or articles on request;
- request (but not require) individuals or groups to co-operate for health protection purposes;
- restrict contact with, or relocate, a dead body for health protection purposes.

## 8.2 Exercising local authority powers

When a local authority seeks to impose restrictions or requirements, criteria must be met similar to those that apply to orders granted by a JP. In order to exercise its power in relation to school children or dead bodies, the local authority must be satisfied that:

- they are dealing with a case, or a likely case, of infection or contamination;
- the infection or contamination is one which presents, or could present, significant harm to human health;
- there is a risk that others may become infected or contaminated;
- the chosen action is necessary to remove or reduce that risk;
- the action is a proportionate response to that risk.

No criteria are specified before a local authority can disinfect or decontaminate a thing or premises on request, though they may wish to bear such considerations in mind.

The “request” power can only be used for the purpose of preventing, protecting against, controlling or providing a public health response to the incidence or spread of infection or contamination which presents, or could present, significant harm to human health.

### 8.2.1 Notices

In respect of most of the local authority powers, a notice must be served setting out the restrictions or requirements the local authority wishes to impose. Details of what these notices must contain are given in the guidance to each power below.

The general provisions applying to the serving of notices in section 60 of the Public Health (Control of Disease) Act 1984 apply to all notices served by a local authority under these powers.

### 8.2.2 Powers of entry and inspection

A local authority has various powers to enter premises to carry out health protection functions. Judicial oversight is necessary to gain entry to a private dwelling or to secure entry to a premises without notice. Where entry under these powers is refused, a local authority can apply for a warrant under which entry can be forced. A warrant may also be required, for example, during the course of the investigation of the potential source of an outbreak.

Appendix 5 sets out these enforcement powers in more detail. It also identifies how the details of these powers were changed as a result of amendments to the 1984 Act.

## 8.3 Details of local authority powers

The local authority powers covering health protection are detailed below. Algorithms are included to show the steps a local authority should follow in applying each power and examples to illustrate when the powers might be used.

## 8.4 Keeping a child away from school

***Regulation 2: What is the power?***

A local authority may use this power to require that a child be kept away from school to help to prevent the transmission of infection or contamination in an environment where children are in close contact for much of the day. This may be particularly important in relation to younger children, who may not have as strong an immune response or be able to maintain as high standards of hygiene as older children or adults.

Where attempts to secure voluntary cooperation from a parent to keep a child away from school are not effective, despite the parent of the child having been made fully aware of the issue, the local authority may wish to consider using this power. The responsibility for meeting the requirement will lie with the parent of, or person with parental responsibility for, the child.

***When can this power be used?***

The power can only be used if:

- the child is, or may be, infected or contaminated; **and,**
- if the child's attendance at school could cause significant harm to the health of others because of the risk of infection or contamination; **and,**
- if it is necessary to keep the child away from school in order to reduce or remove that risk; **and,**
- if keeping the child away from school is a proportionate response to the risk of infection or contamination presented by that child.

It is not necessary for a formal notification to have been made by an RMP to the proper officer under the Health Protection (Notification) Regulations in respect of the child nor for the child to be presenting symptoms at the time. The key issue, as stated above, is the risk the child presents to others.

The power can only be used when:

- the child in question is under the age of 18, and,
- the child is in full or part time education, and,
- the school is an educational institution providing primary or secondary education, or a maintained nursery school.

The power cannot be used:

- against a person who is aged 18 or more;
- to exclude a child from any other form of gathering (other than at the educational institutions specified above) including any other form of extra-curricular activity (e.g. attendance at a scout group, Sunday school, or sports club).

If a further restriction on the child's movements or contact with others is required, then the local authority should make a formal request using the 'request' power outlined below or apply to a JP for a Part 2A Order.

***How should the requirement be imposed?***

The local authority imposes the requirement by serving written notice of the requirement on a parent of the child concerned. It is then that parent's responsibility to keep the child away from school. Parent in this context includes any person who, in respect of a child, has parental responsibility for that child, or who has care of that child.[18]

This notice must contain all of the following information:

- the date from which the requirement commences;
- the duration of the requirement (up to a maximum of 28 days);
- why the requirement is believed to be a necessary and proportionate measure;
- the penalty for failing to comply with the notice; and,
- contact details for an officer of the local authority who is able to discuss the notice.

A suggested template for the notice is provided at Appendix 4.

The local authority is required, as soon as is reasonably practicable, to inform the headteacher of the child's school that a notice has been served to keep the child away from school.

[18] Parental responsibility has the same meaning as in the Children Act 1989. Note that in determining whether an individual has care of a child, any absence of that child at a hospital or boarding school – or any other temporary absence – should be disregarded.

### *How long should the requirement last?*

How long a child should be required to stay off school will vary with the nature and severity of the infection or contamination, the duration of the illness and the risk posed by the individual circumstances. The notice must therefore state the duration of the requirement, up to a maximum of 28 days. If evidence suggests that a child still presents a risk after the expiry of a notice, the local authority may serve a further notice. This must be subject to the same decision-making process as the original notice.

When a notice expires and no further notice is to be served, the local authority must inform the parent of the child and headteacher of the child's school.

### *Can the requirement be reviewed?*

The parent may request a review of a current notice to keep a child off school. The first time the parent makes such a request, the local authority is required to review the notice within five working days. There is no requirement to conduct further reviews of the same notice at the request of the parent and therefore the local authority has discretion whether to conduct subsequent reviews.

If a new notice is served in respect of the same child, then the parent can request a further review and again the local authority is required to carry this out within five working days.

It is for the local authority to determine the form the review should take. However, the review should be conducted in consultation with other appropriate health protection professionals.

The purpose of the review is not to challenge the original decision, but rather to review whether the criteria for keeping a child off school are still met on the date of the review. As a result of a review, a notice may be varied or revoked, or remain in place.

The local authority must inform the parent of the child and the headteacher of the child's school of the outcome of any review, and if the notice has been revoked or varied in any way as a result of that review.

### *The child's right to an education*

The use of this power does not affect a child's right to an education. Local authorities have a standing duty under section 19 of 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.[19]

[19] Department for Children, Schools and Families guidance at http://www.dcsf.gov.uk/everychildmatters/ete/schools/alternativeprovision/altprovision/

***Is there a penalty for non-compliance?***

Where the parent fails to comply with a notice requiring them to keep their child off school they are liable to pay a fine on conviction not exceeding level 2 on the standard scale. A further fine (up to 50% of a level 1 fine) is payable for each additional day after conviction the parent fails to keep the child off school.

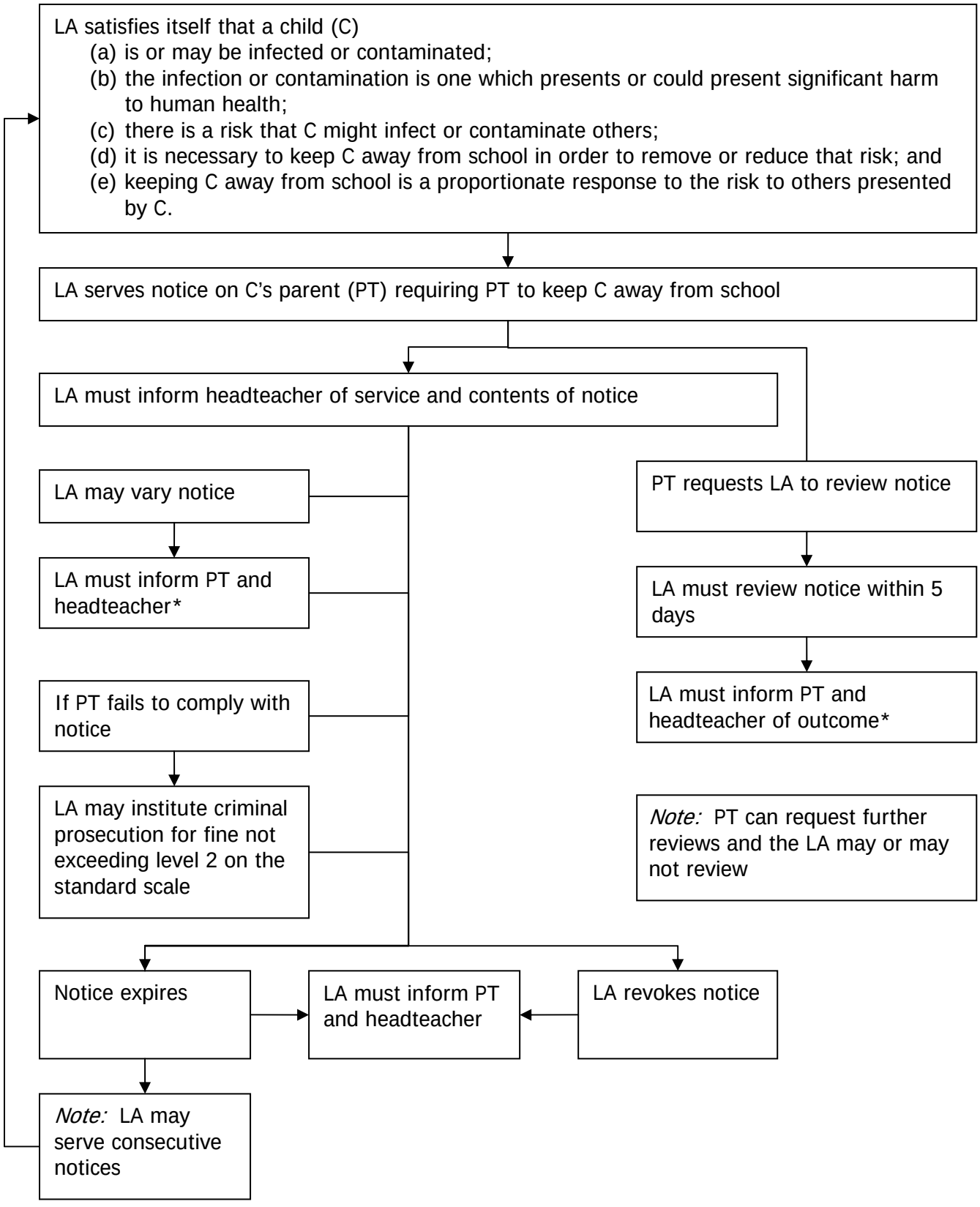
If non-compliance continues, the local authority may wish to consider further action to mitigate any risk to public health.

***Why might a child need to be kept away from school to protect public health?***

**Example 19: Measles in a child**
If a child is suspected of having measles, it would be essential for the child to remain off school for a period of five days after the onset of the rash to prevent additional cases arising through contact.

**Algorithm 2: Keeping a child away from school**

Health Protection (Local Authority Powers) Regulations 2010 (Regulation 2)




*as soon as reasonably practicable

## 8.5 Requirement for a headteacher to provide contact details of children attending school

### *Regulation 3: What is the power?*

This power enables the local authority to obtain information needed to conduct a contact-tracing exercise to establish who might have been exposed to a health risk while on the premises of a school.

### *When can this power be used?*

The local authority can require the headteacher of a school, or in the headteacher's absence the person deputising, to supply the contact details of all children attending the school, or a group of children attending the school, if the local authority has reason to believe that they may have been exposed to an infection or contamination which presents, or could present, significant harm to human health.

Possible exposure could be from anyone who is, or has recently been, on the school's premises. This could include a member of staff, or any other adult or child that children may have come into contact with in the course of their attendance at the school and while on the school premises.

All of the following conditions must be met for this power to be used:

- a person (any adult or child) who has recently been on the school's premises is, or may be, infected or contaminated;
- the infection or contamination is one that presents, or could present, significant harm to human health;
- there is a risk that the person may have infected or contaminated pupils at the school;
- the list is necessary to trace children who may have had contact with the person so as to ascertain whether they are, or may be, infected or contaminated;
- requiring the list (and contacting children who may be infected or contaminated) is a proportionate response to the risk; and,
- the school is an educational institution providing primary or secondary education, or a maintained nursery school.

This power cannot be used to require the provision of contact details of children if the potential exposure did not occur on the school's premises. If the potential exposure occurred off the school premises, but those who may have been exposed subsequently returned to the school premises thereby potentially infecting or contaminating other pupils, then this power could be used to obtain the contact details of relevant pupils.

If a local authority needs contact details for school pupils who may have been exposed to a health risk while off the school's premises, and the headteacher refuses to provide them, the local authority could make a formal request using the power to request cooperation for health protection purposes, or if necessary apply to a JP for a Part 2A Order.

This power cannot be used to require the contact details of adults in any setting.

***How should the requirement be imposed?***

In order to exercise this power, the local authority must serve a written notice on the headteacher. The written notice must:

- specify a time limit by which the contact details must be provided to the local authority;
- specify an address where the list is to be sent;
- provide contact details for an officer of the local authority who is able to discuss the notice.

The legislation allows the headteacher to supply the requested contact details via electronic communication (i.e. e-mail) **but**:

- the person receiving the contact details must have consented, in writing, to receiving them electronically;
  **and**,
- the contact details must be sent to the address, or number, specified by the person who is to receive them.

A suggested template for the notice is provided at Appendix 4.

***Is there a penalty for non-compliance?***

It is expected that a headteacher's professional responsibility for children in their care will ensure compliance. Nevertheless, if the headteacher fails to comply with the requirement without reasonable excuse, they may be liable upon summary conviction to a fine at level 1.

***What about data protection?***

A notice requiring a headteacher to provide children's contact details can only be served where necessary and appropriate for the purposes of protecting human health. A headteacher is under a legal duty to disclose the information and is therefore exempt from the non-disclosure principles of the Data Protection Act.

However, with electronic as with other methods of communication, the person sending the information to the local authority, and the local authority receiving it, should take any necessary steps to ensure that the data is transmitted and held securely.

Although the legislation refers only to the contact details of pupils, the local authority may use this information to liaise with the parent of the pupil at that address (including someone who is not a biological parent but who has parental responsibility for, or care of, the child).

