



THE SCOUTMED (CODE OF CONDUCT) POLICY COVERING:

Patient Report Forms.
Duty of Care.
Confidentiality & Disclosure.
Fitness to Practise and Conduct
Capacity & Consent
Training & Recruitment
Disciplinary Procedure

Version 3: 2010.

Notes:

This policy will apply to all members of ScoutMed. Where the male gender is mentioned it applies equally to the female gender.

The term “member” will apply to any member of ScoutMed who works either in an operational or support role.

The term “young person” refers to anyone under the age of 18 years.

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INTRODUCTION.

PURPOSE.

The purpose of this Policy is to provide a “guidance and safeguarding” framework that balances the rights and needs of the patient, young person (where applicable) and ScoutMed member, thus creating a safe non-threatening environment where patients can receive appropriate and timely care.

RATIONALE.

Members of ScoutMed are obviously in positions of trust. There will be occasions when members of ScoutMed will have access to confidential information regarding patient’s medical histories and social problems.

In addition, members of ScoutMed may well have to undertake examinations of patients and render treatments. Many of our patients will be young people; therefore, this places ScoutMed members in a unique position of trust.

Remember you will often be dealing with people who are at their most vulnerable because of illness or injury, and may be additionally vulnerable because of who they are; the elderly and children are examples.

Therefore, a policy covering conduct is required for the protection of both patients and members. This is in line with other organisations that care for patients.

ScoutMed members should do nothing that brings them, ScoutMed or the Scout Association into disrepute. Following this policy will help to ensure that this does not happen.

SECTION 1: PATIENT REPORT FORMS.

RATIONALE.

A Patient Report Form (PRF) is a legal record of your actions at an incident and your actions with regard to patient care. It allows you to document your actions: **what you saw, what you found, what you did**, and just as importantly, **what you didn't do**.

POLICY OBLIGATIONS.

- 1.1. A PRF must be completed for every patient that you see.
- 1.2. If the patient is sent to hospital, or referred to a doctor, the PRF will become part of the patient's medical records, which will be viewed by those involved in the patient's ongoing care. It can also be used in court under certain circumstances. It is, therefore, very important that a PRF is filled out with as much detail as possible.
- 1.3. In the case of health care professionals, please remember you are also under an obligation under the terms of your professional registration to maintain accurate record keeping.¹ Failure to do so may lead to action by your Registrant Body.
- 1.4. Once completed, a copy of the PRF must be handed to any health care professional that takes over the patients care. E.g. ambulance crew, nurse etc. If the patient refuses treatment a note must be made on the PRF to this effect and the patient asked to sign a disclaimer.
- 1.5. ScoutMed should retain a copy of the PRF for its records. This will enable ScoutMed members involved in the treatment of the patient to refer back to the PRF at a later date in the event of a query arising.
- 1.6. The PRF could form the basis of a defence should a matter proceed to court. In addition, if the circumstances surrounding an incident ended up before a court, the PRF will act as an aide memoir and factual legal record.
- 1.7. The legal view of medical records generally is that **if it wasn't recorded it wasn't done**.
- 1.8. All relevant information relating to the patient should be recorded on the PRF. This typically would include:
 - 1.8.1. The age and sex of the patient
 - 1.8.2. The circumstances leading up to the incident.

¹ Health Professions Council. *Standards of Conduct, Performance and Ethics*. London. HPC; 2008. Nursing and Midwifery Council. *Standards of Conduct, Performance and Ethics for Nurses and Midwives*. London. NMC; 2008. General Medical Council *Good Medical Practice. The duties of a doctor registered with the General Medical Council*. London. GMC:2009.

- 1.8.3. The patients presenting complaint (what is it that has made them call for, or seek, help).
- 1.8.4. The patients past medical history.
- 1.8.5. Any medications that the patient is on and any known allergies.
- 1.8.6. What examination of the patient revealed including your observations: for example pulse, respiration etc., any injuries found and so on.
- 1.8.7. What treatment you carried out and at what time.
- 1.8.8. Patient disposal: e.g. hospital, home etc., and if the patient is returned to camp or sent home, any ongoing advice given.
- 1.8.9. Also include **pertinent negatives** if applicable. A pertinent negative is what you didn't do or couldn't find and the reasons for this.

E.g. "The patient refused to let me examine him. The patient's breath smelled of alcohol. Because of this I was unable to assess the extent of his injuries"

Note: that the patient has not been accused of being "drunk" because this is hard to prove without the necessary tests. However, the reasons for NOT being able to examine the patient (pertinent negative) have been recorded and the reasons why.

SECTION 2: DUTY OF CARE.

RATIONALE.

A very real concern of people going out to assist others is the fear (real or perceived) of litigation in the event of things going wrong.

The grounds that are frequently cited in legal cases are usually a *failure in the duty of care towards the patient* resulting in a claim for *negligence*.

Most patients, however, who are unhappy at any aspect of their care, often find that they have no case for legal action. Therefore, most patients who are unhappy at the way in which they have been treated usually resort to the complaints procedures that the various service providers have in place.

Complaints should always be taken seriously because this may be one way in which major faults in a system, or a persons abilities, are identified and drawn to the attention of the organisation concerned. Failure to take complaints seriously, may lead to other patients having grounds for legal action in the future if an identified and foreseeable cause of harm is not remedied.

The fact that legal cases for negligence are not as common, or as successful, as people like to think, should not lull health care providers into a false sense of security, because where cases do succeed the damages awarded are usually substantial.

POLICY OBLIGATIONS.

2. This Policy cannot cover all aspects of the law relating to the care of patients. However, it will attempt to cover some basic principles to guide ScoutMed members carrying out their duties.
 - 2.1. Patients who are aggrieved at their standard of care and who think that they have a case in law will almost certainly attempt to bring an action for negligence. They will resort to the *Tort* system, or civil law. In essence, they will have to bring an action through the civil courts because the individual feels that they have been wronged. This is opposed to the criminal law where the action is brought by society, the Crown, irrespective of the position of the individual, because it is society that has been wronged.

There are also two standards of proof depending on which court system is used:

- 2.2. Criminal cases (those that are brought by the Crown) have to be proved **beyond reasonable doubt**.
- 2.3. In cases under the Tort system (civil law) cases have to be proved on the **balance of probabilities**.
- 2.4. The standard of proof in the civil courts, therefore, is lower than in the criminal courts.

- 2.5. For a negligence action to succeed the person bringing the action (**the claimant**) must be able to prove three things:²
- 2.5.1. First, the persons being sued had the responsibility for the patients care at the time of the alleged mishap. In other words the person(s) being sued (the **defendant(s)**) owed the patient a **DUTY OF CARE**.
 - 2.5.2. Second, the claimant has to show that the standard of care given by the defendant(s) fell short of that prescribed by law. The law will frequently use the standards set by the defendants peers to assess whether the standard of care fell short.³ For example, if a paramedic was being sued for some alleged failure, the courts will ask and seek clarification as to what other reasonable paramedics (the peers of the defendant) would have done under the same circumstances. If the body of opinion amongst the paramedic profession states that they would have taken the same course of action under the same circumstances, then this area of the claimant's case may fail. Thus the defendant would not be held to be negligent.
 - 2.5.3. Third, the claimant has to show the harm that they are suing for is as a result of, and caused by, the defendant(s) failure to practise properly. Showing the defendant owed a duty of care then breached it will amount to little, even if the defendant was at fault, if the claimant is unable to show that failing to provide a satisfactory standard of care was the cause of the harm suffered. To do this the claimant must demonstrate that "but for" the defendants negligence he would not have suffered the harm in respect of which he seeks damages.⁴ This is usually very difficult to prove.
 - 2.5.4. If the claimant cannot meet and prove all three of the tests for negligence, namely, duty of care, failure in the duty of care standard, and causation, the action will fail.

DUTY OF CARE.

- 2.6. When do you owe someone a duty of care?
- 2.6.1. There has to be a connection between the defendant and claimant. If the connection between the two is very tenuous the courts might well accept that it is inappropriate to hold the defendant to account. In addition courts will often consider the arguments appealing to public policy. A duty of care, for example, will only exist where it is just and reasonable.
 - 2.6.2. In some circumstances establishing a duty of care is straightforward. If a patient is in hospital, then hospital staff will owe that patient a duty of care, and may be liable in Tort if a member of staff through a reasonably foreseeable action causes harm to the patient.

² McHale. J., Fox. M. Gunn. M., Wilkinson. S. *Health Care Law: Text and Materials*. Second Edition. (London. Sweet & Maxwell. 2007).

³ *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118

⁴ *Barnett v Chelsea and Kensington Hospital Management Committee* [1968] 1 All E.R.