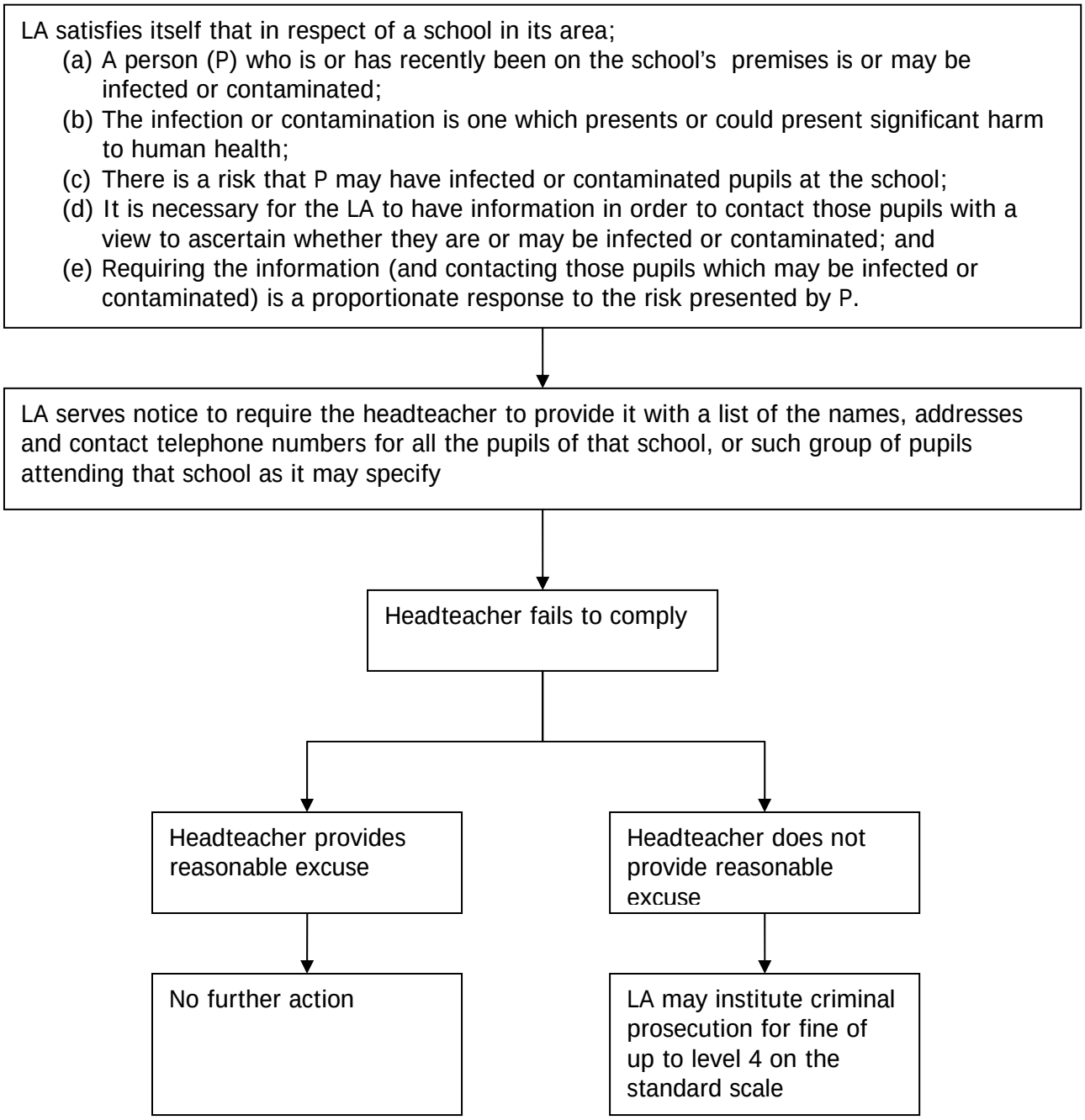
***Why might a local authority require a headteacher to provide a list of contact details of pupils attending a school?***

**Example 20: *Escherichia coli* O157 outbreak**

A child at primary school is diagnosed with *E. coli* O157. Subsequently several other children from the same class present with bloody diarrhoea. It is reasonable to suspect that the children's illnesses are linked cases in an outbreak of a potentially fatal infection. It is essential for these cases to be identified and appropriately investigated in order to prevent further spread of the infection through food/water borne and/or person-to-person transmission.

**Algorithm 3: Requirement for headteacher to provide contact details of children attending school**

Health Protection (Local Authority Powers) Regulations 2010 (Regulation 3)



## 8.6 Disinfection or decontamination of things or premises on request

***Regulations 4, 5, 6 and 7: What are the powers?***

The local authority has a discretionary power to disinfect or decontaminate:

- a thing on the request of the owner;
- a thing on the request of the person with custody or control of it;
- a premises on the request of the owner;
- a premises on the request of the tenant.

Premises has a wide meaning and includes any place, land, vehicles (including a train, vessel or aircraft) and any tent or movable structure; it can also refer to an offshore installation.

In the case of a request by a tenant in respect of premises, the local authority must be reasonably satisfied that the premises in question will not lose financial value as a consequence of the disinfection or decontamination.

The local authority is not obliged to act on the request.

If the local authority does choose to fulfil the request, then they can, if they wish, arrange for the disinfection or decontamination to be carried out by another party rather than undertaking the task themselves.

***Can the local authority make a charge?***

If the local authority decides to fulfil the request, it may make a charge for the cost incurred. The person who makes the request is liable to pay that charge. The local authority may only make a charge if:

- before the work is carried out, it obtains the agreement of the person requesting the service to pay the charge; and,
- the charge does not exceed the cost incurred by the local authority in carrying out the disinfection or decontamination (either directly or through a contractor).

***What about disinfection or decontamination without a request from the owner or tenant?***

There may be cases where the local authority considers it necessary (due to a risk of significant harm to human health) for an article or premises to be disinfected or decontaminated, but has not received a request, and the owner, person with custody or control of the thing, or tenant of the premises is unwilling to cooperate. In such cases, the local authority might use the power to request cooperation, and/or apply to a JP for a Part 2A Order to require disinfection or decontamination.

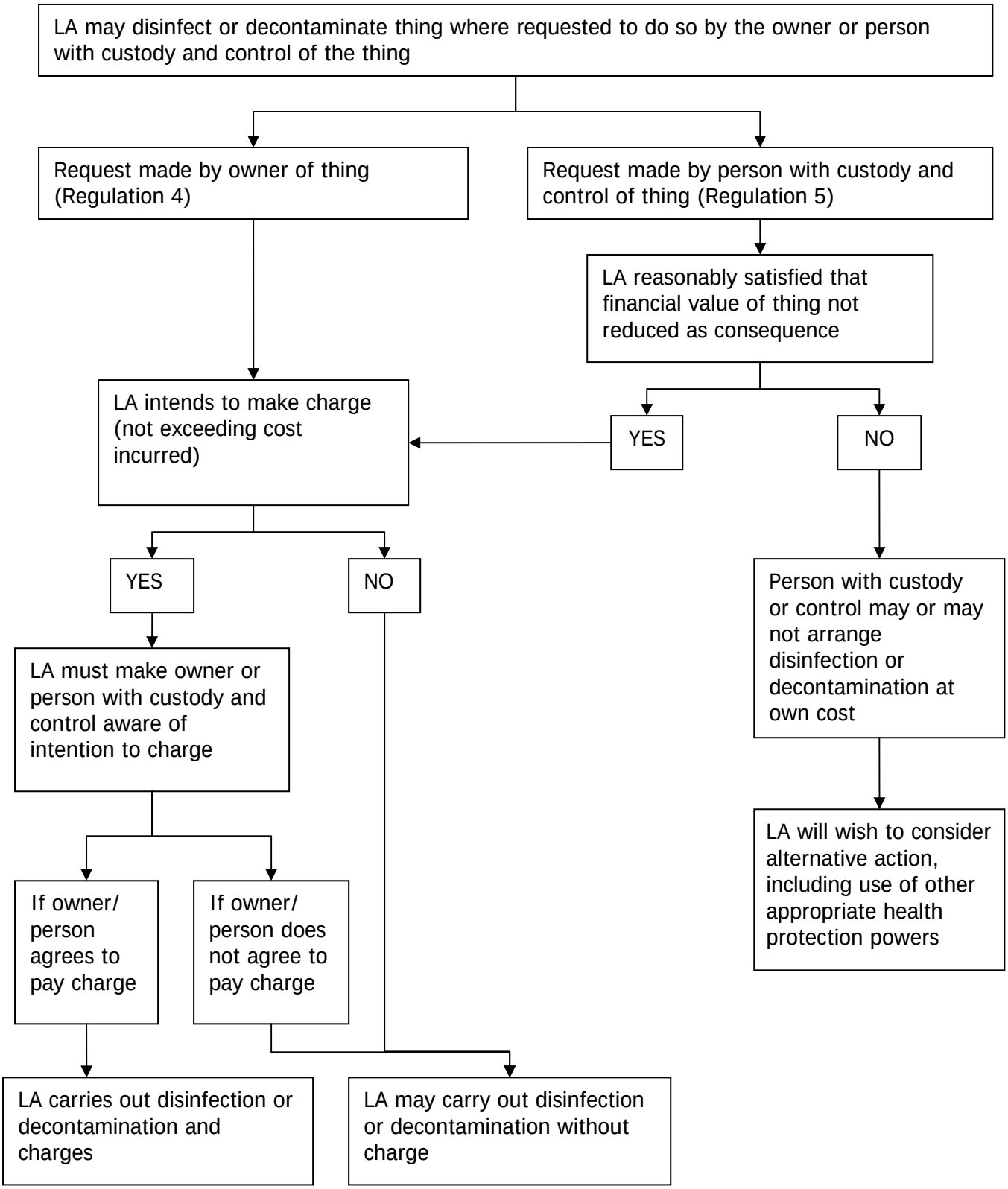
***Why might it be necessary for premises to be disinfected or decontaminated?***

**Example 21: Cyanide salt**

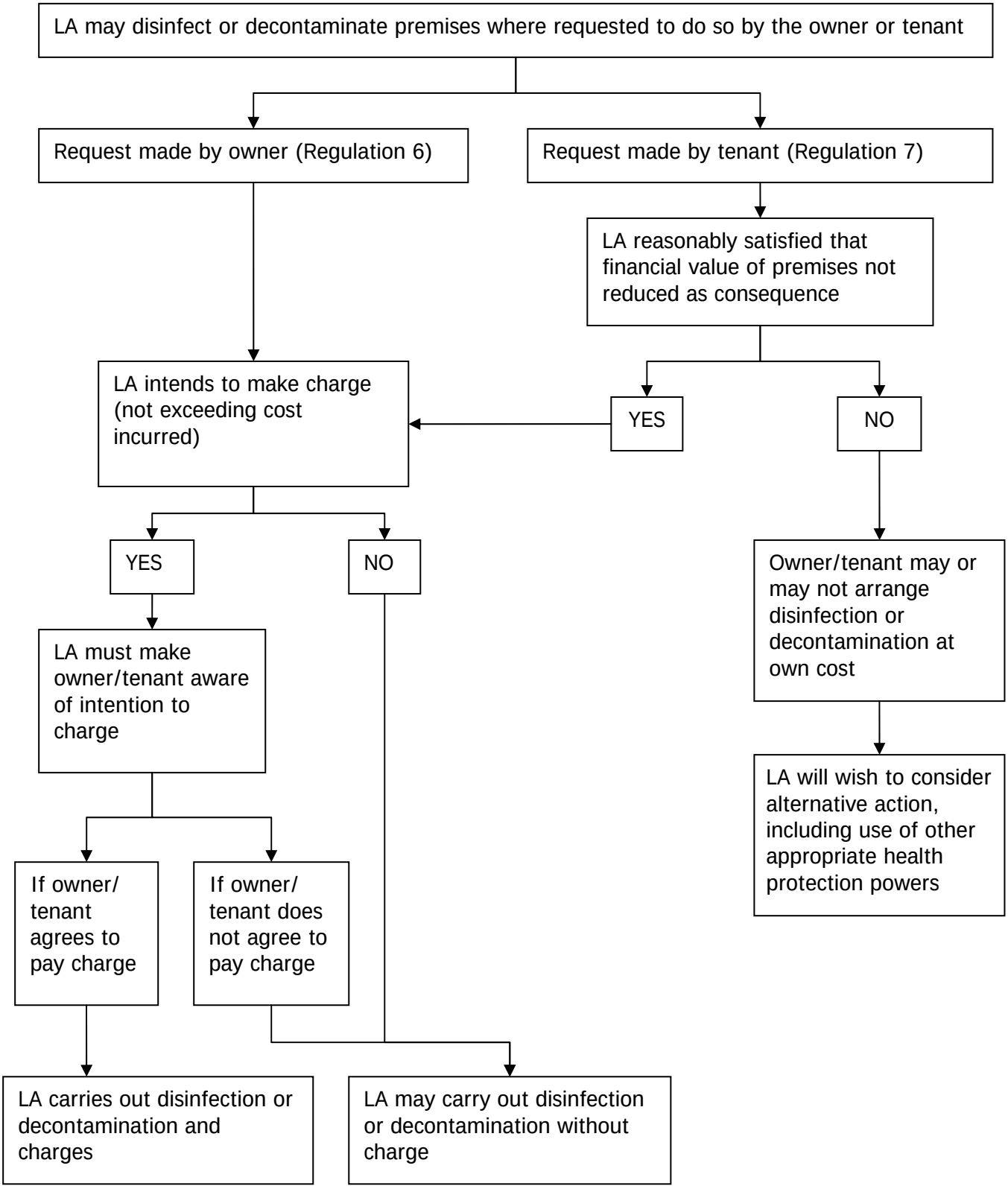
A jeweller commits suicide by ingesting a cyanide salt in a privately owned family home. Cyanide salts are suspected to have been dispersed around the property. The site is further contaminated by vomiting of the individual as a consequence of ingestion. The police attend the property and secure it, advising the other family members to seek alternative accommodation. A visible container of cyanide salts is removed by a specialist waste contractor called out by the police, but no further decontamination is carried out.

Under the local authority power to decontaminate on request, the local authority could, on the request of the family, decontaminate the property (and recover the costs if appropriate), thereby avoiding a situation in which the property remains unoccupied and the family are denied access to their home or possessions.

**Algorithm 4: Disinfection or decontamination of things or premises on request**
Health Protection (Local Authority Powers) Regulations 2010 (Regulations 4 and 5)



**Algorithm 5: Disinfection or decontamination of things or premises on request**
Health Protection (Local Authority Powers) Regulations 2010 (Regulations 6 and 7)



## 8.7 Requests for co-operation for health protection purposes

### *Regulation 8: What is the power?*

Local authorities have a general power to ask a person, or a group of people, to take, or refrain from taking, any action to protect human health. This allows a flexible response to unforeseen threats to human health where no other local authority power is relevant and where application for a JP order is not required.

The request must be for the purpose of preventing, protecting against, controlling, or providing a public health response to infection or contamination that presents, or could present, a significant harm to human health.

### *How does this power relate to applying for a JP order?*

It is not necessary for a local authority to make a request using this power before applying for a JP order. However, the JP might legitimately ask what steps had been taken to secure voluntary compliance with health protection measures before making an application for an order. In certain circumstances, it may therefore support the application for the JP order to demonstrate that compliance has first been sought through use of this request power.

If a person does not comply with the request made under the request power, the local authority can still apply for a JP order if appropriate and necessary.

### *Can the local authority offer compensation or expenses?*

The local authority can offer a compensation payment or expenses as part of the request.

### *How should the request be made?*

The local authority makes its request by serving a notice on the person or group of people in question setting out the terms of their request. The notice must include contact details for an officer of the local authority who is able to discuss the request.

A suggested template for the notice is provided at Appendix 4.

***Why might a local authority need to make a formal request for co-operation?***

**Example 22: Requesting food handlers to stay away from work, e.g. a chef infected with Shigella who wants to return to work**

A chef, who has been identified as positive for the highly infectious food poisoning infection Shigella, is keen to return to work earlier than recommended by national guidance. The guidance says that before returning to work as a food handler a person must have two stool samples, taken at intervals of not less than 48 hours, which are clear of the infection.

The local authority power to request cooperation could be used to formally request that the individual stay off work and provide the necessary stool samples for microbiological testing. The request could remind the chef of his obligation to inform the Food Business Operator (FBO) of his infection as is required under food hygiene legislation. If this request were not effective, the local authority could apply for a Part 2A Order from a JP to prevent the chef from working.

*NB: Used in this way, the request power – backed up by a Part 2A Order if necessary – replaces powers in the Public Health (Infectious Diseases) Regulations 1988, which enabled a local authority to require infected food handlers to stay off work and undergo medical examination.*

## 8.8 Restriction of contact with, access to, or relocation of, dead bodies

***Regulations 9, 10 and 11: What are the powers?***

A local authority has specific powers in relation to dead bodies. Where a body is, or is suspected of being, infected or contaminated and may present a risk to human health, the local authority may restrict contact with or access to the body, or may relocate the body.

The legislation allows a local authority to:

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

***When can these powers be used?***

These powers can only be used by a local authority where strict criteria are satisfied regarding the risk the body represents. **All** of these criteria must be satisfied:

- the body is or may be infected or contaminated;
  **and**
  the infection or contamination is one which presents, or could present, significant harm to human health;
  **and**

- there is a risk that the body might infect or contaminate people;
  **and**
- it is necessary to take the required action in order to remove or reduce that risk;
  **and**
- taking the required action is a proportionate response to the risk presented by that body.

***Is the body under the coroner's jurisdiction?***

Where a body is under the jurisdiction of the coroner, the coroner has the right to possession of the body and has authority over its physical control, including relocation.

The legislation does not in any way limit or restrict the duties of the coroner. Therefore:

- the legislation does not, and cannot, prevent someone with coronial authority from exercising their legal right to have access to, or contact with, the body;
- coronial jurisdiction overrides any permission the local authority might grant under the legislation for an individual to have contact with a body.

This means that, although consent from a local authority to have access to the body may have been given to a person under health protection legislation, it does not mean that the access to the body is necessarily lawful since the access may be unlawful under coronial law. Therefore, in granting access or contact in such circumstances, the local authority may have acted contrary to coronial law.

Where a local authority decides it is necessary and proportionate to use these powers, it should therefore inform the coroner's officer and confirm that there are no objections. Coroners and their deputies are always available, through their officers. Contact details for the coroner's office should be available to local authorities, but if not they can be obtained from the local police, including out-of-hours contact details in the event of an emergency.

***What degree of contact should be restricted?***

A frontline health protection professional is best placed to make a decision about the type of contact with the body that presents a risk (perhaps by seeking advice from other professionals as appropriate). It is for the local authority to decide whether it is necessary to restrict contact with the body only, or to take the further measure of restricting access to the room where the body is located.

***Can the local authority grant permission for certain individuals to have contact with a body?***

The local authority can specify the individuals it authorises to have contact with the body when a restriction is in place. Again, the frontline health protection professional should be consulted in deciding whether and what contact is appropriate. The local authority might have regard to requests in respect of, and even reach agreements with, the individuals who need to be in contact with the body, for example those who prepare the body for viewing or burial or those involved in the performance of religious offices.

No offence is committed by any person acting with the authority and under the instruction of a coroner.

### *Relocating a body*

If the location of the body means that contact cannot be effectively restricted, then the local authority can use this power to relocate the body to another place where contact can be effectively restricted. The local authority can arrange for the body to be relocated by another party.

Before relocating the body, the local authority must take reasonable steps to inform the person with charge or control of the premises where the body is located of its intention to take action. That person is then obliged to cooperate – failure to do so is a criminal offence.

This power can only be used subject to a coroner not having jurisdiction over the body.

Relocation might be as simple as moving the body to a room with a lockable door, or an even more secure location, such as a mortuary, if this is believed to be necessary.

This regulation is only to be used to protect people from infection or contamination. Relocating the body must be a proportionate response to the risk of significant harm to human health.

These powers do not deal in any way with disposal of the body. A local authority can apply to a JP to make an order for burial or cremation under Part 2A of the Public Health (Control of Disease) Act 1984 (see subsection 10.3). Part III of the 1984 Act covers disposal of bodies in certain other circumstances.

### *How should the situation be handled?*

The death of a relative or loved one is an emotional time for relatives, partners and friends. There may also be cultural and religious considerations concerning an individual's death rites and burial. As set out above, the power to restrict contact with the body should only be used if it is a proportionate response and the relevant criteria are satisfied.

There are no specific requirements in law regarding communications between the local authority and the relatives of the deceased. The local authority will wish to ensure that appropriate communication is conducted sensitively.

### *How should the restriction be imposed?*

In order to restrict contact with or access to a body, the local authority must serve a written notice on the person with charge or control of the premises in which the body is located. The notice must contain all of the following information:

- clear instruction that unauthorised contact with the body and/or entry to the room where the body is located (as appropriate, according to the powers used) is prohibited;
- the statement that breach of the prohibition is an offence;

- contact details for an officer of the local authority who is able to discuss the notice; and,
- details of the legislation under which the prohibition is imposed.

The person receiving the notice served by the local authority must, without delay, arrange for a copy of the notice to be conspicuously displayed near the body, or on all entrances to that room where entry into the room is prohibited.

Suggested templates for these notices are provided at Appendix 4.

***How can the restriction be enforced?***

The following constitute offences if the action was taken without reasonable excuse:

- a person breaches a prohibition in relation to a body;
- a person in charge of the premises in which a body is located and in receipt of a notice fails to arrange for a copy of the notice to be displayed;
- a person removes or defaces a displayed notice;
- a person in charge of a premises in which a body is located fails to co-operate with a local authority exercising the power to relocate a dead body.

These offences are punishable upon summary conviction with a fine at level 3.

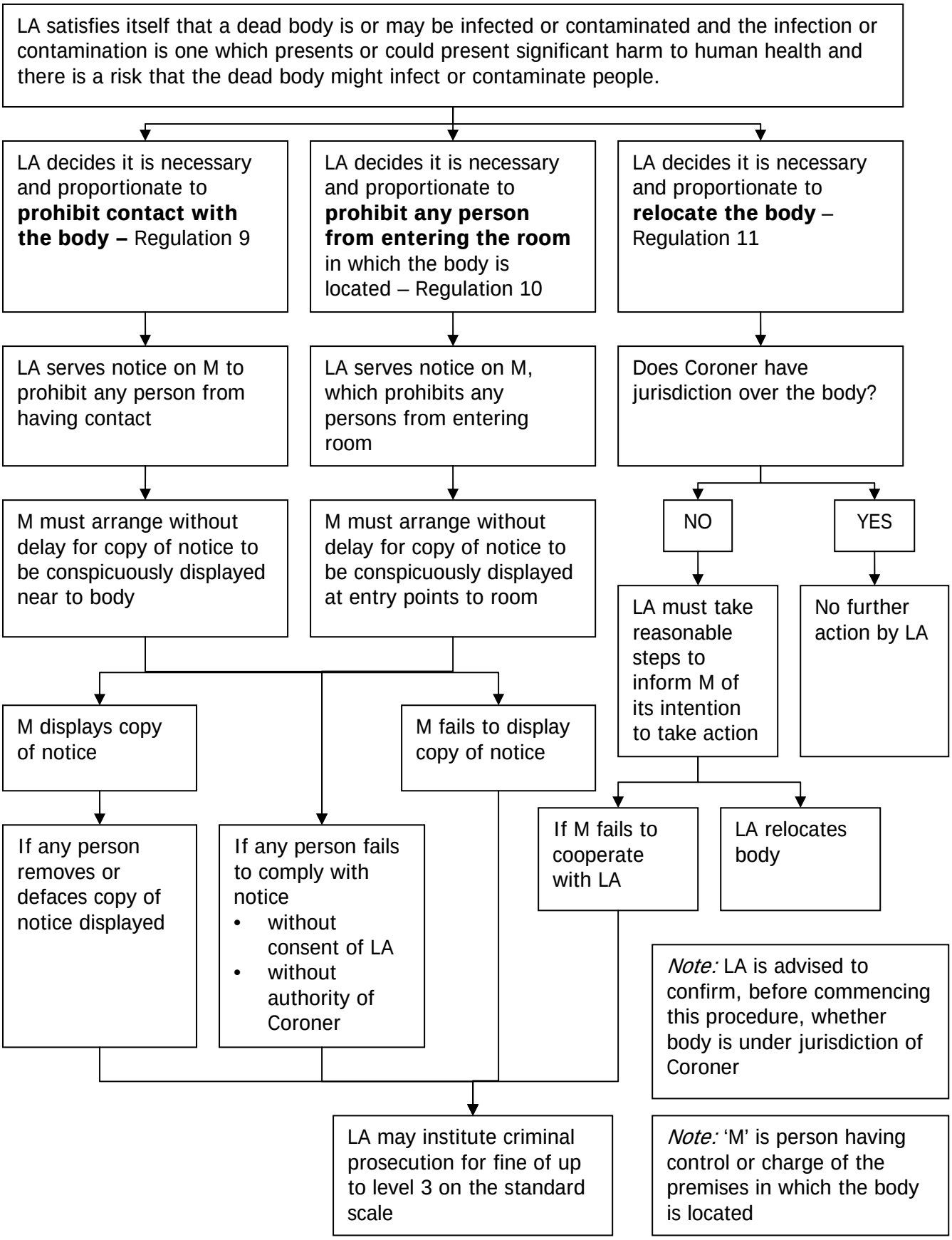
An offence has **not** been committed in relation to the first bullet point (above) if:

- the person has the consent of the local authority to have contact with the body;
- the person is exercising the functions of a coroner or is acting under the authority of a coroner.

***What type of restriction or requirement relating to the handling, transport or disposal of human remains might a local authority need and why?***

**Example 23: Disposal of a body following death from self-poisoning with cyanide salt**
In the event that an individual dies from self-poisoning with a cyanide salt (see example in subsection 9.3.3) within a communal setting, such as a jewellery shop or workshop, the bodily fluids and body remain a risk to other close contacts handling the body. Under these powers, access to the body could be restricted, or the body relocated, to prevent the risk of spreading contamination to other people.

**Algorithm 6: Restriction of contact with, access to, or relocation of dead bodies**
Health Protection (Local Authority Powers) Regulations 2010 (Regulations 9, 10 and 11)



# 9. Part 2A Orders

## 9.1 General Points

A local authority can apply to a justice of the peace for an order (Part 2A Order) if it considers it necessary to deal with a threat to human health from infection or contamination that presents, or could present, significant harm. It is for the JP to decide whether an order is necessary to address the risk. If the JP is satisfied by the local authority's case, an order can be made under the 1984 Act.

It is not necessary for the local authority to have used the "request" power (see 8.7) before applying for an order. An immediate application for a Part 2A Order could be the right step to deal with an urgent situation quickly.

Where more than one local authority is involved, or it is not clear which local authority should apply for an order, local authorities are required to agree which one of them should do so.

A Part 2A Order can be made in relation to:

- a **person** (or persons),
- a "**thing"** (or things),
- a **body or human remains**,
- **premises.**

A Part 2A Order can also be made requiring a person to give information about a "related party", "related person" or "related thing", as relevant to the particular case.

In the 1984 Act, and the regulations made under it, the word "thing" has a wide meaning and includes animals and plant material as well as inanimate objects. It can also, in certain contexts, mean a body or human remains. "Premises" also has a wide meaning and includes any place, land, vehicles, train, vessel or aircraft, and any tent or movable structure. It can also refer to an offshore installation.

The powers available to the JP are flexible, in that they allow the JP to make an order to address the particular problem at hand. The 1984 Act lists a range of restrictions or requirements that an order may impose. The JP can also impose additional restrictions or requirements to those listed, if they are necessary to reduce or remove the risk in a particular case. Subsection 10 gives details of the different types of Part 2A Orders and the restrictions and requirements that might be imposed.

A restriction or requirement cannot be imposed for any purpose other than to reduce or remove the risk. Furthermore, if an additional restriction or requirement that is not listed in the 1984 Act is applied, it must not be more restrictive or onerous than those listed (which outline the maximum limits of the respective restrictions or requirements which may be imposed). For

example, a JP could not include in a Part 2A Order a requirement that a person must accept medical treatment.