- 2.6.3. Overall, however, there is an absence of an established duty of care. English law does not impose upon doctors or other health care professionals any obligation to provide treatment to those who require it, although there is likely to be a professional duty to provide care to those in need.⁵
- 2.6.4. The law has been markedly reluctant to impose duty of care obligations on professionals and institutions, although some limited exceptions have been made. In *Barnett v Chelsea and Kensington Hospital Management Committee* it was established that where a patient presents at a casualty department there is an obligation to provide care.⁶ General practitioners are also obligated to provide emergency care to *their* patients within their practice area.⁷ Until recently these were the established exceptions, and if a patient could not bring themselves within them, they would have had to positively show that they were owed a duty of care before bringing a claim for medical negligence.
- 2.6.5. English law is also currently marked by a strong reluctance to hold emergency service providers liable in negligence, however egregious their failure to help those in need.⁸ Common law systems, such as that used in the UK, have traditionally taken the view that private citizens should not be subject to compulsory altruism especially if they are unequipped and untrained to help those in need.⁹ English law jurisprudence appears to have applied this principle to members of the emergency services. The police¹⁰, fire brigade¹¹ and coastguard¹² have no duty to go to the assistance of people or property in peril, there is no private law obligation to respond to summons for help and if and when they do turn up, need pay no damages unless by active carelessness make a bad situation worse. There is in effect no public duty on publicly funded rescue services to rescue. The reasons are most probably down to the reluctance of the judiciary to impose duties of affirmative action, fearing an indeterminate number of claims that may drain budgets and have detrimental effect on public services.^{13 14}
- 2.6.6. Until recently this principle of the altruistic emergency service seemed to apply to ambulance services. They appeared to be under no legal obligation to provide emergency care to anyone who was not already a patient of the professional in question. The NHS ambulance service had assumed that it was

⁵ McHale, J., Fox, M. Gunn, M., Wilkinson, S. *Health Care Law: Text and Materials*. Second Edition. (London. Sweet & Maxwell. 2007).

⁶ [1968] 1 All E.R. 1068

⁷ NHS (General Medical Services Contracts) Regulations 2004 SI 291, Reg 15(6).

⁸ Williams, K. Litigation Against NHS Ambulance Services and the Rule in *Kent v Griffiths*. *Medical Law Review*. (2007) 15, 153.

⁹ McHale, J., Fox, M. Gunn, M., Wilkinson, S. *Health Care Law: Text and Materials*. Second Edition. (London. Sweet & Maxwell. 2007).

¹⁰ *Alexandrou v Oxford* [1993] All E.R. 328

¹¹ *Capital and Counties Plc v Hampshire CC* [1997] Q.B. 1004

¹² *OLL Ltd. v Secretary of State for Transport* [1997] 3 All E.R. 897

¹³ Williams, K. Litigation Against NHS Ambulance Services and the Rule in *Kent v Griffiths*. *Medical Law Review*. (2007) 15, 153.

¹⁴ Interestingly the situation appears slightly different in Scotland. See *Gibson v CC of Strathclyde* [1999] S.C. 420 (police liable after failing to warn motorists over collapsed road bridge) and *Duff v Highlands and Islands Fire Board* [1995] S.L.T. 1362 (negligent fire authority not immune from liability).

under no duty to respond to calls for help. A landmark ruling in *Kent v Griffiths* established, at least in part, as with general practitioners and casualty departments, NHS ambulance services had a duty to respond under certain circumstances.¹⁵ It was ruled that NHS ambulance services were more akin to hospitals who owed a duty of care to their patients rather than the other services who undertook a rescue function to the public at large.¹⁶

- 2.6.7. Case law has essentially established that if you decide to stop at an incident, whilst “off duty” and *offer* some form of first aid assistance, you are under a duty of care to the patient (as any member of the public would be) You are, however, not under any contractual obligation and, therefore, owe no legal duty of care to stop in the first place, or even offer the assistance once you have stopped. Provided that you have not offered assistance you are quite free legally to get in your car and drive off. This is of course morally reprehensible and, in the case of registered health care professionals, may invite professional sanction.
- 2.6.8. If you are on duty as a ScoutMed member, you are almost certainly under a duty of care if a patient arrives at the treatment centre, because you have established a place of treatment akin to an A&E department, or GP surgery. If you accept a call to respond for medical/first aid assistance away from the treatment centre, and have resources available, once you have indicated that you will respond to that request for help, ScoutMed will then owe that patient a duty of care. If no resources are available to send, then the duty of care requirement is not likely to exist until they are available and can be sent.

STANDARD OF CARE.

- 2.7. The standard of care that you provide would be subject to the **BOLAM TEST**. This very important standard was established in a case in 1957. In *Bolam v Friern Barnet HMC* it was held that¹⁷:

“A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art...a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view. At the same time, that does not mean that a medical man can obstinately and pig-headedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion...”

- 2.7.1. The Bolam test has been used by the courts in a number of cases and essentially means that health care professionals will be judged against the

¹⁵ [2001] Q.B. 36. Mrs Kent suffered an asthma attack whilst pregnant. Her doctor dialled 999 and asked for an ambulance. The ambulance inexplicably took 40 minutes to travel the six and half miles to her home, an average speed of 12 miles per hour. The crew also falsified the paperwork showing an earlier arrival time. Mrs Kent suffered a respiratory arrest, brain damage and miscarriage which the court held would most likely have been averted had there not been an unreasonable delay.

¹⁶ *Kent v Griffiths* [2001] Q.B. 36, per Lord Woolf at 40.

¹⁷ [1957] 2 All ER 118 per McNair J. at 121.

standards of their peers.¹⁸ ScoutMed members who are not professional health care providers are still under obligation not to do anything outside the scope of their training. In the event of mishap, ScoutMed members would be judged against the standards of their peers, in other words other ScoutMed members, or other similar reasonable body. The extent of the training and experience of the members concerned would also have to be taken into account. Members of ScoutMed who are health care professionals would be judged against the opinions and standards set by their professional peers (as they would be in their usual professional role). The courts have reserved the right to override peer opinion, however, on the rare occasion when that opinion is manifestly wrong: the judiciary must satisfy themselves that the opinions offered are both respectable and responsible and stand up to logical analysis.^{19 20}

- 2.7.2. If you work within the boundaries of your training and experience, carrying out such treatment that is in accordance with a reasonable and responsible body of peer opinion (following guidance laid down in ScoutMed guidelines, up to date first aid books etc., will bring you within that opinion) then it is most unlikely that you will ever be found to be in breach of duty.

CAUSATION.

- 2.8. Proving causation is often very difficult. Even if the defendant behaved negligently and unprofessionally, if the resulting harm would have occurred anyway - the courts will find in favour of the defendant. Four particular problems have been identified when a claimant tries to prove causation:²¹

- 2.8.1. First, the claimant may have difficulty in proving that any exacerbation of his ill health was attributable to the negligence of the defendant rather than just a simple progression of the illness/injury, especially given the courts willingness to accept even the smallest odds of harm occurring other than through negligent acts.²²
- 2.8.2. Second, medical knowledge has its limits and the aetiology of illness is not always understood even by those with medical expertise.²³ Nor are the side-effects and long term effects of all drugs known.²⁴ Consequently if there is no expert consensus on how an illness will progress or how a drug, especially a new one, will act under different circumstances, then there is no comparator against which to judge negligence by.

¹⁸ *Whitehouse v Jordan*. [1981] 1 All ER 267. Also *Sharkoor v Situ* [2000] 4 All E.R. 181, *Maynard v West Midlands HA* [1985] 1 All E.R. 635, [1984] 1 W.L.R. 634, *De Freitas v O'Brien* [1993] 4 Med. L. R.

¹⁹ *Sidaway v Bethlem RHG* [1985] 1 All E.R. 643, [1985] 1 A.C. 871.

²⁰ *Hucks v Cole* [1994] 4 Med. L. R. 393.

²¹ McHale. J., Fox. M. Gunn. M., Wilkinson. S. *Health Care Law: Text and Materials*. Second Edition. (London. Sweet & Maxwell. 2007).

²² *Howard v Wessex Health Authority* [1994] 5 Med. L.R. 57.

²³ *Kay v Ayrshire and Arran Health Board*. [1987] 2 All E.R. 417.

²⁴ *Loveday v Renton* [1990] 1 Med L.R. 117.

- 2.8.3. The third difficulty is establishing causation when there are multiple causal agents at work.²⁵
- 2.8.4. The fourth difficulty, is establishing causation to the requisite standard of proof. The claimant has to establish on the balance of probabilities that the injuries were more likely than not caused by the defendant's negligence. A misdiagnosis *per se* is not necessarily negligent. The House of Lords has ruled that if a misdiagnosis is made it can only be negligent if it can be shown a correct diagnosis, and subsequent treatment as a result of a correct diagnosis, would probably have worked to avoid or reduce harm.²⁶
- 2.9. Ordinarily, given the scope of work that ScoutMed performs, and provided you do not step outside of your training and experience and adhere to the laid down policies and guidelines, members will always have a robust defence should any claim ever be lodged.