A Part 2A Order can be expressed in conditional terms, that is, that the action is only to be taken if certain things happen, or fail to happen. Similarly an order might refer to consequential stages. For example, it may state that certain articles are to be decontaminated, but in the event that this fails to deal with the risk then the articles are to be destroyed.

A Part 2A Order can contain a power of entry – and should do so – if this is needed to effect the order. A JP can order the same entry powers and ancillary powers under a Part 2A Order as they can under a warrant under section 61 of the 1984 Act. If the local authority believes this is necessary, this should be made clear in its application for an order. The person authorised to enter by the Part 2A Order may be, but does not have to be, a proper officer.

Information about liaising with courts and the procedure for applying to a JP for a Part 2A Order is provided in subsection 9.7.

### 9.1.1 Compensation, expenses and costs

A JP can require payment of compensation or expenses in connection with the measures specified in a Part 2A Order. For example, a local authority could be required to pay compensation to a person who incurs financial loss as a result of an order.

However, the JP cannot assign liability for the costs of carrying out the measures in the Part 2A Order. (Note that this does not affect the JP's ability to apportion the costs of the proceedings.) In some cases, where the local authority needs to take action as a result of a Part 2A Order, the authority may make a charge. (For more details, see subsection 9.6.)

### 9.1.2 Authority for action

The JP may direct that certain action is to be taken to give effect to the Part 2A Order. This could apply, for example, if the JP wished to require a person to be detained in hospital. Then the order could direct a primary care trust or hospital trust, or another appropriate body, to allocate a bed for that person and to ensure that the person did not abscond. (Normally, of course, the availability of a bed would be arranged beforehand, and its inclusion in the order would be a formality.)

If a Part 2A Order requires anyone to take any action, then the order itself provides the authority for that person to take that action. For example, an order might require a hospital manager to detain a person in hospital in which case the order confers the legal authority to detain that person.

### 9.1.3 Part 2A Orders applying to groups of people, things or premises

Where necessary, an order can apply to more than one person, thing or premises, or to a group of people, or things, or premises. There is no need for multiple orders.

This guidance should be read with this in mind so that any reference to a person, a thing, or premises, can also refer to more than one, or a group. This also applies to related persons, things or premises. The JP will need to be satisfied that the relevant criteria are met in respect of each individual person, thing or premises in the group to be covered by the order, and the relevant requirements – for example, relating to evidence – must be met in each case. In addition, the local authority may request the JP to combine one or more orders.

### 9.1.4 Duration of Part 2A Order

A Part 2A Order must specify the period for which it is to apply. The maximum period of effect of any order relating to a person is 28 days from the date of the order. There are no time limits in the legislation for other orders that relate to premises or things. If the problem has not been resolved when the order expires the JP can extend the period of the order, again limited to a maximum of 28 days if the order relates to a person.

The legislation provides that any extension of a Part 2A Order is “by further order”. That further order requires the same process as the original order – it is subject to application by the local authority and the same requirements apply.

Because Part 2A Orders relating to people are time-limited, they are likely to be most useful in short-term situations. They are not a tool for managing long-term problems.

### 9.1.5 Enforcement of a Part 2A Order

A person who fails without reasonable excuse to comply with a restriction or requirement imposed by or under a Part 2A Order, or obstructs a person in the execution of an order, commits an offence and is liable on summary conviction to a fine of up to £20,000. The court may additionally require anyone convicted of such an offence to take or pay for any remedial action required as a result of the offence.

If a person is required by a Part 2A Order to be detained, or to stay in isolation or quarantine, but absconds, they may be taken into custody by the police while the order remains in force.

A proper officer (or other officer if authorised by the Part 2A Order) may enter premises (other than a private dwelling) if necessary to check if any contravention of an order has taken place, subject to giving the occupier 24 hours’ notice. See Appendix 5 on powers of entry and inspection.

## 9.2 The local authority’s powers and duties

To make an application for a Part 2A Order, the local authority should first determine through a risk assessment that an order is necessary to protect human health, that the required evidence is available and that the relevant criteria appear to be met. In determining whether to apply for an order in relation to a person(s), the local authority should consider the advice given in 10.1.2.

It is the local authority's responsibility to prepare the application. For a Part 2A Order about a person, the local authority must provide the required evidence, which will include assessing the suitability of the evidence-giver(s).

The local authority **must:**

- notify certain people of any application made for a Part 2A Order (see 9.3);
- send a report to the HPA of all applications for orders, and all variations and revocations (see 9.4);
- provide information to people who are the subject of an order (see 10.1.5);
- in the case of certain Part 2A Orders about people, have regard to the impact of the order on the welfare of the person concerned (see 10.1.6).

The local authority may apply for variation or revocation of a Part 2A Order at any time (see 9.5).

The local authority may charge for costs of measures relating to Part 2A Orders about things and premises (see 9.6).

### 9.3 Duty to give written notice when applying for a Part 2A Order

Whenever an application is made for a Part 2A Order about a person, a thing or premises, the local authority has a legal duty to notify certain people.

The duty applies only if the relevant people are known to the local authority and can be contacted, following, if necessary, reasonable enquiries as to their existence and whereabouts. It is for the local authority to decide what is reasonable, but it should not allow these enquiries to jeopardise protection of human health.

The legislation does not set a timescale within which the notification must be made, but it is clearly good practice to do this as soon as practicable, in order to give the person notified an opportunity to be present at the hearing of the application. If that is not achievable, the notification ensures the person concerned can exercise their right as an affected person to apply for variation or revocation of the order, if one is made.

The local authority is not required to notify a person if it takes the reasonable view that the person is likely to abscond if they are told about the application, or is likely in some other way to take steps to frustrate the application.

There is no set requirement for the form of the notification, but it must be in writing. E-mail should not be used.

A JP may make an order even if notice has not been given, where they consider it necessary. This might, for example, apply in an emergency situation, or where a person is likely to abscond (as explained above).

***Who must be notified of applications for an order imposing a restriction or requirement on a person or group of people?***

The following individuals should be informed:

- the person, or people, concerned;
- if the person is a child (under 18), a person with parental responsibility;
- any "decision-maker", including a person (sometimes called a donee or appointee) with lasting or enduring power of attorney, or a deputy appointed by the Court of Protection, if that person has the authority to act in respect of such matters on behalf of the person.

If the person concerned is a child, and the local authority is aware that there are exceptional circumstances about the case which mean that it would not be in the child's best interests to notify a person with parental responsibility, the local authority need not do so. For example, in the rare circumstance where a Part 2A Order is contemplated in the case of a child, there may be concerns that notifying a person with parental responsibility at that stage would not be desirable, particularly if there were an issue relating to the child's sexual health. This exception from the requirement to notify a parent is more likely to apply to a child whom the courts are likely to regard as competent to make their own decisions. It is expected that it would normally be in the best interests of a child who was not competent in this way for a person with parental responsibility to be notified.

***Who must be notified of applications for an order about things?***

When applying for orders about things, a local authority must notify the owner of the thing and anyone with custody or control of the thing.

***Who must be notified of applications for an order about a body or human remains?***

When applying for orders about a body or human remains, the local authority must notify the dead person's next of kin.

In this context, next of kin means the first available person in the list below. If there is more than one person in the relevant category, only one of them need be notified:

- if the dead person was a child, a person with parental responsibility;
- the person's husband, wife or civil partner;
- anyone who had been living with the person as if they were their husband, wife or civil partner;
- the person's child, if 18 or over;
- the person's parent;
- the person's brother or sister (aged 18 or over).

***Who must be notified of applications for an order about premises?***

When applying for orders about premises, the local authority must notify the owner and any occupier of the premises.

### 9.4 Duty to report applications to the HPA

Whenever an application is made for a Part 2A Order (whether it relates to a person, thing, body, or premises) the local authority must make a written report to the chief executive of the HPA.

The report must be made as soon as practicable, and within 10 days of the application being granted, dismissed or withdrawn. The report can be made by e-mail to Part2AOrders@hpa.org.uk or in writing to the Chief Executive, HPA.

It is important to note that the purpose of these reports is to allow the use of Part 2A Orders to be monitored, not to initiate any action on individual cases. The HPA will provide a summary of the reports to the Department of Health annually, and the information will be published.

The report must include:

- the name of the local authority;
- contact details for the officer responsible for the report;
- a copy of the application for the Part 2A Order, with the information that would enable identification of the person who is the subject of the application removed;
- where a Part 2A Order is made – a copy of the order, again with identifying details removed; or
- where a Part 2A Order is not made – the reason for it not being made.

A further written report must also be made whenever a Part 2A Order is varied or revoked. In this case the details that must be supplied are:

- the name of the local authority;
- contact details for the officer responsible for the report;
- a copy of the Part 2A Order varying or revoking the original order, with the information that would enable identification of the person who is the subject of the order removed;
- a copy of the original Part 2A Order, again with identifying details removed.

This report must be sent as soon as practicable after the order is varied or revoked, and no later than 10 days after the authority becomes aware of the variation or revocation.

### 9.5 Applications to vary or revoke a Part 2A Order

A JP may vary or revoke a Part 2A Order on application from certain parties. These are:

- the local authority;
- any other authority required to execute or enforce the order (for example, a PCT where an order is to detain a person in hospital);
- an “affected person”, as set out in the legislation.

There are no particular requirements as to how applications for variation or revocation of orders are to be made.

Anything done under a Part 2A Order remains valid if an order is subsequently varied or revoked.

### 9.5.1 "Affected persons"

In the case of an order about people, the "affected persons" are:

- the person who is the subject of the order;
- if the person concerned is a child, a person with parental responsibility;
- the person's husband, wife or civil partner, or anyone living with them as such.

Should the "affected person" be the subject of an order requiring them to remain in quarantine or isolation, consideration should be given to allowing arrangements for the person to have appropriate representation before the JP or communication with the JP, for example by telephone, e-mail or facsimile. An application from anyone representing the person, not just a barrister or solicitor, could be made at the JP's discretion, but the JP would need to be satisfied that the representative was acting with the authority of the person. If there are concerns about possible transmission to the JP or others involved in the process, advice should be sought from the HPA as to how this can be avoided.

In the case of an order about things, the "affected persons" are:

- the owner, and
- anyone with custody or control of the things.

In the case of an order about a body or human remains, the affected person is:

- the deceased's next of kin.

The next of kin is to be determined in the same way as in 9.3 above, except that if there is more than one person at the highest "rank" in the list, they are all affected persons. For example, if the deceased person had no spouse or partner and lived alone, but had two adult children, each of those would be an affected person with the right to apply for variation or revocation of the order.

In the case of an order about premises, the "affected persons" are:

- the owner, and
- any occupier.

Anyone required under an order to answer questions about a thing or premises is an affected person.

### 9.6 Local authority power to charge

If a Part 2A Order is made requiring a person to take specified action relating to a thing, or to premises, but the person does not do so, for any reason, the local authority might consider it necessary to undertake the action itself. In such circumstances, the authority may levy a charge against the person who should have been responsible for the action. This could happen if an owner or person with control of the relevant "thing", or an owner or occupier of the relevant premises, was unable to take the action, or refused to do so, and action was needed to protect human health.

Any charge must not exceed the actual costs to the authority, including any staff costs incurred, and must be reasonable in the circumstances. It would be good practice to itemise the charges so that the person can understand the basis for them.

It is for the local authority to decide what is reasonable. However, they should take account of the circumstances of the person who may be liable to be charged, and act in accordance with any local charging policies. Where relevant, consideration should be given to the impact of any charge on a small business affected by a Part 2A Order.

### 9.7 Liaison with JPs and courts

It is important for local authorities to have arrangements in place to enable contact to be made with a JP during both working hours and out-of-hours. Direct contact with a JP will not generally be permitted and so contact will normally be effected through the court office during working hours, and through a legal adviser at other times.

These arrangements should be negotiated with the local Justices' Clerk. There are, as yet, no national arrangements for legal advisers to be available to public authorities out-of-hours and so it is particularly important for clear local arrangements to be made for this contact.

Hearing time will need to be set aside to deal with the application and so an early warning of a possible application will be appreciated. The court office will also be able to provide details of the date, time and place for the hearing which can then be included in any notices which have to be served.

#### 9.7.1 The procedure for giving notice

Local authorities applying for a Part 2A Order will be required to satisfy the JP that adequate notice of the application has been given (or that the grounds for dispensing with the service of the notice are made out).

The purposes of giving notice include:

- to allow persons affected by the application to arrange legal representation (if they wish);
- for them to arrange to be present at the hearing;

- for them to prepare their response to the application.

In deciding whether the time between the giving of the notice and the hearing is adequate, the JP is likely to weigh up the level of the risk of harm to other people if the application is not heard immediately against the seriousness of the consequences for individuals who would be affected by any order. Applicants should be ready to address the JP on this issue.

Where the urgency of the application means that there is a short period of time between the giving of notice and the hearing of the application it will generally be good practice to effect personal service.

Applicants should be ready to prove that service of the notice has taken place as required by the legislation, or to give their reasons for not doing so (see 9.3).

Section 60 of the 1984 Act sets out the procedure for the service of a notice. The notice may be delivered to individuals or left at, or sent in a pre-paid letter to any person at, their usual or last known residence. Notices may be served on companies by delivering it to the Company Secretary or Clerk at their registered or principal office or by sending it in a pre-paid letter to that office. Special arrangements are available for the service of documents on Coroners or relevant proper officers of local authorities, or on the owner or occupier of a premises, and the 1984 Act should be consulted as necessary.

Note that there is no requirement for the JP to issue a summons to the person who is the subject of the application.

### 9.7.2 Confidentiality and access

Most court hearings are required to take place in “open court” under section 121 of the Magistrates’ Courts Act 1980. However, provision has been made to exempt applications for Part 2A Orders from this requirement.[20] This means that it is open to applicants to ask the JP to exercise a discretion to hold such hearings in private. This request should be made where applications involve giving sensitive health information about individuals.

A JP may conduct a hearing elsewhere than in a courtroom, subject to his or her discretion. This might be necessary in an emergency where an order is sought out-of-hours.