²⁵ *Wilshire v Essex AHA* [1988] 1 All E.R. 871 (HL). A two-day-old premature infant was given too much oxygen whilst in hospital. Later the child was discovered to be blind. The overdose of oxygen was in itself negligent and can lead to a condition causing blindness. A complication of being born premature is also blindness, in fact it was established that there were potentially four other possible causes of blindness other than the oxygen overdose. The House of Lords ruled that as the claimant could not as a fact prove the oxygen was the most probable cause for the blindness, struck out the claim for negligence.

²⁶ *Hotson v East Berkshire AHA* [1987] 2 All E.R. 909.

SECTION 3: CONFIDENTIALITY.

RATIONALE.

The ethical principle of confidentiality within health care is centuries old. It is believed that reference to confidentiality was made by the Greek physician Hippocrates 2,500 years ago and laid down in the Hippocratic Oath²⁷ although the Oath has since been updated.²⁸

A duty of confidence arises when one person discloses information to another, for example patient to clinician, in circumstances where it is reasonable to expect that information will be held in confidence²⁹. For many years the principle of confidentiality was satisfied provided a health care provider did not talk laxly about their patients to others.

Many patients will be treated by a multi-disciplinary team, sensitive information is increasingly held electronically with many staff, clinical and non-clinical, able to access it; and there is often a demand for patient data from leaders, insurance companies, and Scout Headquarters etc.

There are, therefore, numerous opportunities for inappropriate disclosure and access to information. Sometimes what is held on a patient record goes far beyond what is required to simply diagnose and treat a patient's illness, some of this information is likely to be very sensitive in nature and even very damaging in the wrong hands.

Under the Data Protection Act 1998 patient records are automatically classed as "sensitive data" which places additional conditions on their use.³⁰ This legislation covers all accessible patient records including those held electronically and in manual filing systems.³¹ Processing of information under the Act includes the holding, obtaining, recording, using and disclosing of patient information. Health care providers and others handling data become "data processors" and are expected to comply with its principles. Overseeing of this compliance will rest with the "data controller". The responsibilities of the Data Controller within ScoutMed will rest with the Clinical Operations Manager.

The first data protection principle, that information has to be processed *lawfully* and *fairly*, is found in the schedules contained within the Act³². The schedules are drawn partly from statute and partly from the common law of confidentiality. To satisfy the *lawful* requirement, the first data principle has two sets of criteria that have to be satisfied by both data processors and controllers, the first because patient records contain personal data and the second because they contain sensitive data.

²⁷ "And about whatever I may see or hear in treatment, or even without treatment, in the life of human beings, I will remain silent, holding such things to be unutterable". Hippocrates (460-377 BC). Given that the oath starts "I swear by Apollo the physician and by Asclepius and Hygieia and Panacea...to bring the following oath to fulfilment" it has been updated to reflect contemporary society, although its original principles hold true.

²⁸ General Medical Council. *Good Medical Practice*. London. General Medical Council; 2006.

²⁹ Department of Health. *Confidentiality: NHS Code of Practice*. London. DoH; 2003.

³⁰ Data Protection Act 1998, Section. 2(e).

³¹ Data Protection Act 1998 Section. 1(a-d).

³² Data Protection Act 1998. Schedule 1, Part I, II.

To satisfy the first criteria, one of the following conditions has to be met: the patient has consented to use of the data; it is necessary to process the data in the patient's vital interests; and it is necessary to process the data to carry out a statutory or government function.³³ It is believed that provided data is only handled for the purposes of record keeping or audit, consent under the first criteria need only be implied and not explicit, provided the patient is given general information as to what uses the data will be put.

The second set of criteria requires that one of the following conditions is met: the patient has given explicit consent to the information being used; processing the information is vital in protecting the interest of the patient where it is not possible to gain consent; processing is necessary for the purpose of, or in connection with, legal proceedings, or is otherwise necessary for the purposes of establishing, exercising or defending legal rights: the processing is necessary for medical purposes and is undertaken by a health professional or a person owing a duty of confidentiality equivalent to that owed by a health professional.³⁴

Confidentiality, however, is not absolute. Where the wider public may be at risk the legislature has intended that proportional release of information is permitted whether the patient has consented or not.

The Data Protection (Processing of Sensitive Personal Data) Order 2000 allows processing and disclosure of data without explicit consent where: to seek such consent may be prejudicial; and where it is in the substantial public interest and is necessary to protect the public from; a) the commissioning of an unlawful act, whether alleged or established; b) malpractice, dishonesty or seriously improper conduct of any person, alleged or established; c) mismanagement in the administration of, or failures in services provided by, any body or association, whether alleged or established.³⁵

In cases of child protection breaking a confidence in good faith, where there is reasonable suspicion that a patient may be abusing a child, is lawful and is seen as a positive obligation.^{36 37 38} Disclosure is also allowed to maintain public order and to prevent terrorist acts.^{39 40} In the event that a case reaches court the efficiency of the justice system will override maintaining confidentiality. If a judge requires confidential information to be revealed by a health care professional then the professional has to comply.⁴¹

³³ Data Protection Act 1998, Schedule 1, 2.

³⁴ Data Protection Act 1998, Schedule 1, Part I, II.

³⁵ Statutory Instrument 2000, No.417, Section 1, 2, 3.

³⁶ *Re M* [1990]1 All E.R. 205, 213. The Court of Appeal (Civil Division) ruled that documents relating to the welfare of children would enjoy a special form of immunity and disclosure could be justified in the circumstances of a particular case. If there was doubt as to the validity of disclosure courts could inspect documents to decide if the material was of real importance to the parties proposing or seeking disclosure.

³⁷ Department of Health, Home Office, Department for Education and Employment. *Working Together to Safeguard Children*. London. Stationary Office. 1999.

³⁸ Children Act 1989, Section 47, Sub Section 9.

³⁹ Crime and Disorder Act 1998, Section 115.

⁴⁰ Anti-Terrorism, Crime and Security Act 2001, Section 17.

⁴¹ *AG v Mulholland* [1962] 2 QB 477, 489.

POLICY OBLIGATIONS.

The guiding principle when dealing with patients is to ensure their safety and to respect their privacy. Sometimes, however, these two principles will conflict and clear policy will guide ScoutMed members.

3. A breach of patient confidentiality, except in specified circumstances, will be dealt with as an act of **gross misconduct**.
 - 3.1. A member breaching confidentiality, except in specified circumstances, will be liable to dismissal from ScoutMed.
 - 3.2. Members of ScoutMed will not disclose any information about patients to others except in the following circumstances:
 - 3.2.1. Information relevant to a patients care should be passed on to others taking over this care. E.g. ambulance crew, doctor, nurse etc. Indeed it is important to relay as much relevant information as possible to others taking over a patients care.
 - 3.2.2. It is recognised that from time to time information may have to be passed onto various sections within the Scout Association regarding patients with whom ScoutMed has had to deal with. General information (gender, age, details of the incident, rough outline of the problem) etc may be given to Scout Association Officials, provided it does not identify anything of a *personal* nature. It will be up to the discretion of ScoutMed members if the patients name is released. The patients name may be required in the event of formal investigations. Generally it is not acceptable to state anything that will give away details about any personnel problems, “preferences”, past medical history, etc.
 - 3.2.3. The overriding duty of ScoutMed is the safety of young people, patients and members of the Scout Association. In the event of any incident where there have been concerns with regard to health and safety, it would be acceptable to release any necessary details to enable an investigation to take place following an incident. As a rough guide the information that ScoutMed should provide will be in line with the information that is required when filling in the various HSE reporting forms that are in use. Under these circumstances the release of the patient’s name, address and general details of injuries, plus a full report into the circumstances will be allowed, but details of the patients past medical history, any personal problems etc, which have come to light, will not.
 - 3.2.4. Wherever possible the consent of the patient will be sought prior to discussing their problems with any relatives, leaders etc, unless implied consent is given. For example, if a patients next of kin (or leader) is present whilst you deal with the patient and the patient has no objection to him/her being there.
 - 3.2.5. If the patients consent to disclosure cannot be obtained due to incapacity or lack of mental capacity, it will be acceptable to discuss the patient’s condition with the next of kin or another close relative, or if on a scout duty with the

responsible leader, in order to obtain and pass on information about the patient to assist in their care.

- 3.2.6. It is a matter of good practice to inform parents whenever a child is conveyed to hospital as the hospital may require the parents consent to treat under certain circumstances. However, if a young person is “Gillick competent” and they specifically ask that you do not discuss their problems with a parent (or anyone else) you should not do so except as outlined below. However, you should still inform the parent if the child is going to hospital.
- 3.2.7. Members of ScoutMed will have a duty to disclose where it is in the **interests of society to do so**. For example, if it becomes apparent during your dealings with a patient, that he or she intends to harm another person, or indeed has harmed another person, the matter must be reported.
- 3.2.8. If you genuinely believe that a young person (under 18 years) may have intentions of harming himself or herself, this must be disclosed to the appropriate agencies. In the case of patients aged 18 years or over threatening self harm: if the patient lacks mental capacity (see Section 5) you may discuss their case with others to obtain advice. If a patient over the age of 18 years has mental capacity (see Section 5) and declines to consent for you to discuss their case with others, then you would have to be able to justify any breach in confidentiality. Remember that the law recognises the right of rationale people to do irrational things.⁴²
- 3.2.9. **In suspected cases of child abuse it will be ScoutMed policy to report and disclose all factual information to the relevant authorities.**
- 3.2.10. It is now generally accepted that drug abuse by an *adult* patient will remain confidential unless there is an overriding reason why it should be reported. Any ScoutMed members reporting an *adult* patient's drug abuse habits to the relevant authorities would have to show an overriding reason for doing so.
- 3.2.11. The rights of the patient need to be balanced against the rights of society; therefore co-operation with the police may be necessary at some incidents. Except in cases that fall under 3.2.9, the release of information should not be routine and only factual information which is strictly necessary should be released. For example, if a patient who is HIV positive is assaulted, it would probably be perfectly proper and acceptable to discuss the details of the assault with the police regarding injuries etc., it would, however, be most improper to disclose the patients HIV status, or other medical problems, without the patients consent unless disclosure was required to protect others.

Where the patient is deceased the police may act as coroner's officers. HM Coroner has far reaching powers and may request information through the police, and such requests for information must be met if it is possessed. The coroner and his representatives are sensitive to the needs of the patient's relatives and will usually only seek information that is really necessary.

⁴² *B v NHS Trust* [2002] 2 All E.R. 449.

- 3.3. All information about a patient should be recorded on a PRF.
- 3.3.1. The following guidance should be followed with regard to PRF's.
- 3.3.2. It will be ScoutMed policy that the patient will be entitled to see their medical records (PRF).
- 3.3.3. They will also be entitled to obtain a copy of the PRF at a later date for which an administration charge may be payable. The administration charge will be decided by the ScoutMed Executive and periodically reviewed.
- 3.3.4. If the patient is requesting to view a copy of the PRF later on after an incident, or wishes to collect a copy, an appointment should be made and the patient requested to bring some form of identification to verify who they are.
- 3.3.5. Acceptable forms of identification are:
- Passport.
 - Driving licence with photograph.
 - A known works identification card
- Or
- At the discretion of ScoutMed, another form of identification that can clearly identify the patient, and which can easily be validated.
- 3.3.6. The patient may also apply for a copy of their records to be sent to them in the post. All applications must be in writing. Reasonable attempts should be made to ensure that the patient has mental capacity (see Section 5) and it is the patient making the request. For example, phoning the patient and talking to them.
- 3.3.7. A patient's medical records can be released to others if the patient gives their written consent for this to be done. Reasonable attempts should be made to ensure that the patient has mental capacity (see Section 5) to consent. For example, phoning the patient and talking to them. If the patient lacks mental capacity the request should come for the patients Lasting Power of Attorney accompanied by an appropriate form of identification. In the case of young people, if they are "Gillick competent" they have the right to request their records be released, or withheld, subject to the provisos laid down in this policy. If they lack Gillick competence, the request for information will have to come from the young person's parent or legal guardian, with appropriate proof of identification being supplied.
- 3.3.8. A copy of the PRF should always be passed on to other health care providers taking over the patient's care.

- 3.3.9. Copies of PRF's will be kept secure at all times. They must not be left laying around in general view. Electronic patient data must be password protected and must not be sent via email unless the message can be encrypted.
- 3.3.10. PRF's will be kept for ten years and in the case of children for ten years after they reach the age of majority.
- 3.3.11. Once this time limit has expired, copies of the PRF must either be shredded or incinerated. **Under no circumstances should the PRF's be disposed of in domestic refuse**

SECTION 4: FITNESS TO PRACTISE AND CONDUCT.

RATIONALE.

Because those who are called upon to help people in their hour of need are in a unique position of trust, and the fact that it may be quite hard for a patient to prove negligence, it is incumbent on organisations that provide this care to rigorously “police themselves”.

Indeed the courts look to health care provider organisations to “self regulate”, and have proper procedures in place to deal with complaints while ensuring that the highest standards of best practice are maintained.

The patient has a right to expect to be treated with respect and dignity by individuals who are of the highest integrity. Patients will trust you and it is up to all members of ScoutMed to ensure that this trust is not misplaced.

POLICY OBLIGATIONS.

To meet our obligations of trust, it is necessary to specify conduct criteria within which ScoutMed members will be expected to work.

4. A member of ScoutMed will automatically be removed from membership **permanently**, if they receive a **criminal conviction**, or accept a **police caution**, for the following offences:
 - 4.1. Theft or fraud, whether or not arising during the course of ScoutMed duties.
 - 4.2. Indecency or sexual offences, whether or not arising during the course of ScoutMed duties.
 - 4.3. Violence or assault upon a member of the public or patient arising during the course of ScoutMed duties.
 - 4.4. Consideration will be given to removing ScoutMed personnel from first aid duties, either temporarily or permanently, if an act of gross misconduct is committed whether it results in formal police and/or court action or not.
 - 4.5. Gross misconduct will be defined as follows:
 - 4.5.1. Sexual, racial or other unlawful harassment contravening statute or accepted codes of practice during the course of ScoutMed duties.
 - 4.5.2. Malicious damage to ScoutMed property.
 - 4.5.3. Carelessness or negligence resulting in harm to a patient during the course of ScoutMed duties. This includes harm induced by practising outside the scope of your training, or through using equipment on which you have not been formally trained, assessed, and formally deemed competent to use.

- 4.5.4. Unjustified breach of confidentiality during the course of ScoutMed duties.
- 4.5.5. Provocative, turbulent or abusive behaviour towards patients, bystanders, relatives or colleagues, during the course of ScoutMed duties. This includes conduct that can be construed as bullying, harassing or demeaning towards colleagues.
- 4.5.6. Treating patients while your judgement is impaired through alcohol or illegal drugs whilst on duty.
- 4.5.7. Bringing ScoutMed into serious disrepute.
- 4.6. To promote the professionalism of ScoutMed, personnel should always conduct themselves in a polite, tactful and calm manner and should introduce themselves to the patient.
- 4.7. Remember that restraint and control are the hallmark of a professional even in the face of patients who may not be particularly pleasant or polite. However, this does not mean that you have to accept verbal or physical abuse. If the patient is verbally abusive, or aggressive, they should be warned that their behaviour is unacceptable. If the abuse continues and/or you feel your safety may be compromised you may decline to treat them. If the abusive patient has potentially life and/or limb threatening injuries, you should seek further advice as to the next steps that may be required to safeguard them and you.
- 4.8. It is necessary to consider the modesty and privacy of your patient and to protect their psychological safety and well-being. It is good practice to follow a few simple guidelines in this regard:
 - 4.8.1. Only undress a patient as much as is necessary to examine or treat them and then try to protect their modesty at all times. It is sometimes necessary to undress a patient fully to thoroughly examine them, by not doing so important information may be missed and this could be seen as being negligent. A sensible balance between modesty on the one hand and patient welfare on the other has to be struck.
 - 4.8.2. Always have a chaperon present when you examine a young person and patients of the opposite sex to the examiner. The chaperon should be another member of ScoutMed wherever possible and ideally, in the case of females being examined by a male member, the chaperon should be female.
 - 4.8.3. Always explain to the patient what you are going to do and the reasons for doing it. (See Section 5).
- 4.9. ScoutMed members must never act outside the scope of their training even if they come under pressure from others to do so.
- 4.10. ScoutMed members should always fully cooperate with other health care professionals who will be involved in the care of the patient, and if necessary hand over responsibility to those who possess a higher skill level.