### 9.7.3 Content of Part 2A Orders

JPs have a broad discretion to impose restrictions or requirements in Part 2A Orders (see 10.1). Applicants should propose the restriction(s) and/or requirement(s) which they consider to be necessary to deal with the health protection problem at hand. The JP will consider these

[20] Article 10 of the Health and Social Care Act (Commencement No. 15, Consequential Amendments and Transitional and Savings Provisions) Order 2010: http://www.opsi.gov.uk/si/si2010/uksi_20100708_en_1

in the light of the evidence presented, which must accord with the requirements for such evidence (see 10.1.4) and the criteria for making an order.

### 9.7.4 Giving evidence

Applicants and their witnesses presenting oral evidence will be required to give evidence on oath or affirmation. If the application is being made at a courthouse during working hours, a full range of oaths and holy books will be available. If the application is being made out-of-hours, a full range of oaths and holy books may not always be available. The court or the JP can also allow evidence to be given upon affirmation.

# 10. Applying for and implementing Part 2A Orders

This subsection details the steps a local authority needs to take in applying for and implementing a Part 2A Order in relation to a person, a thing, a dead body or human remains, or premises. The restrictions and requirements that a JP may impose in making an order are explained. Algorithms are included to give an outline of the process and examples to illustrate the type of scenarios in which Part 2A Orders might be applied.

## 10.1 Orders concerning a person

A Part 2A Order can require a person to:

- undergo medical examination (NOT treatment or vaccination);
- be taken to hospital or other suitable establishment (in some cases an alternative to hospital, such as a care home, might be more appropriate);
- be detained in hospital or other suitable establishment;
- be kept in isolation or quarantine;
- be disinfected or decontaminated;
- wear protective clothing;
- provide information or answer questions about their health or other circumstances;
- have their health monitored and the results reported;
- attend training or advice sessions on how to reduce the risk of infecting or contaminating others;
- be subject to restrictions on where they go or who they have contact with;
- abstain from working or trading.

A JP may impose any of the above restrictions or requirements, or more than one if needed. The JP may also impose further restrictions or requirements not listed above, if needed for the same health protection purpose. Any such restriction or requirement should complement the one(s) imposed under the list above, and must not be more restrictive or onerous for the person concerned than those listed (which are indicative of the maximum limits of the respective restrictions or requirements which may be imposed). For example, if a Part 2A Order requires that a person be detained in hospital to avert a risk to others, the order cannot additionally require that the person accept treatment.

### 10.1.1 A “related party”

An order can be made to require a person to give information about, and/or disclose the identity of:

- someone they have, or may have, infected or contaminated; or
- someone who has, or may have, infected or contaminated them.

The legislation refers to such a person as a “related party”. This can apply to more than one person if necessary.

An application for an order concerning a related party might be made if an infected or contaminated person has been in contact with one or more people and there is a risk of further spread of the infection or contamination, but the person refuses to disclose details to allow contacts to be traced.

### 10.1.2 How does the local authority decide whether to apply for a Part 2A Order?

In deciding whether to apply for an order in relation to a person(s), a local authority will need to determine that the application is a proportionate, necessary and appropriate response to the risk to human health.

This determination will involve careful consideration of the criteria that a JP must be satisfied about before they can make an order. These are listed in 10.1.3 below.

A decision to apply for a Part 2A Order in relation to an individual would ordinarily involve their treating clinician, if the person has one. Only in exceptional circumstances should a local authority pursue an application for a Part 2A Order against the advice of a treating clinician. A multi-professional case review may be helpful. This would normally involve the treating clinician and local HPA staff.

In considering the evidence required in an application for a Part 2A Order relating to a person who has an infection, it is important that, where possible, well-informed, accurate and case-specific information is provided both on the infection itself and on the infectiousness of the person concerned, with as much detail as is possible in the circumstances. This will ordinarily be available from the treating clinician, if the person has one, and local HPA staff.

#### Considerations relating to sexual health/ HIV

As well as diagnosing and treating people with sexually transmitted infections (STIs) and advising on safer sex, sexual health services engage on a daily basis in contact tracing and partner notification, attempting to identify, reach, test, diagnose and, if necessary, treat sexual contacts of those who have presented with HIV or other STIs. This is a vital part of their function and for this process to be effective the voluntary and frank cooperation of sexual health /genitourinary medicine (GUM) clinic patients is required.

Sexual health services work within a strict and well-established framework of confidentiality. For example, they keep records separate from the rest of the NHS, and only in exceptional circumstances would a clinic disclose a person’s HIV/STI status to someone else without the patient’s consent. Patient confidentiality is seen as a cornerstone of sexual health service provision and there is nothing within the updated health protection legislation that is intended to alter this.

***Implications for common scenarios***

**Repeated STIs**. It is not uncommon for sexual health services to provide care for people who present repeatedly with STIs, some of whom may also have a long-term infection such as HIV or hepatitis C. It is not intended for Part 2A Orders to be routinely used in relation to people who continue to engage in unsafe sex, posing a risk to their partners. Longer-term and consensual interventions remain the usual and preferred approach for long-term conditions such as HIV or hepatitis B or C infection.

**Contact tracing**. In general, a Part 2A Order would not be an appropriate intervention in the normal contact tracing process, as it would not usually meet the test of "necessity". It also may not be an effective means of eliciting information about sexual contacts of an individual. Practitioners should bear in mind the risk that such action could seriously undermine the willingness of many people, particularly if asymptomatic,[21] to attend a sexual health/GUM clinic for testing or treatment.

Where, in exceptional circumstances, an application for a Part 2A Order is considered in relation to a person with a sexually transmitted infection, any benefit from such action in that case should be weighed against possible loss of trust amongst relevant communities in the confidentiality of the local sexual health/GUM clinic, and the possible wider implications for public health. It is recommended that advice be sought from the treating clinician and, if appropriate, the clinical director of the relevant local sexual health service.

In all aspects of the handling of a case involving sexual health issues, there would need to be particular care not to disclose a person's medical information to parties who do not need it. Local authorities should consider applying for confidentiality measures in relation to any legal proceedings in the exceptional circumstances where an application for a Part 2A Order were made in relation to a person with HIV or another STI. See subsection 9.7.2.

### 10.1.3 How does the JP decide?

The 1984 Act sets out the criteria that a JP must be satisfied about before they can make an order. These are:

- that the person is, or may be, infected or contaminated
  **and**
- that the infection or contamination presents, or could present, significant harm to human health
  **and**
- there is a risk that the person might infect or contaminate others
  **and**
- an order is necessary to remove or reduce the risk.

[21] Many common STIs are asymptomatic and HIV can be asymptomatic for many years.

It is not always essential to be certain that the person is **definitely** infected or contaminated before applying for an order. Similarly it is not always essential to be sure about the **nature** of the infection or contamination. However, the risk of the person being infected or contaminated, and of the infection or contamination presenting significant harm, will need to be demonstrated before the JP can judge that the criteria for an order have been met.

The fourth criterion – that an order must be necessary to remove or reduce the risk – is important. For the JP to be satisfied that an order is necessary, the application would need to show that there was no alternative way to deal with the matter, or that if there were, that it was not practicable, or would fail to adequately address the risk to human health. If the problem could reasonably and satisfactorily be tackled in some other way, it follows that it would not be necessary to make an order. The JP is likely to expect that the application will show that the measures sought under the order have a realistic prospect of success.

### 10.1.4 Evidence required for the application for an order

For orders about people, there are legal requirements about the evidence which must be available to the JP to help him or her to make a decision.

The evidence required may be given orally or in writing.

#### *Who gives the evidence?*

The evidence must be given by one or more persons who are suitably qualified to do so. The legislation does not specify who such people might be. It is for the JP to decide if the person(s) giving the evidence is/are suitably qualified. This gives the JP flexibility to decide who they consider to be suitably qualified in each case. For example, a medically qualified person may not be regarded as suitably qualified to give evidence in a case of contamination: a scientist in the relevant discipline might be more appropriate. It is not expected that the JP will always require evidence from a person with the highest level of qualification in the relevant field.

For applications for an order which would deprive a person of their liberty, it is expected that an RMP would give evidence (with other suitably qualified persons if appropriate to the case).

To assist the JP, it is recommended that the local authority include in its application an explanation of the reasons why it considers the evidence-giver(s) to be suitably qualified in the circumstances. If the JP does not agree that the person(s) is/are suitably qualified, they can ask for evidence to be given by someone else. If this is not forthcoming, the JP may refuse to make an order.

#### *What the evidence must cover*

The evidence must support the four criteria in subsection 10.1.3 as well as any additional supporting evidence that the JP may request.

**(i) To show that the person is, or may be, infected or contaminated:**

Normally, evidence should be provided about all four points below, but at a minimum it must cover at least one. The points are:

- the person's signs and symptoms of the infection or contamination;
- 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.

For each of these points, if no evidence is available, the local authority must state the reasons why.

These requirements for evidence allow an application to be made in a situation where the picture is not yet clear, if the risk justifies this. For example, a situation might arise where a person has been exposed to a dangerous infection or contamination, but has no signs or symptoms, no diagnosis is available at the time and no test results are yet available. It is an emergency because the person is behaving, against the best advice, in a way that puts others at risk from spread of the suspected infection or contamination. An application for a JP order could be the only way to deal with the risk to others. The evidence brought to the JP would need to explain that the symptoms, diagnosis and test results were not available, and why. In this scenario, the focus would be on the likelihood that the person really has been exposed to the infection or contamination and how their behaviour puts others at risk.

**(ii) To show that the infection or contamination presents, or could present, significant harm to human health:**

The evidence must provide a summary of the characteristics and effects of the suspected infection or contamination. This should cover an explanation of:

- the mechanism by which it spreads;
- how easily it spreads, and
- the impact on human health, taking account of symptoms including pain, disability and the likelihood of death.

It should always be possible to provide this evidence even in an emergency, because otherwise there could be no justification for an application. However, the level of detail might vary according to the circumstances.

**(iii) To show that there is a risk that the person (or related party) might infect or contaminate others:**

An assessment must be given of the risk, including anything the person (or related party) is doing, or is expected to do, or alternatively, is not doing or is expected not to do, which affect the risk.

**(iv) To show that an order is necessary to remove or reduce the risk:**

The evidence required here must provide an assessment of the options available to deal with the risk that the person, or related party, presents. The assessment would need to explain how the requirements of the order will deal with the risk, and why other options for dealing with the risk are not suitable.

The evidential requirements above only apply to orders about a person, or persons, not to any other type of order. The JP must, of course, still be satisfied that the relevant criteria are met in the case of other types of orders.

### 10.1.5 Duty on the local authority to provide information

If the JP decides to make a Part 2A Order imposing any restrictions or requirements on a person, the local authority must take reasonable steps to ensure the person understands:

- the effect of the order and what they are required to do to comply;
- why it was made and under what legal powers; and,
- that they have a right to apply for the order to be varied or revoked.

This must be done as soon as reasonably practicable after the order is made. There is no requirement to provide the information in any particular format providing, of course, that the person can read and understand the information given.

Different people might require different types of support according to their need. For example, the person concerned may have difficulty reading English, or may have a disability which affects their ability to read or understand the order. It is for the local authority to determine how best to help the individual.

The authority must also ensure the person knows about any locally available support services that would be relevant to their situation and how to access them. Whether a service is relevant will depend on the circumstances, but domestic help or social services might fall into this category. The local authority is not required to provide any service not already available to a person in that situation, and where appropriate may make charges under the usual arrangements.

If the person concerned is a child under 18, the local authority must provide this information to a person with parental responsibility for that child.

### 10.1.6 Duty to have regard to the impact of the order on a person's welfare

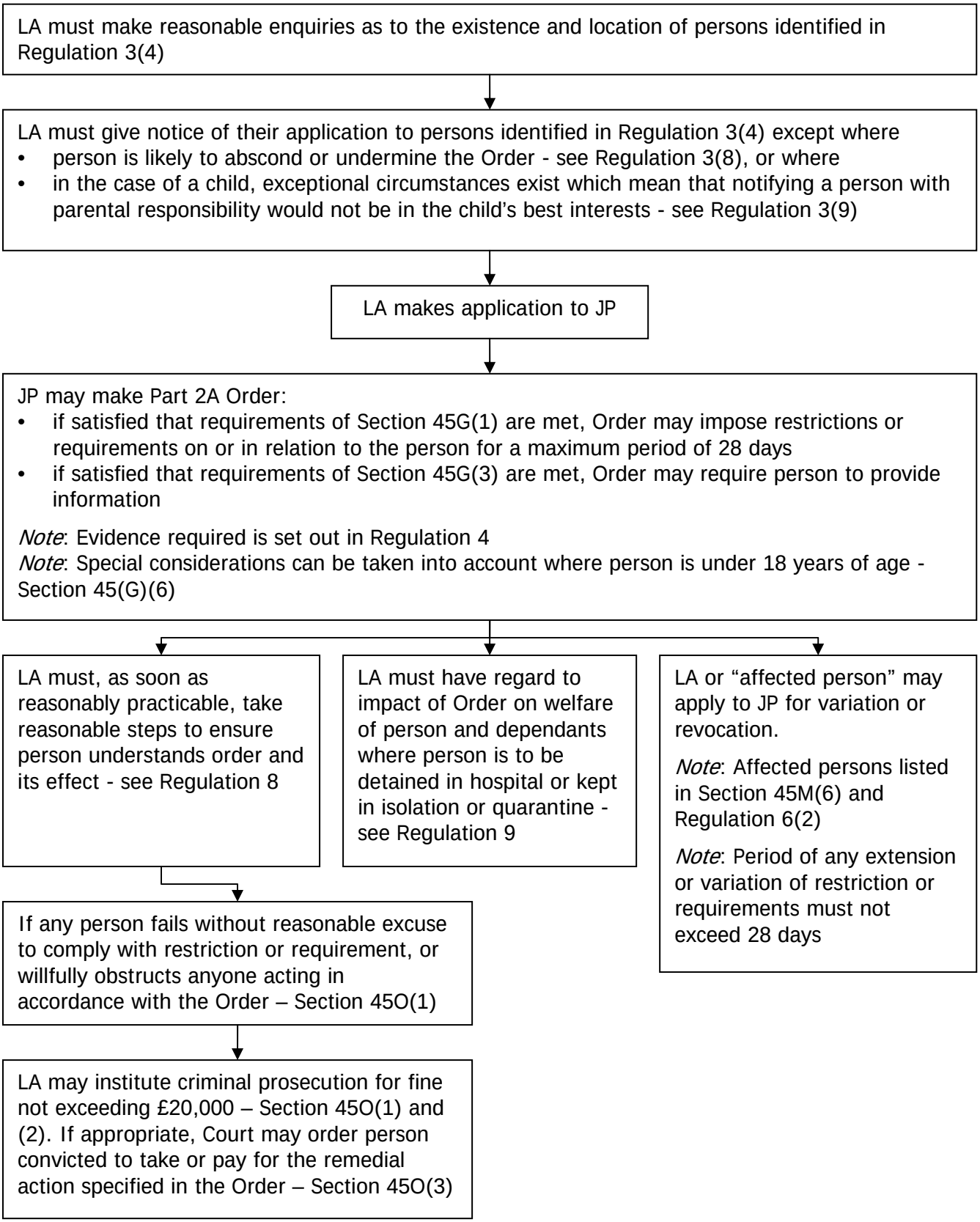
If a Part 2A Order is made detaining a person in hospital (or anywhere else), or placing them in isolation or quarantine, the local authority must have regard to the impact of the order on the welfare of the person and any dependants. The legislation does not specify what action(s) the authority must take, because that will depend on the circumstances of the case. It could, for example, involve the provision of food and essential services for the person or the provision of care for dependants. Liaison with social services may be needed.