- 4.11. In the event of a distressing incident there should be a debrief. Each member of ScoutMed who attended the incident should be given the opportunity to discuss what he or she did in detail in an **atmosphere free from blame and recrimination**. This will enable personnel to learn from their mistakes so that lessons can be learned. This debrief may be opened up to members who were not involved directly in the incident (provided that this is practical and those involved do not object) as others may learn from the experience. This could also act as a counselling session to enable personnel to “offload” stress.
- 4.12. ScoutMed members should also be aware of the risks of cross infection between themselves and their patients. Given the scope that ScoutMed members operate within, it is unlikely that they will transfer any serious infections to the patient should a ScoutMed member be suffering from one.
 - 4.12.1. However, as a precaution if a member of ScoutMed is unsure whether they are suffering from a potentially infectious illness, they should seek medical guidance before attending duties and treating patients.
 - 4.12.2. If a member of ScoutMed becomes aware that they may be suffering from Hepatitis (B & C strain especially) or HIV/AIDS infection, their practise will need to be modified in accordance with medical advice. It may be necessary for that individual to cease to treat patients altogether.
 - 4.12.3. An individual who suspects that they may have, or who knows they actually have, a serious *infectious* condition, must seek medical advice and not treat patients until they have been advised that it is safe to do so. Members so affected must inform the member in charge of ScoutMed. This information will be treated in the strictest confidence.
- 4.13. Although sensible precautions (wearing of personal protective equipment) will usually more than suffice in preventing any infection being transferred to ScoutMed personnel, it is a sensible precaution to ensure that vaccinations are up to date.
- 4.14. It is recommended that personnel ensure that they are covered for the following:
 - 4.14.1. Tuberculosis by means of the BCG vaccination.
 - 4.14.2. Polio.
 - 4.14.3. Tetanus & diphtheria.
 - 4.14.4. Hepatitis B
 - 4.14.5. Annual flu vaccination

- 4.15. Following the guidelines in this section will help to ensure that the patients that ScoutMed are called upon to treat will receive a high standard of care, by people displaying the highest levels of integrity and professionalism.

SECTION 5: CAPACITY AND CONSENT

RATIONALE - ADULTS.

It is necessary, not only from a legal viewpoint, but from the point of good practice to obtain the consent of patients before examining and treating them. There has been a major piece of law enacted since the last Policy was issued that relates mainly to adult patients – the Mental Capacity Act 2005, which came into force in 2007.

From the outset it is worth noting that the MCA has little to add to the position regarding adult patients with established contemporaneous capacity. If they are competent to consent, then consent must be sought prior to providing treatment to avoid liability in trespass to the person. Indeed one of the five statutory principles⁴³ of the MCA states that:

A person must be assumed to have capacity unless it is established that they lack capacity”

Consent should be obtained from the patient wherever possible for the treatment and probably the examination to be lawful.

Before anyone can give valid consent to medical treatment they must possess the requisite capacity.⁴⁴ Essentially if patients are competent to consent, then consent must be sought prior to providing treatment to avoid liability in trespass to the person. By definition this presumes patients have capacity, rationality, autonomy and freedom to make decisions free from coercion. The difficulty will arise where there is reason to believe that a person does not have the capacity to consent to treatment, it will then be necessary to consider whether an adult presumption of capacity can be rebutted.

It should be noted that members who attend unconscious patients may have broad protection under the MCA. **Provided there is no available evidence as to the patient’s advanced wishes, health professionals and others are granted general authority to act in the patients “best interests”.**⁴⁵ In the case of emergencies best interests are taken to mean to do what is immediately necessary to preserve life and prevent deterioration in health. This broadly upholds the status quo of common law principles namely, health professionals have a duty to their patients,⁴⁶ negligently failing to treat them may invite criminal charges⁴⁷ and professionals/others can treat patients under the common law doctrine of necessity⁴⁸ The MCA does not actually define what “best interests” are, merely that carers and professionals looking after a person lacking capacity should have a *reasonable belief* that they are acting in the persons best interests.⁴⁹

⁴³ Mental Capacity Act 2005, Section 1.

⁴⁴ See McHale. J., Fox. M. Gunn. M., Wilkinson. S. *Health Care Law: Text and Materials*. Second Edition. (London. Sweet & Maxwell. 2007), Chapter 5.

⁴⁵ Mental Capacity Act 2005, Section 4 & 5.

⁴⁶ *Barnett v Chelsea and Kensington HMC* [1968] 1 ALL ER 1068

⁴⁷ *R v Bourne*. [1938] 3 ALL ER 615, 618.

⁴⁸ *Re F* (Mental Patient: Sterilisation) [1990] 2 AC 1.

⁴⁹ The MCA does not define best interest but provides guidance to try to ascertain what the person who lacks capacity would have wanted, see Department for Constitutional Affairs. *Mental Capacity Act 2005: Code of Practice*. (London. TSO. 2007) page 65 & 66.

The functional test of capacity within the MCA is based on the legal case of *Re C*⁵⁰. It has to be established that that the patient is *unable* to: understand the information relevant to the decision he has to make; retain that information; to use that information as part of the process of making the decision; to communicate his decision (whether by talking, sign language etc). If a patient cannot meet these criteria they may be said to lack mental capacity.

Further caveats, however, are that a person is not to be treated as incompetent just because they make an unwise decision⁵¹ and the inability to make the decision must relate to an impairment of, or a disturbance of the mind or brain, which may be temporary or permanent.⁵²

The courts have also warned that professionals and others must not be tempted to assume that just because a patient makes an unwise decision they lack capacity.⁵³

The overriding obligation is to work in the interests of the patient, not the relatives or carers.

To assist patients in case of future incapacity the MCA introduced two key elements into Statute:

The first was to create, and give statutory recognition to, the appointment by the patient (the donor) of a relative or friend to the position of Lasting Power of Attorney (LPA). The LPA is authorised to manage a patients affairs if and when that patient becomes incompetent.

The second is to obligate professionals and carers to follow any advance decisions made by the patient should they become incompetent, provided the advanced decision is valid and applicable to the circumstances.

Competent people over the age of 18 may make an advanced decision to refuse *specified medical treatment*, using lay terms if preferred to describe the medical treatment being refused, for a time in the future when they may lack capacity to consent to, or refuse that treatment.⁵⁴ If the advanced decision relates to the refusal of life sustaining treatment it must be in writing, signed and witnessed, and state clearly that the decision applies even if life is at risk. Health care professionals and others *must* follow the advanced decision *provided* that there is proof that it exists, is valid and applicable in the current circumstances, and having tried to establish contemporaneous capacity they are satisfied that the person to whom the advanced decision refers lacks it, after applying the *two stage capacity test*.⁵⁵

⁵⁰ [1994] 1 All E.R. 819.

⁵¹ Mental Capacity Act 2005, Section 1(4).

⁵² Mental Capacity Act 2005 Section 3.

⁵³ *B v NHS Trust* [2002] 2 All E.R. 449.

⁵⁴ Mental Capacity Act 2005, Section 24, 25, 26.

⁵⁵ Mental Capacity Act 2005, Section 2(1) (2). “*For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain*”. A person lacks capacity if: they have an impairment or disturbance (E.g. a disability, condition, or trauma) that affects the way their mind or brain works, and the impairment or disturbance means that

The donor, while they still have the capacity to do so, are given new rights to appoint a *Welfare LPA* who will not only have the authority to manage the donor's affairs, but also has the authority to make healthcare decisions on the donor's behalf once they lack capacity.⁵⁶ This includes making the decision to accept or refuse life sustaining treatment, either by ensuring that an advanced decision is observed, or in the absence of such a decision making a decision in the donor's best interests.

There is formality when appointing a LPA requiring independent verification of capacity of the donor, verification that appointment of a LPA was made freely, the LPA has to be registered with the Office of the Public Guardian who will act as the new "watchdog" to ensure that LPA's act in accordance with regulations, and LPA's have a duty to act in the donor's "best interests".^{57 58}

An LPA cannot exercise their authority to make a decision to either agree to, or refuse, life sustaining treatment on behalf of a donor: if the donor has capacity to make the decision⁵⁹; if the donor has made an advance decision to refuse the proposed treatment⁶⁰; unless the LPA document that is registered with the Office of the Public Guardian expressly authorises a LPA to make decisions on life sustaining treatment – if it does this in turn places a duty on the LPA to act in the donor's best interests⁶¹; if the donor is detained for a mental disorder under the Mental Health Act 1983.⁶²

It does not allow acts that are motivated by bringing about a patient's death⁶³ and Section 4(5) states that:

they are unable to make a specific decision at the time it needs to be made. The loss of capacity does not have to be permanent to come under the umbrella of the Act, but if a person is likely to regain capacity in the short term then decisions should be put off if possible until the person regains capacity. A two stage test is used to ascertain if a person lacks capacity. Stage 1: does the person have an impairment of, or a disturbance in the functioning of, their mind or brain, including conditions associated with some forms of mental illness, dementia, significant learning disabilities, the long term effects of brain damage, physical or medical condition that cause confusion, drowsiness or loss of consciousness, delirium, concussion following head injury, the symptoms of alcohol or drug abuse; Stage 2: does the impairment or disturbance mean that the person is unable to make a specific decision when they need to. If the answer is affirmative to the two stage test then the person can be assumed to lack capacity.