Having regard for the welfare of the person could help to secure compliance with the order by removing possible reasons for the person's failure to co-operate.

The authority may make a charge for any services it provides (under section 93 of the Local Government Act 2003), as appropriate to the case.

## Algorithm 7: Part 2A Orders concerning a person

Public Health (Control of Disease) Act 1984 (section 45G) and Health Protection (Part 2A Orders) Regulations 2010



### 10.1.7 Examples of the use of Part 2A Orders in relation to a person(s)

#### (a) Requiring an individual to be medically examined

**Example 24: Typhoid in a food handler**

A restaurant chef is a known close contact of a confirmed case of typhoid fever. The public health imperative is to determine whether this individual is a typhoid carrier and therefore capable of spreading this infection to others by contaminating food. A medical examination (including a stool sample) will ascertain whether or not he is in the clear. But he fears losing pay – or even his job – if he is identified as infected with typhoid.

If the chef does not cooperate voluntarily, or following a formal request from the local authority, it may be necessary to apply for a Part 2A Order requiring a medical examination. The order allows the chef to be tested for infection with typhoid during the microbiological testing of a stool sample collected as part of a medical examination. If the result is positive he could be excluded from work so as to prevent additional typhoid cases occurring from this source.

#### (b) Requiring someone to be removed to, or detained in, hospital or another suitable establishment to protect public health

**Example 25: Infectious tuberculosis (TB)**

A patient with infectious TB who is not complying with treatment poses a health risk because he could spread TB to others with whom he has close contact. Despite the best efforts of the NHS and others, he is not taking medication as a result of a chaotic lifestyle and, as a consequence, he develops multi-drug resistant TB.

Removing him/her to a setting without direct close contact with others to whom he can spread TB infection is essential to reduce or remove the risk of spread. If the patient complies with treatment, he should become non-infectious after two weeks.

*NB: An order cannot impose treatment.*

### (c) Requiring a person to be kept in isolation or quarantine

**Example 26: SARS–like infection**

A journalist returns to England from a country where people are infected and hospitalised with a SARS-like agent. Although he may have been infected through close contact with patients during face-to-face interviews, the journalist is keen to sell his story, and is adamant that he intends to urgently visit media colleagues – despite the risk of infecting others. The journalist rejects infection control advice to remain in voluntary quarantine at home.

If the local authority decides that their power to formally request the journalist to remain at home would be unsuitable to deal with the threat, perhaps due to the urgency of the situation or because they believe that the journalist won't comply with the request, a Part 2A Order might be sought to ensure that proportionate control measures are taken to deal with the risk of human-to-human transmission of a highly infectious viral agent. The order could require the journalist to remain isolated during the incubation period for such an infection. If he does not present symptoms of the infection during this period the requirement for isolation can then be lifted.

### (d) Requiring someone to be disinfected or decontaminated

**Example 27: Anthrax contamination after 9/11**

Following the anthrax incidents that occurred in the USA after 9/11 in 2001, there were concerns that 'white powder' discovered in mail sorting offices in England might also have been contaminated with anthrax. This situation required management in a precautionary way. Anthrax infection, caused by inhalation of the spores, can have serious or fatal consequences.
If anthrax spores had been deposited on the clothing of staff at the sorting offices, the spores could have been passed on to other people. It would therefore have been essential to ensure that any person who might have been in contact with anthrax spores, and their clothing, had been properly decontaminated.

Most people will agree to decontamination, but there can be some who refuse to cooperate because they fail to appreciate the risk posed to themselves and to others.

If the owner of a premises takes no action to arrange decontamination, and is unwilling to cooperate with a formal request, then a Part 2A Order provides a mechanism to ensure that exposed individuals and buildings are decontaminated.

### (e) Requiring an individual to wear protective clothing

**Example 28: Infectious tuberculosis (TB) and the use of a mask during initial treatment**

A patient is newly diagnosed with infectious TB which is multi-drug resistant as a result of previous non-compliance with TB medication. He agrees to take directly observed therapy provided that transport is organised to transport him to the TB clinic each day because the local bus services are poor. In order to minimise the possibility of spread of TB, the patient is required to wear a face mask whilst in the ambulance that takes him to and from the TB Clinic. He refuses to do so voluntarily and an order is needed to require this.

### (f) Requiring someone to provide information or answer questions about their health or other circumstances, including, in particular, information or questions about the identity of a related party

**Example 29: Cluster of whooping cough cases related to a student party**

A student living in university halls of residence goes to his GP with a one-week history of a hacking cough. The GP has seen eight other students with similar symptoms within the past two days. Pernasal swab testing confirms whooping cough (pertussis) infection in all the students. The eight students all report that they had attended the first student's 21st birthday party, a fortnight earlier. But the student who hosted the party refuses to give any details of partygoers. He is aware that illicit drugs were used at the party and is fearful of the consequences of disclosure.

The information is needed so that other people at risk of infection, through their attendance at the party, can be contacted and given preventive antibiotics (prophylactic erythromycin) as necessary. If the host remains adamant that he will not voluntarily provide details of the guests, he could be required to disclose the information by a Part 2A Order.

### (g) Requiring an individual to be subject to health monitoring

**Example 30: Lassa fever case identification and health monitoring of contacts**

An aid worker returns from Sierra Leone and starts work as a supply teacher in a boarding school. She is admitted to hospital with sudden onset of fever, rigors and drowsiness. She is initially suspected of having malaria, but the blood malarial screen is negative. Subsequent specialist tests confirm that she has Lassa fever and she is transferred to an appropriate infectious disease isolation unit for further clinical management. She is known to have had close contact with 30 individuals, some of whom are adamant that they do not want to come forward for risk assessment and further follow-up. An order could be made to require these reluctant contacts to be subject to health monitoring, involving daily temperature recording for up to 21 days.

**(h) Requiring someone to attend training or advice sessions on how to reduce the risk of infecting or contaminating others**

**Example 31: Lead poisoning from property development**
A man supplements his income by renovating old properties and selling them. His family moves from property to property with him as he does this. He exposes himself and his family by sanding old lead paint. One of his children becomes unwell. The GP investigates and finds that the child has high blood levels. If the property developer continues with the renovations despite the warning from his GP about the risks from the lead in the paint, a Part 2A Order requiring him to attend training or advice sessions on how to reduce the risk of contaminating others may be required.

**(i) Requiring an individual to abstain from working or trading**

**Example 32: Childminder with *Escherichia coli* O157**
A woman, who is known to be *E. coli* O157 positive, earns her living as a self-employed childminder. She often prepares food for the children she minds, but does not disclose information about her health to the parents. Despite a recommendation not to continue working, given in accordance with national guidance and food safety legislation, she persists in order to earn her livelihood. A Part 2A Order could require her to abstain from working or trading until she provides stool samples for microbiological testing that confirm she is clear of the infection. It could also require her to attend training sessions on infection control precautions to be taken in her childcare role.

### 10.2 Orders about things

A JP may make a Part 2A Order to require that a thing is:

- seized or retained;
- kept in isolation or quarantine;
- disinfected or decontaminated;
- destroyed or disposed of.

A JP may impose any of the above restrictions or requirements, or more than one if needed. The JP may also impose a further restriction or requirement not listed above, if needed to reduce or remove the risk to human health in the particular circumstances. Any such restriction or requirement should complement that imposed under the list above and not be more restrictive or onerous.

An order can also be made to require the owner of a thing, or anyone who has or has had custody or control of it, to provide information or answer questions about it. This can include information about where the thing has been, or about anyone, or other things, that have had contact with it (a “related person” or “related thing”).

### 10.2.1 How does the JP decide?

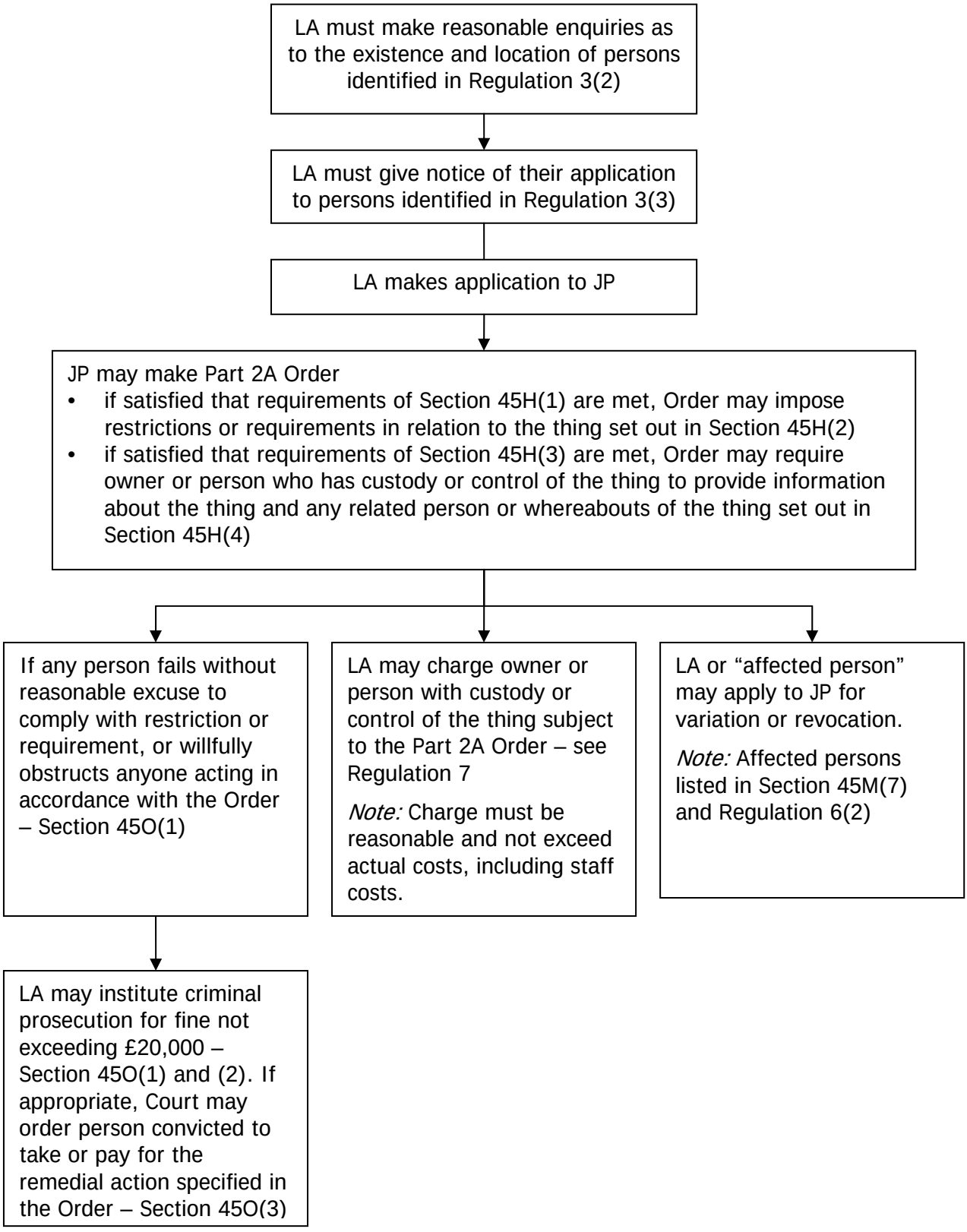
The criteria that a JP must be satisfied about before they can make a Part 2A Order about a thing are:

- that the thing is, or may be, infected or contaminated
  **and**
- that the infection or contamination presents, or could present, significant harm to human health
  **and**
- there is a risk that the thing (or a related person, or related thing) might infect or contaminate humans
  **and**
- an order is necessary to remove or reduce the risk.

There are no prescribed evidential requirements for applications for an order applying to a thing. The local authority is free to submit whatever supporting evidence is needed to help the JP decide about the criteria listed above.

**Algorithm 8: Part 2A Orders about things**

Public Health (Control of Disease) Act 1984 (section 45H) and Health Protection (Part 2A Orders) Regulations 2010



### 10.2.3 Examples of the use of Part 2A Orders in relation to a thing

#### (a) Require that a thing is seized or retained

**Example 33: Legionella contamination of a poorly-maintained domestic hot tub**

A health protection investigation is launched to find the source of an outbreak of Legionnaires' disease. Investigations suggest that the people infected are linked by the fact that they had recently visited (during the incubation period) a domestic hot tub owned by their neighbour. A visit to the neighbour's house reveals that the domestic hot tub is poorly maintained and is used during parties held at the premises.

The owner of the hot tub refuses to cooperate with efforts to collect samples of the water for laboratory testing. A Part 2A Order is required so that the hot tub can be seized, drained and appropriate laboratory samples taken of the hot tub water. Decisions can then be made about what disinfection/maintenance measures are necessary to minimise the risk of additional associated Legionnaires' disease cases.

#### (b) Keep a thing in isolation or quarantine

**Example 34: Old trainers containing mercury tilt switches to illuminate the heels**

Some children break into a waste tip by climbing through broken fencing. The children carry away a number of old trainers in a wheelbarrow. These trainers start to leak shiny droplets of silver metal which they proceed to play with and share among their friends. When one child arrives home with mercury in their pocket, the mother realises it is dangerous. She strips the child's clothes off and puts them in the washing machine. The following morning she calls the parents of the other children and the local council. During the consequent health protection investigation it transpires that there is a distinct possibility that the trainers were leaking mercury from the heels.

The mother has a home-based job of washing and ironing as a contractor to a laundry company. She refuses to give up her washing machine, dismissing the notion that her machine is contaminated with mercury and requires disposal. The mother continues to refuse to comply following a formal request from the local authority. A Part 2A Order might then be required to ensure that the washing machine is kept in isolation until the possibility of mercury contamination has been confirmed and appropriate action taken.

### (c) Require that a thing is disinfected or decontaminated

**Example 35: Cryptosporidiosis related to a private swimming pool**

A cluster of cryptosporidiosis cases is identified in children living in a village. The diagnoses are confirmed by a laboratory following symptoms of diarrhoea and vomiting. The health protection investigation indicates that all the infected children visited the private swimming pool of a local family. This pool could continue to be a source of infection for pool users and disinfection is needed to remove the risk. Health and safety legislation related to commercial pool operators would not apply in this setting and, if voluntary cooperation is not forthcoming, it might be necessary to deploy health protection powers. Ultimately, a Part 2A Order could secure disinfection/decontamination of the pool and installation of an effective filter.

### (d) Require that a thing is destroyed

**Example 36: Body piercing and hepatitis B**

A teenager purchases a body piercing equipment kit from a practitioner who has gone into liquidation. The equipment is a health risk because of the potential transmission of bloodborne viruses, in particular hepatitis B, when contaminated needles are used to pierce a number of the teenager's friends and associates.

Should the teenager refuse to co-operate with voluntary disposal of the equipment, then the continued risk of transmission could be stopped by requiring destruction of the needles, for the purpose of preventing the spread of a serious bloodborne infection. If a formal request to cooperate by the local authority is ineffective, ultimately a Part 2A Order might be sought.

### (e) Require any person who has custody or control of a thing to provide information or answer questions about the thing (including information about where the thing has been or about the identity of any related person or the whereabouts of any related thing)

**Example 37: Radioactive mineral collection**

A collector of rare antiquities dies from a rare form of cancer and leaves his possessions to his relatives. From the inventory, the collector appears to have kept a range of rare minerals which he displayed to his friends/guests to his house over a number of years.

There is concern that certain of the minerals may still be a source of radioactivity. For example, Metatorbernite – originating from the uranium mines of the Shaba Province in Zaire – emits radioactive rays that are harmful to health. The executor of the will, who has custody of the collection, could be required to provide details of the collection in order to inform an assessment of the risk to the health of others. If a formal request to cooperate by the local authority is ineffective, ultimately a Part 2A Order might be sought.

### 10.3 Orders in relation to dead bodies or human remains

A Part 2A Order can be made to require that a body or human remains be buried or cremated, or that human remains are otherwise disposed of.

#### 10.3.1 How does the JP decide?

The JP must be satisfied about the same criteria as apply to other orders before they can make an order. In this context the criteria will be:

- that the body is, or may be, infected or contaminated
  **and**
- that the infection or contamination presents, or could present, significant harm to human health
  **and**
- there is a risk that the body (or a related person, or related thing) might infect or contaminate humans
  **and**
- an order is necessary to remove or reduce the risk.

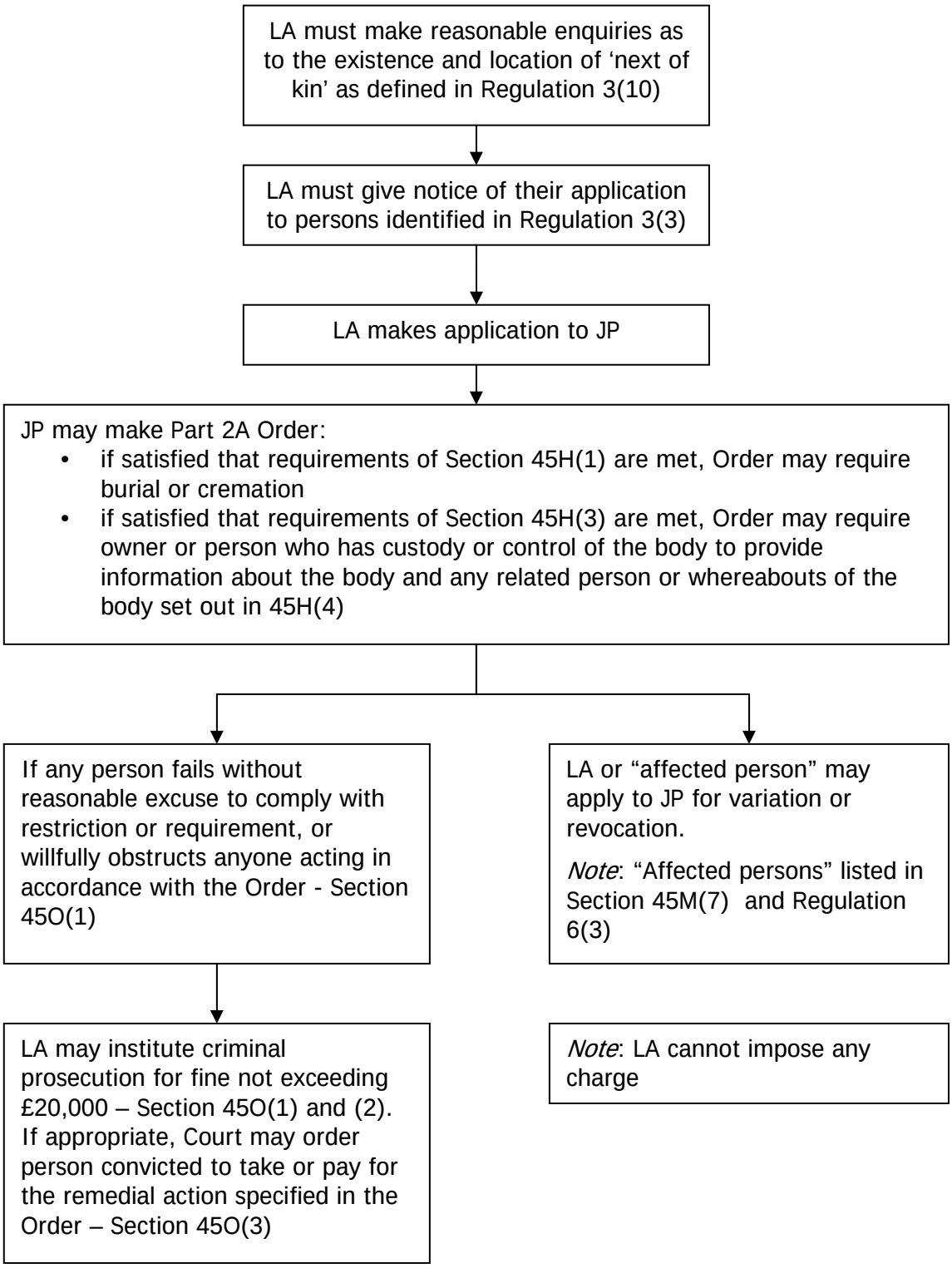
There are no prescribed evidential requirements for applications for an order. The local authority is free to submit whatever supporting evidence is needed to help the JP decide about the criteria listed above.

The next of kin must be notified in the case of an application for an order of this kind.

The local authority may not make any charge in connection with any measures it undertakes as a result of an order about a body or human remains.

**Algorithm 9: Part 2A Orders concerning dead bodies or human remains**

Public Health (Control of Disease) Act 1984 (section 45H) and Health Protection (Part 2A Orders) Regulations 2010



### 10.4 Orders concerning premises

A JP may make a Part 2A Order to require that:

- the premises are to be closed;
- in the case of a conveyance or movable structure, it is to be detained;
- the premises are to be disinfected or decontaminated;
- in the case of a building, conveyance or structure, it is to be destroyed.

A JP may impose any of the above restrictions or requirements, or more than one if needed. The JP may also impose a further restriction or requirement not listed above, if needed to reduce or remove the risk to human health in the particular circumstances. Any such restriction or requirement should complement that imposed under the list above and not be more restrictive or onerous. For example, an order might be made that premises are to be decontaminated and also to be marked in a way that allows identification.

A Part 2A Order can also be made to require the owner or occupier of the premises to provide information or answer questions about the premises. This can include information about "related persons" or "related things", defined in this context as:

- someone who has or may have infected or contaminated the premises;
- someone who has or may have infected or contaminated someone else who is or has been on the premises, or a thing which is or has been on the premises;
- someone who may have been infected or contaminated by the premises;
- someone who has or may have been infected or contaminated by someone who, or a thing which, is or has been on the premises.

See Appendix 5 on powers of entry and inspection.

#### 10.4.1 How does the JP decide?

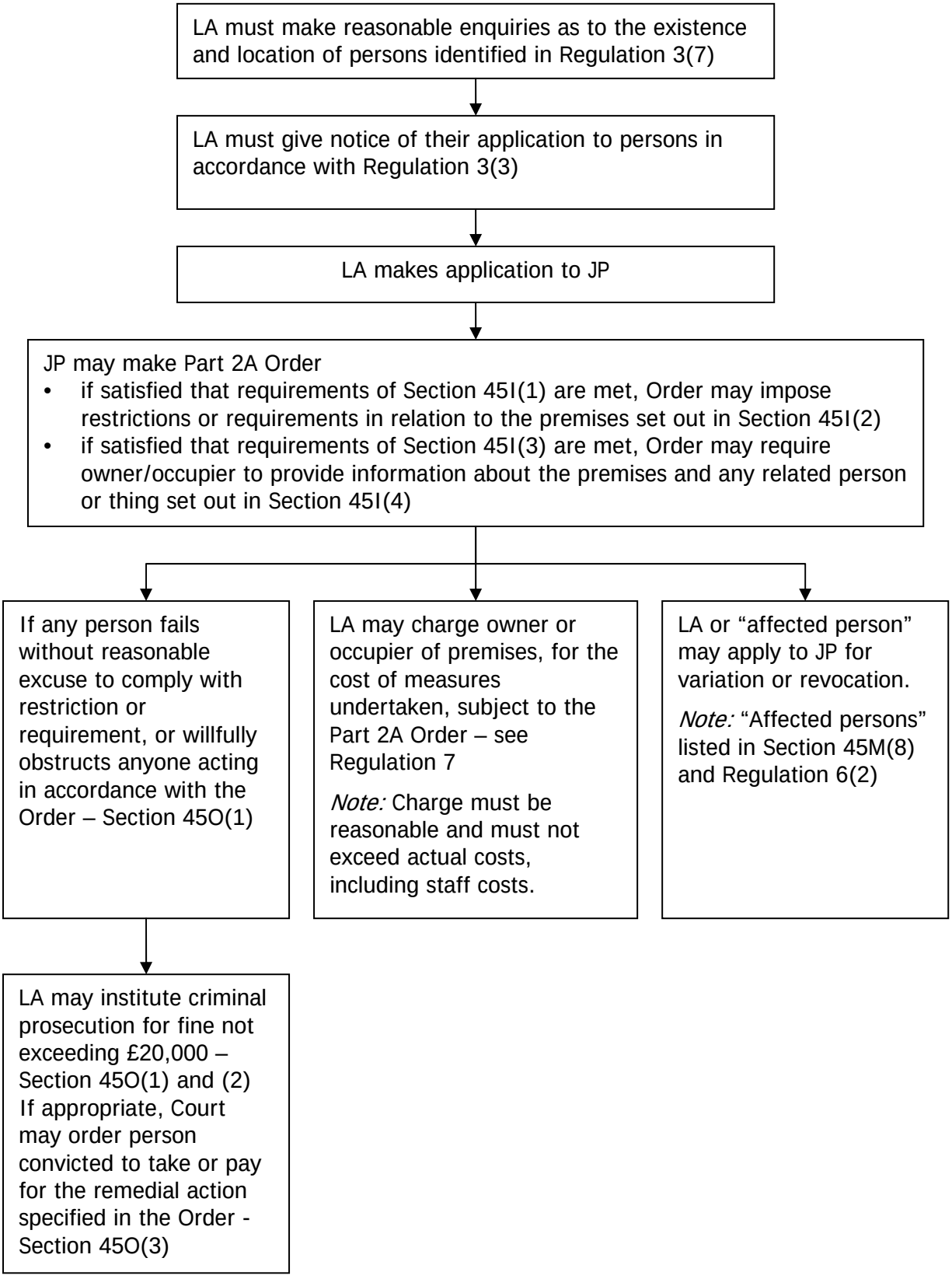
The criteria that a JP must be satisfied about before making an order about premises are:

- that the premises are, or may be, infected or contaminated
  **and**
- that the infection or contamination presents, or could present, significant harm to human health
  **and**
- there is a risk that the premises (or related person, or related thing – see above) might infect or contaminate human
  **and**
- that an order is necessary to remove or reduce the risk.

There are no prescribed evidential requirements for applications for an order. The local authority is free to submit whatever supporting evidence is needed to help the JP decide about the criteria listed above.

**Algorithm 10: Part 2A Orders concerning premises**

Public Health (Control of Disease) Act 1984 (section 45I) and Health Protection (Part 2A Orders) Regulations 2010



### 10.4.3 Examples of the use of Part 2A Orders in relation to a premises

#### (a) Require that a premises is closed

**Example 38: Evacuation of a block of flats following the release of an unknown substance**

A substantial spill of kerosene has occurred undetected over a period of time due to a leaking storage tank in a residential property. Contamination of soil and groundwater has lead to kerosene migrating under and into the foundations of a block of flats (containing a mixture of rented and privately owned flats). Residents have complained persistently regarding hydrocarbon odours, dizziness, headaches, and nausea. It usually takes a considerable period of time to remediate these types of spills – residents are likely to be reluctant to leave their homes if their insurance/landlord refuse to pay for alternative accommodation. A Part 2A Order could provide the basis for requiring the closure of the affected properties should the residents refuse to voluntarily co-operate.