⁵⁶ Mental Capacity Act 2005, Section 9(1).

⁵⁷ Department for Constitutional Affairs. *Mental Capacity Act 2005: Code of Practice*. (London. TSO. 2007). See Chapter 7 at 7.7. The Office of the Public Guardian is established under Section 57 its primary purpose is to monitor and supervise LPA and Deputies and investigate complaints against them.

⁵⁸ Mental Capacity Act 2005, Section 10(4). More than one LPA can be appointed by the donor who can specify if they are to act "jointly", "jointly and severally", or "jointly in respect of some matters and jointly and severally in respect of others"

⁵⁹ Mental Capacity Act 2005, Section 11(7)(a).

⁶⁰ *Ibid*, Section 11(7)(b). Note: if the donor has made an LPA after the advanced decision, and has given the LPA the right to consent or refuse the treatment, the attorney can choose not to follow the advanced decision.

⁶¹ *Ibid*, Section 11(7)(c). Anyone who doubts that a LPA is acting in the person's best interests can apply to the Court of Protection for a decision.

⁶² *Ibid*, Section 28.

⁶³ The Mental Capacity Act 2005, Section 62 makes it clear for the avoidance of doubt that nothing in the Act is to be taken to affect the law relating to murder, manslaughter or assisting suicide.

“All reasonable steps which are in the person best interests should be taken to prolong their life. There will be a limited number of cases where treatment is futile, overly burdensome to the patient or where there is no prospect of recovery. In circumstances such as these it may be that an assessment of best interests leads to the conclusion that it would be in the best interests of the patient to withdraw or withhold life sustaining treatment, even if this may result in the person’s death. The decision-maker must make a decision based on the best interests of the person who lacks capacity. They must not be motivated by a desire to bring about the persons death for whatever reason, even if this is from a sense of compassion”

Where consent is sort it should be informed, that is the patient/LPA is told about the treatment (and the examination) and why you are doing it. However, English Law does not require the consent to be fully informed. Only a broad outline of the treatment need be given. This may be important in an emergency where there isn’t time to explain everything.

POLICY OBLIGATIONS – ADULTS.

5. If the adult patient has mental capacity, consent must be obtained from them prior to commencing examination and treatment. It may not be necessary for the patient to verbally agree to you treating them; their actions alone may signal consent. For example the patient who is asked to consent to having their blood pressure taken may not verbally agree to it, but may roll up their sleeve and hold out their arm for it to be done. Therefore, the act of preparing for the examination is in itself an act of consent. (This is an example of implied consent). Where consent is obtained it is the reality of the consent that matters not the form that it is given in. In other words there is no legal distinction to be drawn between the efficacies of written, oral or implied consent.
 - 5.1. The competent adult patient is entitled to reject advice and treatment even if the rejection seems irrational.
 - 5.2. If the patient lacks capacity, reasonable enquires should be made regarding any advanced decisions that may be in force, or liaise with any LPA who has authority to make treatment decisions on the patient’s behalf. In the presence of advanced decisions, or authorised LPA, you are obligated to follow the wishes expressed by the patient via these channels – even if they conflict with your personal beliefs. You may be committing a criminal offence if you ignore them.

However, you are not bound by an advanced directive or instructions from an LPA if you have genuine doubts over the status, or validity, of what you are being told or presented with. If you have reasonable doubts over the validity of expressed wishes, or there is no information regarding the patient’s wishes, or in a time critical emergency when there is no time to ascertain this information, you must treat the patient and act in their best interests. Under these circumstances health care providers are expected to carry out their obligations to the best of their abilities, provided that a group of their peers would have done the same or similar thing, under the same circumstances. For example, in the case of a cardiac arrest you will not have the patients consent to carry out resuscitation, and in the absence of any advanced decisions to the contrary, it is perfectly acceptable for

you to resuscitate because a group of your peers would do the same thing under the same circumstances.

RATIONALE – YOUNG PEOPLE.

Regarding issues of capacity and consent in relation to medical treatment in young people, most of the MCA applies to young people aged between 16 and 17 years. There may occasionally be overlap with other laws⁶⁴, but essentially a health care provider is protected from liability when assessing capacity in a 16 or 17 year old patient if he/she complies with the capacity assessment provisions contained within the MCA.⁶⁵ In addition, someone with parental responsibility is generally able to consent to treatment for a young person lacking capacity under the MCA.⁶⁶

Regarding patients under the age of sixteen years, common law principles will apply when weighing up the context of capacity.

It is instructive as a starting point to briefly consider the case of *Gillick v West Norfolk and Wisbech Area Health Authority*.⁶⁷ *Gillick* was the leading case in establishing the concept of the mature minor, or as it has become known “*Gillick competent*” minor, able to consent to his or her own medical treatment provided they have the mental capacity to do so. This in theory allows the *Gillick* competent child to make decisions about their own medical treatment.

The stumbling block to this assumption is that in order for a child to be competent they would by definition have to follow a linear thought process. They would need to possess the emotional maturity to weigh up risks and make choices. This in turn requires autonomy based decision making that will vary on the maturity of the child, and it is often impossible to set an age when children become capable of autonomous decision making. It is generally acknowledged that each child is likely to be different, reach maturity at different ages and the requisite capacity will vary. When dealing with children who do not have the capacity to consent, people with parental responsibility can consent to treatment on a patient’s behalf as a proxy decision

⁶⁴ Children Act 1989.

⁶⁵ Mental Capacity Act 2005, Section 5.

⁶⁶ *Ibid*, Section 2(1).

⁶⁷ [1986] 1 AC 112. Mrs Gillick had sought a declaration from her local health authority that her daughters, who were under the age of 16 years, would not be prescribed contraceptives without her prior knowledge and consent. The basis for her action was that any such action by the health authority would violate her parental rights. The lower court found against her, the Court of Appeal for, and finally the House of Lords against, albeit by a majority of three to two. Their Lordships decided not to confine their legal minds to just the issue of contraception. They weighed up the issue of parental rights within a wider medical context. Lord Scarman observed: “...I would hold it as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law. Until the child achieves the capacity to consent, the parental right to make the decision continues save only in exceptional circumstances. Emergency, parental neglect, abandonment of the child, or inability to find the parent are examples of exceptional situations justifying the doctor proceeding to treat the child without parental knowledge and consent; but there will arise, no doubt, other exceptional situations in which it will be reasonable for the doctor to proceed without the parents consent.” per Lord Scarman at 435

maker.^{68 69} In addition those who have care of a child but do not have parental responsibility may do “what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child’s welfare.”⁷⁰ This includes the power to consent to medical treatment.⁷¹

In *Gillick* emergency treatment was considered an area where parental consent was not required⁷² and other common law cases have assumed this as being a correct legal position.⁷³ Lord Donaldson ruled in *Re J*:

*“ The doctors owe the child a duty to care for it in accordance with medical practice recognised as appropriate by a competent body of professional opinion... This duty is however subject to the qualification that, if time permits, they must obtain the consent of the parents before undertaking serious invasive treatment. ”*⁷⁴

This does not negate attempts to try to obtain patient and parental consent, for to do so make any treatment both morally and legally appropriate. Where, however, no such consent is forthcoming and there are no pre-existing court orders, or medical guidance in force, the health care provider can exercise paternalistic judgement and proceed without consent in emergencies involving young people.

POLICY OBLIGATIONS – YOUNG PEOPLE:

- 5.3. When the young person reaches **sixteen years** of age their consent becomes as effective as if he or she were an adult. This would seem to apply to **giving consent** rather than withholding it.
- 5.4. Once a young person reaches the age of sixteen years they can fully consent to treatment in the same way that an adult would - provided they have contemporaneous mental capacity, even if those with parental responsibility are opposed to treatment.
- 5.5. Under common law parents still have responsibility for their children up to the age of eighteen years. A person with parental responsibility may consent to a young person under the age of eighteen years being treated against their wishes. People with parental responsibility are usually the young person’s parents.

Note: the following persons have parental responsibility:

- A mother automatically has parental responsibility for her child from birth.

⁶⁸ Family Law Reform Act 1969, Section 8(1-3). Note: someone attaining sixteen years of age can consent to a surgical, medical or therapeutic procedure in the same way as someone who has reached the age majority and there is no requirement to obtain consent from a parent or guardian. In the face of a refusal to consent by a person aged 16 or 17 years, although not entirely clear in the Act, it has been assumed that a parent or guardian can still consent to treatment by proxy.

⁶⁹ Children Act 1989, Section 2(1).

⁷⁰ Ibid, Section 3(5).

⁷¹ *B v B* [1992] 2 F.L.R. 327.

⁷² (*A Minor*) (*Wardship: Medical Treatment*). [1993] 1 F.L.R. 386. Also see *Re S* (*A Minor*) (*Medical Treatment*) [1994] 2 F.L.R. 1065.

⁷³ *Re S* [1994] 2 F.L.R. 416, 420.

⁷⁴ *Re J* [2005] EWHC 2293 (Fam). per Lord Donaldson M.R. at 930.

- A father has this responsibility only if he is married to the mother when the child is born, or
 - has acquired legal responsibility for his child through one of these three routes:
 - (from 1 December 2003) by jointly registering the birth of the child with the mother.
 - by a parental responsibility agreement with the mother.
 - by a parental responsibility order, made by a court.
- 5.6. A person without parental responsibility but who has care of the child or young person (perhaps a grandparent with whom the child is staying, or leader on camp) can give consent on the young persons behalf. *Section 3 (5) of the 1989 Children's Act* states that a person who has care of a child but has no parental responsibility can do: "What is reasonable in all circumstances of the case for the purpose of safe guarding or promoting the child's welfare".
- 5.7. Therefore, if the child/young person under 18 years refuses treatment but a parent, or someone with care of the child gives consent to treatment, this will be sufficient to go against the child/young persons wishes - but only as far as is necessary.
- 5.8. However, just because you have consent from the parent, or person with care, do not ignore the young person. Wherever possible you should still encourage the child to cooperate and consent. It will be much easier to deal with a cooperative patient then one who is not.
- 5.9. Furthermore, it may be detrimental to the patient's condition to force treatment or examination upon them. Just because you have consent does not necessarily mean that you should proceed. You will have to balance what you want to do against the welfare of the young person (risks versus benefits) at all times. The patient's welfare must take precedence.
- 5.10. If you have a non-consenting young person but have consent from authorised others, it will probably be better only to force treatment on them where "life or limb" is at stake. However, with patience and tact it will usually be possible to obtain consent from the patient to examine and treat them for non-life or limb threatening conditions.
- 5.11. In an emergency where there is no one to give, or it is not possible to obtain, consent, it will be permissible to carry out emergency treatment on the young person without consent, because a reasonable body of your peers would undoubtedly do the same thing under the same circumstances.
- 5.12. In practice most young people and parents are only too happy to be helped and the issue of consent is rarely, if ever, a problem in the pre hospital situation.

- 5.12.1. It is rare for a parent, or a person with care, to withhold consent in an emergency. In fact most health care providers will never come across a case of this happening in many years of service. However, in this unlikely event what is the legal position?
- 5.12.2. If the young person is *over sixteen years* provided the child consents willingly to treatment and has the required mental capacity (even if the person with parental authority disagrees), there will be no problem in law because the child's consent is as valid as an adult.
- 5.12.3. However, if the child is *under sixteen* and the parents or person with care refuse treatment on the child's behalf, then an assessment will have to be made to see if the child is "Gillick competent".
- 5.12.4. The general view is that provided a young person is old enough (they do not have to be morally mature) to understand the reasons for treatment (and examination), and the possible consequences of not accepting the treatment, they can give their consent even if they are under sixteen years of age. This means the young person can be treated even in the face of opposition from the person with parental responsibility or care. Clearly this would be a difficult situation and would require tact and diplomacy. You may also have to seek assistance from the relevant agencies.
- 5.12.5. If both the young person and the person with parental responsibility/care refuse consent you may still act in a *life-threatening* situation, because you are acting in the best interests of the child. You may need assistance from the statutory authorities under these circumstances. The law would take a common sense view if you were trying to help a child who was seriously ill or injured.

SECTION 6: RECRUITMENT AND TRAINING.

RATIONALE.

It is recognised that ScoutMed needs to recruit sufficient numbers of *suitable* personal to meet the growing demands placed on our organisation. It is also important to recognise this must not be at the expense of maintaining clinical quality and standards, or jeopardising good inter team relations and harmony.

While ScoutMed does not discriminate on the grounds of gender, race, religious belief or sexuality, and will wherever possible accommodate the less able bodied within the organisation, **ScoutMed reserves the absolute right to refuse membership to any individual whom it deems unsuitable.** Unlike any other section in scouting, members of ScoutMed will by definition be coming into regular physical contact both with children and adults on a regular basis, undertaking investigations and examinations, carrying out treatments, and on occasions helping children undress.

Treatments carried out will on occasions need to be of a high clinical standard and at other times may be painful and distressing for the patient.

Only individuals of high personal integrity, judged to be suitable for the training and demands of the job, willing and able to commit themselves to the organisation, and able to work as part of a team need apply or will be accepted.

There will be no exceptions to these requirements. Young people and their parents, as well as our adult patients, deserve nothing less as they are placing their complete trust in us.

POLICY OBLIGATIONS.

6. The following recruitment and training processes will be followed:
 - 6.1. Potential applicants to ScoutMed should put their application in writing stating any relevant qualifications that they will bring to the organisation. Any professional qualifications will be reviewed by the Clinical Operations Manager or his nominated deputy for relevance and applicability.
 - 6.2. The application will be considered by an Executive Committee specially convened for the purpose, and the applicant will be either invited for interview, or turned down at this stage.
 - 6.3. At interview the Executive Committee specially convened for the purpose will outline the functions of ScoutMed and the commitment required. The applicant will be free to ask questions.
 - 6.4. The minimum standard for undertaking ScoutMed operational duties is a current First Aid at Work Certificate. The applicant must agree to undertake this training as soon as practicable if they do not possess this qualification, and wish to undertake first aid duties.

- 6.5. If there is any doubt as to the physical or mental fitness of the applicant they will be required to undergo a medical examination at their expense, and obtain a letter from a medical practitioner deeming them fit.
- 6.6. The applicant must agree to undergo the recommended course of vaccinations (flu vaccine excepted) unless there is a valid medical reason why they cannot do so.
- 6.7. The applicant must understand that any convictions or cautions for dishonesty, assault, or sexual offences will be an automatic bar to joining ScoutMed. This includes any “spent convictions”.
- 6.8. Potential applicants to ScoutMed are required to undergo an enhanced CRB disclosure check in accordance with the Policy, Operations and Rules of the Scout Association. This applies to all applicants even if they are current members of the Scout Association. Applying to join ScoutMed will be deemed as applying for a “new position” within the Association.
- 6.9. Subject to successful interview, CRB check, and references if applicable, the applicant will be offered a position within ScoutMed for a trial period of one year and on satisfactory completion will be offered a permanent position.
- 6.10. If the applicant is deemed unsuitable either at interview or during the trial period, they will be unable to continue service with ScoutMed.
- 6.11. Current members of ScoutMed undertaking operational first aid duties need to maintain a minimum qualification of First Aid at Work.
- 6.12. Support staff are encouraged but it is not a requirement as a condition of their membership, to maintain a first aid qualification of some description. Support staff are equally valued for the additional skills that they bring to the organisation.
- 6.13. There is no requirement for operational members to undergo advanced first aid training although they are encouraged to do so. Each component of advanced first aid training is in stand-alone modular form. Only members completing a training module, and successfully passing a module assessment (if applicable), may practise the procedures and use the equipment covered in the module. If you are not signed off to do something then do not do it.
- 6.14. Registered health care professionals are required to act within their respective professional codes of conduct and will remain accountable to their Registrant Body’s.
- 6.15. Members must maintain efficiency in their basic skills. Efficiency may take the form of attending duties regularly, teaching first aid, attending training sessions, professional health care employment etc. Operational members who are absent from ScoutMed duties for long periods may be deemed inefficient and taken off operational duties until they have undergone suitable refresher

training/supervised duty periods. The Clinical Operations Manager or his nominated deputy will judge each case on its merits.

SECTION 7: DISCIPLINARY PROCEDURE.

RATIONALE.

ScoutMed is a Scout Association National Active Support Unit and as such, its members are required to abide by the requirements as laid down in the Scout Association Policies, Organisation and Rules (POR), and are subject to sanction as laid down in POR.

Given that ScoutMed members are in a unique position of trust, this Policy will operate in addition to the Scout Associations POR. It should be remembered that an action that would not necessarily carry a sanction under the Scout Associations POR may carry a sanction under sections of this Policy.

POLICY OBLIGATIONS.

PRINCIPLES.