#### (b) Require a conveyance or movable structure to be detained

**Example 39: Vehicle contamination**

A lorry transporting waste chemicals crashes in a country road leading to the spillage of the chemicals onto the road and a nearby car towing a caravan. Detention of the contaminated car and caravan would be required to ensure that an appropriate assessment is made of the need for decontamination or disposal of the vehicles safely without endangering health through chemical exposure. Should the owner/insurers not agree to the cars and caravan being detained for the prolonged period necessary for tests and/or decontamination to be carried out then a Part 2A Order could ensure that the vehicle is detained for assessment and potential decontamination.

#### (c) Require premises to be disinfected or decontaminated

**Example 40: Anthrax decontamination**

In the aftermath of the US anthrax incidents, during which there were five fatalities, several buildings required decontamination. Should a similar event occur in England, then Part 2A Orders could be used to ensure that the appropriate decontamination steps are taken (using chlorine dioxide gas). This would apply if the owners refused to allow decontamination of their property despite every effort being made to secure their consent, including the formal local authority power requesting cooperation.

**(d) Require the owner or any occupier of the premises to provide information or answer questions about the premises (including, in particular, information about the identity of any related person or the whereabouts of any related thing)**

**Example 41: Giardia infection related to a private swimming pool**

A laboratory confirms a diagnosis of giardia in a child who has symptoms of chronic diarrhoea and weight loss. A health protection investigation indicates that the child visited a swimming pool owned by a friend's family. It is important to identify others who used the pool. If the owners refused to voluntarily disclose information about visitors who used their pool they could be required to do so through a Part 2A Order.

# APPENDICES to Section A: Notification Regulations

## Appendix 1: Registered medical practitioner notification form template

| *Health Protection (Notification) Regulations 2010: notification to the proper officer of the local authority* | |
|---|---|
| Registered Medical Practitioner reporting the case | |
| Name | |
| Address | |
| | |
| Post code | |
| Contact number | |
| Date of notification | |
| Notifiable disease | |
| Disease, infection or contamination | |
| Date of onset of symptoms | |
| Date of diagnosis | |
| Date of death (if patient died) | |
| Index case details | |
| First name | |
| Surname | |
| Gender (M/F) | |
| DOB | |
| Ethnicity | |
| NHS number | |
| Home address | |
| | |
| Post code | |
| Current residence if not home address | |
| | |
| Post code | |

| | |
|---|---|
| Contact number | |
| Occupation (if relevant) | |
| Work/education address (if relevant) | |
| | |
| Post code | |
| Contact number | |
| Overseas travel, if relevant (destinations & dates) | |

## Appendix 2: Laboratory notification form template

| *Health Protection (Notification) Regulations 2010: notification to the Health Protection Agency* | |
|---|---|
| Laboratory reporting the organism | |
| Name of laboratory | |
| address | |
| | |
| Post code | |
| Identified organism | |
| Date of sample | |
| Nature of sample | |
| Organism identified | |
| Tests carried out | |
| Test results | |
| Person who solicited the test | |
| Name | |
| Organisation | |
| Contact number | |
| Address | |
| | |
| Post code | |
| Index case details | |
| First name | |
| Surname | |
| Gender (M/F) | |
| DOB | |
| Ethnicity | |
| NHS number | |
| Home address | |
| | |
| Post code | |
| Current resident if not home address | |
| | |
| Post code | |

# APPENDICES to Section B: Health protection powers

## Appendix 3: Summary of transitional arrangements

This table summarises the transitional arrangements for duties and powers that have not been fully exercised or discharged by 6 April 2010. They are contained within the Health and Social Care Act 2008 (Commencement No. 15, Consequential Amendments and Transitional and Savings Provisions) Order 2010.[22]

| **Health protection power/duty with actions outstanding** | **What happens on 6 April 2010** |
|---|---|
| Notifiable disease/food poisoning diagnosed by a registered medical practitioner (RMP) | Duty to notify as specified in the **new** Regulations, but only if disease is listed in new Schedule 1 |
| Written notification of a notifiable disease or food poisoning received by a proper officer | Duty to treat notification ("certificate") as a **new** notification, but only if it relates to a disease listed in the new Schedule 1 |
| Keeping a person off work | Request still stands, but as a request for cooperation for health protection purposes under the **new** Regulations |
| Keeping a child off school | Notice still stands under the **old** provisions |
| List of pupils at a school | Request still stands, but as a request made under the **new** Regulations |
| Disinfection of premises | Notice still stands under the **old** provisions |
| Justice of the peace (JP) and magistrates court orders | Order to be treated as made under the **new** Part 2A. It can remain in force for a maximum of 14 days from this date (or less if specified by the order) and cannot be extended |
| Dead bodies | Certificate still stands under the **old** provisions |

[22] http://www.opsi.gov.uk/si/si2010/uksi_20100708_en_1

## Appendix 4: Templates of Notices

**Requirement to keep a child away from school: template of notice**

Please note that this template is a model only – the format is not specified in legislation.

STATUTORY NOTICE

Dear *[name of parent]*,

*[Name of child]* is required to stay away from school for *[x]* days, commencing from *[date].*

This is because *[name of child]* has, or may have, *[either* an infection *or* a contamination*]* that could present a risk of significant harm to the health of others. *[Add details of infection or contamination if necessary/appropriate.]* Keeping *[name of child]* away from school reduces or removes the risk of harm to the health of others.

This requirement to keep *[name of child]* off school for the stated period of time is a necessary and proportionate measure because:

_____

_____

_____

_____

As the *[either* parent *or* person with parental responsibility*]* for *[name of child]*, it is your duty to ensure [he/she] does not attend school for the duration specified. Failure to comply with this notice is a criminal offence and you may be liable on conviction to a fine of up to level 2 on the standard scale, *[*equivalent to £_____ *]*, and a fine for continuing non-compliance.

This notice is served under regulation 2 of the Health Protection (Local Authority Powers) Regulations 2010, SI no. 2010/657

If you have any questions relating to this notice you may contact:

| | |
|---|---|
| Name | |
| Address | |
| | |
| Phone number | |

*[local authority name]*
*[date]*

**Requirement to provide details of children attending school: template of notice**

Please note that this template is a model only – the format is not specified in legislation.

STATUTORY NOTICE

Served under Regulation 3 of the Health Protection (Local Authority Powers) Regulations 2010

Dear *[headteacher/deputy]*,

A person who is, or has recently been, on the premises of your school, *[name of school]*, has, or may have, *[either* an infection *or* a contamination*]* that could present a risk of significant harm to the health of *[*other*]* pupils at your school.

In order that we may ascertain whether pupils at the school have been affected, you are required to provide a list of the names, addresses and contact telephone numbers for *[either* all the pupils at your school *or* all the pupils in *[name of department or class]]*. The list must be provided *[either* by *[date] or* within *[x]* days*]*.

You are under a statutory obligation to comply with this notice, which is served under regulation 3 of the Health Protection (Local Authority Powers) Regulations 2010 (SI 2010/657). It is a criminal offence to fail without reasonable excuse to comply with this notice, punishable on conviction by a fine of up to level 1 on the standard scale *[*equivalent to £____ *]*.

You are required to send the list to the officer whose details are given below. This officer is also available to discuss the notice with you.

| | |
|---|---|
| Name | |
| Address | |
| | |
| Phone number | |

Alternatively, you may email the list to us at *[email address]*.

*[local authority name]*
*[date]*

**Request for co-operation for health protection purposes: template of letter of request**

Please note that this template is a model only – the format is not specified in legislation.

Dear *[name]*,

Under Regulation 8 of the Health Protection (Local Authority Powers) Regulations 2010, SI no. 2010/657, *[name of local authority]* hereby request that you:

_____

_____

_____

*[to include an explanation that the request is made for the purpose of preventing, protecting against, controlling or providing a public health response to the incidence or spread of infection or contamination which presents or could present significant harm to human health]*

*[*To help you comply with this request, *[name of local authority]* is willing to pay you *[either* compensation of £_____ *or* expenses for _____ *]. ]*

Please contact us using the details below if you have any queries regarding this notice *[*or to arrange payment*]*.

| | |
|---|---|
| Name | |
| Address | |
| | |
| | |
| Phone | |

*[local authority name]*
*[date]*

**Restriction of contact with dead bodies: template of notice**

Please note that this template is a model only – the format is not specified in legislation.

STATUTORY NOTICE

UNAUTHORISED CONTACT WITH *[either* THE BODY OF *[NAME], if known, or (if unknown)* THIS BODY*]* IS PROHIBITED under Regulation 9 of the Health Protection (Local Authority Powers) Regulations 2010, SI no. 2010/657.

This Regulation is used to restrict contact with a body which is, or may be, infected or contaminated in a way that could present a risk of significant harm to human health.

Breach of this prohibition is a criminal offence. You may be liable on conviction to a fine of up to £_____.

Any queries regarding this notice may be addressed to:

| | |
|---|---|
| Name | |
| Address | |
| | |
| | |
| Phone | |

*[local authority name]*
*[date]*

**Restriction of access to dead bodies: template of notice**

Please note that this template is a model only – the format is not specified in legislation.

STATUTORY NOTICE

UNAUTHORISED ENTRY INTO THIS ROOM IS PROHIBITED under Regulation 10 of the Health Protection (Local Authority Powers) Regulations 2010, SI no. 2010/657

This Regulation is used to restrict access to a body which is, or may be, infected or contaminated in a way that could present a risk of significant harm to human health.

Breach of this prohibition is a criminal offence. You may liable on conviction to a fine of up to £_____.

Any queries regarding this notice may be addressed to:

| | |
|---|---|
| Name | |
| Address | |
| | |
| | |
| Phone | |

*[local authority name]*
*[date]*

## Appendix 5: Powers of entry and inspection

A local authority has various powers to enter premises to carry out health protection functions. These are outlined below.

Note that there are some differences from the powers under the 1984 Act before it was amended. Now:

- entry to a private dwelling always requires a justice of the peace (JP) warrant or order;
- entry to a factory or workplace, as with any other premises, requires 24 hours' notice (unless specifically authorised before then in a case of urgency by a JP warrant or order);
- a JP order under Part 2A may authorise entry in the same way as a warrant (see below) and for the same purpose; in such a case the person authorised to enter does not have to be a proper officer.

**Automatic right of entry**

A proper officer of a local authority (or port health authority) has an **automatic** right to enter premises at all reasonable hours, other than any part of premises used as a private dwelling, in order to:

- find out if a Part 2A Order has been breached; or
- find out if he/she should be taking action in relation to an order; or
- take action in relation to an order; or
- generally, for the performance of the local authority/port health authority functions in relation to an order.

(See section 61(1) of the 1984 Act.)

However, if admission is refused then it cannot be demanded as of right unless 24 hours' notice of the intended entry has been given to the occupier.

If admission is still refused, a warrant will be necessary.

Please note that powers of entry also exist in relation to workplaces under the Health and Safety at Work etc Act 1974 (section 20). A local authority officer authorised under that Act has powers to enter premises for certain purposes.

**Entry by warrant**

Where the local authority can demonstrate reasonable grounds for entry into the premises then an application can be made to a JP for a warrant to authorise entry, if need be by force. Therefore, if the local authority wished to have entry powers equivalent to those provided for in a warrant, they should expressly say so in their application.

The local authority must be able to satisfy the JP:

- that admission to any premises has been refused, or
- that refusal is anticipated, or
- that the premises are unoccupied or the occupier is temporarily absent, or
- that the case is one of urgency, or
- that an application for admission would defeat the object of the entry.

The JP must be satisfied that the local authority has given notice to the occupier of their intention to apply for a warrant, unless

- the premises are unoccupied, or
- the occupier is temporarily absent, or
- the case is one of urgency, or
- the giving of such notice would defeat the object of the entry.

These powers of entry allow the proper officer to carry out any of the following and to take with him or her any other people, and any equipment and materials necessary for the relevant purpose(s):

- search the premises;
- carry out measurements and tests of the premises or anything found on them;
- take and retain samples of the premises or anything found on them;
- inspect and/or take copies of any documents or records found on the premises;
- require electronic information accessible from the premises to be produced;
- seize, detain or remove anything the officer reasonably believes to be relevant evidence.

(See sections 61(1), (2) & (2A) and 62(1) & (1A) of the 1984 Act)

When exercising the power of entry, a proper officer must produce his/her authority on request.

(See section 61(1) of the 1984 Act.)

**Powers of entry under a Part 2A Order**

A Part 2A Order may authorise entry in exactly the same way as a warrant. Therefore, when making an application for a Part 2A Order, in some circumstances the local authority may need to consider a request that the JP provides for the order to authorise entry into the relevant premises, if need be by force (the person authorised need not be a proper officer).

This might apply where, for example:

- a proper officer has been refused entry to a premises; or
- the premises is unoccupied; or

- a proper officer wishes to enter a premises without giving 24 hours notice to the occupier; or
- a proper officer wishes to enter a premises or part of premises which is used as a private dwelling; or
- enforcement is to be carried out by a person other than the proper officer (and a proper officer is not to be present).

As for a warrant, the JP must be satisfied that the local authority has given notice to the occupier of their intention to apply for an order authorising entry, unless

- the premises are unoccupied, or
- the occupier is temporarily absent, or
- the case is one of urgency, or
- the giving of such notice would defeat the object of the entry.

Where the JP authorises entry under a Part 2A Order, the supplementary powers listed above automatically apply.

**General requirements**

A warrant continues in force until the purpose for which entry is necessary has been satisfied. If entry is authorised by a Part 2A Order, that order will specify the period for which it remains in force. When seeking the order the local authority will need to consider for how long they need the power of entry to apply. They may also apply for an extension if that proves necessary.

Where entry has been gained by force, the officer must leave the premises as effectively secured as he or she found them.

(See sections 45K (6), 61(2A), (3) & (4) and 62(1) & (1A) of the 1984 Act.)