7. This policy will apply in cases of:
 - 7.1. Suspected minor or gross misconduct.
 - 7.2. Suspected acts of carelessness, or negligence, resulting in actual or potential harm to a patient or colleague
 - 7.3. This policy will not apply to acts resulting in a “clinical near miss” where the member concerned has made a genuine error and has not attempted to hide the facts. This will be dealt with as a clinical governance issue within a no blame atmosphere, so that any lessons can be learnt and mistakes avoided in future.
 - 7.4. ScoutMed is an open and democratic organisation underpinned by the principles of natural justice. This will be reflected within this policy.
 - 7.5. Any member who comes under investigation will be assumed innocent until proven otherwise no matter how serious the allegation.
 - 7.6. It will be deemed an act of gross misconduct if any attempt is made by a member to smear or defame, either directly or by innuendo, any other member of ScoutMed who finds themselves under investigation.

INVESTIGATION.

- 7.7. Where there are reasonable grounds for suspicion of misconduct a thorough investigation of all the facts must be undertaken without delay. Once the facts have been established, a view must be taken to see if there is a case to answer.
- 7.8. In the event of an investigation being required an Executive Committee especially convened for the purpose of oversight, will appoint a member with suitable experience to carry out the investigation. The Committee reserves the right to ask an outside agency, or independent individual with suitable experience, to

undertake this investigation. In addition, the Executive Committee will appoint a Chair to lead the Committee. The Executive Committee Chair is not permitted to take part in the investigation or sit on any Hearing Panel.

- 7.9. Evidence gathered from witnesses must be in written statement form and signed.
- 7.10. During the course of any investigation the member(s) concerned must be informed that they are under investigation.
- 7.11. It may be necessary to suspend a member of ScoutMed during the course of an investigation. Suspension is not to be used as, or seen as a disciplinary sanction.
Suspension is always done without prejudice to a member's case.
- 7.12. Suspension will ordinarily only be carried out in the following circumstances:
 - 7.12.1. When the alleged misconduct, or alleged act of negligence/carelessness, is serious enough to warrant the immediate removal of a member from ScoutMed duties.
 - 7.12.2. Where the member is thought to be danger to themselves or others.
 - 7.12.3. An allegation involving dishonesty, indecency, or violence will automatically result in suspension until investigations are complete.
- 7.13. An alternative to suspension in less serious cases, is restricting the activities that a member may undertake until such time as the investigation is complete.
- 7.14. During the course of an investigation the member under investigation has the right to appoint a representative to act on their behalf.
- 7.15. If a member is subject to a police investigation and/or criminal court proceedings any disciplinary hearing cannot be held until such time as the legal proceedings are concluded.
- 7.16. The decision to suspend a member will be taken by the Chair of the Executive Committee.

SANCTIONS and HEARING.

- 7.17. Following an investigation, the Executive Committee can decide to take:
 - 7.18. *Informal Action:* In instances of minor acts of carelessness, or minor acts of misconduct, a member may be spoken to by his or her peers holding supervisory, or managerial responsibility. This should be done discretely and should be seen as part of the day to day process of managing a good organisation. This does not count as disciplinary action.
 - 7.19. *Formal Action:* Refer the case for a formal hearing. This can only be done

after the investigation is complete. If following an investigation it is apparent a formal hearing is required, one will be convened. The following procedural provision will be observed:

- 7.19.1. The member under investigation will be informed prior to the hearing of all the evidence gathered during the investigation, and will be given time to prepare a defence.
- 7.19.2. A mutually agreeable venue, time and date will be arranged for the hearing to be held. This should not be less than seven days and not more than three months after the member under investigation has been given the investigation evidence. Hearings may be postponed by mutual agreement, but if the member under investigation unreasonably refuses to attend the hearing(s) proceedings will be heard in their absence.
- 7.19.3. Members of the Executive Committee will appoint a Hearing Panel consisting of three people, one of whom will act as Chair. The Panel can be members of the Executive, or independent individuals asked to sit because they have specialised knowledge of the subject matter. In cases involving clinical issues, at least one member of the Panel must have professional experience in the area concerned. No member of the Panel will have been involved in the actual investigation. Meetings/hearings should be minuted; it is permissible to use the services of an individual agreeable to all parties to undertake this task.
- 7.19.4. The member under investigation has the right to bring along a representative to any hearing to act on his or her behalf.
- 7.19.5. The member under investigation does not have to give evidence at the hearing and no inference of guilt may be made if this is the case.
- 7.19.6. Any person who has giving written evidence during the investigation will be invited to attend the hearing. If they decline to do so, their written evidence will not be admissible at the hearing unless both the Panel and member under investigation agree.
- 7.19.7. The Chair of the Panel will open the hearing and ask for details of the case.
- 7.19.8. The individual who carried out the investigation will outline the case and submit evidence.
- 7.19.9. The Panel will then ask the investigator any questions they may have, the member under investigation and/or their representative may then ask questions.
- 7.19.10. Any witnesses will then be called and questioned by members of the Panel and then by the member under investigation and/or their representative.
- 7.19.11. Finally the member under investigation will be asked to answer relevant questions firstly by the Panel and then by their representative. The

member under investigation can decline to answer and no inference may be made from this.

- 7.19.12. The Panel will then retire to consider whether the case is proved or not. If the case is proved the Panel will decide on the appropriate sanction.
- 7.19.13. Ideally the Panel will reach a decision and deliver it on the same day. This should also be confirmed in writing not less than seven days from the date of the Panels decision.
- 7.19.14. In the event that the Panel cannot reach a decision on the same day, they will consider the matter further and send their decision to the member under investigation in writing as soon as possible.
- 7.19.15. Copies of written Panel decisions will be sent to the Chair of the Executive Committee.
- 7.19.16. Wherever possible the Panel should reach a decision unanimously. If it becomes clear that a unanimous decision will not be reached, despite all reasonable attempts by the Panel members to find a way out of the impasse, a majority decision will prevail. The Chair of the Executive Committee will be informed of this when the Panel makes its decision notification.
- 7.19.17. Panel decisions will be based on the evidence presented at the hearing, working on the balance of probability rather than “beyond reasonable doubt”.
- 7.20. The Panel may award one of the following sanctions if the case is proved:
 - 7.20.1 **Written warning.** This will stay on the member’s record for one year and will then be removed.
 - 7.20.2 **Final Written Warning:** This may be given;
 - 7.20.3 As a first sanction in cases where the conduct of the member gives serious cause for concern.
 - 7.20.4 If the member concerned is already the subject of a written warning and a further breach of discipline has occurred.
 - 7.20.5 A Final Written Warning will remain on record for one year. Provided there are no further breaches of discipline in this time it will then be removed.
 - 7.20.6 **Dismissal:** Dismissal should be reserved for the most serious offences or for repeated breaches of discipline, namely;
 - 7.20.7 Theft or fraud, whether or not arising during the course of ScoutMed duties.
 - 7.20.8 Indecency or sexual offences, whether or not arising during the course of ScoutMed duties.

- 7.20.9 Violence or assault upon a member of the public or patient arising during the course of ScoutMed duties.
- 7.20.10 A breach of discipline by a member already on a Final Written Warning would normally result in dismissal unless there were mitigating circumstances.
- 7.21. Where an investigation leads to the suspension of a member of ScoutMed, or a Panel decides to dismiss a member, where appropriate - a written report of the circumstances should be forwarded without delay by the Chair of the Executive Committee, or his/her nominated deputy, to the appropriate staff at Association Headquarters. The Scout Association may wish to take any further action that it deems necessary.
- 7.22. When a member has been suspended and no further action is taken after investigation, or the member is exonerated following a Panel Hearing, it may also be necessary to notify appropriate staff at Association Headquarters. A clear understanding must be reached by all concerned if this is required.
- 7.23. Whilst complying with the requirements of Section 7, paragraphs 7.21 & 7.22, the Chair of the Executive Committee, or his/her nominated deputy, must be mindful of the requirements concerning patient confidentiality.
- 7.24. If a case of serious misconduct is proved against a registered health care professional, a report will be sent to the professionals relevant Registrant Body's Conduct and Competence Committee.

APPEALS.

- 7.25. Where a member feels that the sanction awarded by the Panel is unduly harsh and/or disproportionate they may, within seven working days of the Panels decision, lodge an appeal in writing with the Chair of the Executive Committee. The appeal will need to state the reasons why the appellant feels that the sanction awarded was unduly harsh and/or disproportionate.
- 7.26. The Chair of the Executive Committee may substitute the Panels sanction for a lesser one. The Chair cannot impose a stricter sanction or overturn the Panels verdict.
- 7.27. In the event of further good evidence coming to light in the future that is sufficient to cast doubt on the Panels original verdict, the Chair of the Executive Committee may ask the Panel to reconvene to consider the new evidence, or if appropriate appoint a new Panel to do so. If a new Panel is appointed, the members of the new Panel must have had no previous connection with the case under consideration. The Panel having regard to all the evidence may either uphold the original verdict, or quash any previously delivered verdict.