# Review of the Public Health Act (NI) 1967

## Final report

## March 2016

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# 1 Executive Summary

The review of the Public Health Act (Northern Ireland) 1967 was commissioned by DHSSPS in October 2013. It was conducted initially by the Northern Ireland Law Commission (NILC) and has been completed by DHSSPS following the closure of NILC in March 2015. The purpose of the review has been to ascertain whether the Public Health Act (Northern Ireland) 1967 is fit for purpose today.

The review has consisted of desk and online research, meetings with key stakeholders, international study visits and a public consultation.

The review has identified a number of deficiencies in the 1967 Act, the most significant of which is the fact that the Act is concerned almost exclusively with infectious diseases, whereas other jurisdictions and international law have adopted an 'all-hazards' approach which seeks to protect populations against the full range of threats including contamination.

The key recommendations are that a new public health bill should be included in the programme for the next Assembly mandate, and that the bill should address all hazards.

A public health bill should also explicitly seek to balance the duty of the state to protect the public's health with the need to respect the rights of the individual.

The review has examined the potential scope of a new public health bill, specifically whether the legislation should continue to be limited to health protection or should include provisions for other domains of public health. This question requires further consideration.

The review has considered the key features that would need to be addressed in a new bill, including powers and duties of various public authorities, and specific interventions that can interfere with individuals' rights, such as compulsory quarantine, isolation, detention and medical examination and treatment.

The review makes 18 recommendations in total.

## 2 Introduction

The Review of the Public Health Act (NI) 1967 began in early 2013 when the then Permanent Secretary of DHSSPS, Dr Andrew McCormick, wrote to the Northern Ireland Law Commission in response to an invitation for proposals on any legislation in need of reform or consolidation.

The Department had been aware for a number of years that the Public Health Act 1967 ('the 1967 Act') had not been updated in any significant respect, whilst new threats to public health continued to emerge. In other jurisdictions and internationally, public health legislation had been updated to enable governments and public authorities to respond effectively to a wide range of incidents and emergencies, involving not only infectious diseases, but also chemical and radiological contamination.

Concerns had also been expressed by a number of authorities with responsibility for dealing with incidents that the 1967 Act remained unclear on certain points and that existing powers could be inadequate to deal with potential public health emergency scenarios.

Attention had also been drawn to deficiencies in the legislation in relation to human rights.

The main arguments for reviewing the 1967 Act were concerned with:

- the narrow scope of the Act, which is concerned almost exclusively with infectious diseases, whereas other jurisdictions have adopted an 'all hazards' approach;
- the need to ensure that the legislation is consistent with the WHO International Health Regulations 2005 ('IHR 2005');
- the need to ensure that authorities' powers are compatible with the Human Rights Act 1998 and ensure that actions which interfere with individual freedoms are proportionate to the public health risk;
- the need to clarify the powers of entry and the roles of authorised officers in carrying out certain functions;
- the need to update the list of notifiable diseases; and
- public health threats that have emerged or become more apparent since 1967 such as SARS and Ebola.

It was agreed in October 2013 that NILC would review the 1967 Act to determine to what extent it was still fit for purpose. The objectives of the review were to:

a) clarify and modernise the 1967 Act in the context of an examination of public health law in Northern Ireland and associated legislation, and
b) to provide informed proposals for the reform of the 1967 Act.

It was anticipated that the review would provide a basis for a much-needed update of the Act and for the preparation of a draft Bill, should it be considered necessary, for consideration by a future mandate of the Northern Ireland Assembly which would modernise, update and where appropriate, consolidate the legislation.

Following a decision in September 2014 to close NILC by the end of March 2015, DHSSPS took responsibility for the completion of the review and put in place alternative project management and governance arrangements. The review has been completed by a Working Group in the Department, and overseen by a Steering Group chaired by the Chief Medical Officer.

## 3 Approach

From spring 2013, NILC conducted preliminary discussions and research with key stakeholders with the aim of drafting and finalising a consultation paper.

The research included an analysis of public health law in other jurisdictions including Scotland, England & Wales, Norway, Sweden and parts of Canada and Australia. Details are in the Technical Supplement to the consultation document. Part of this research was informed by a seminar, held in November 2013, which examined the role of the law, and its limitations, as an instrument of public health policy. The seminar brought together public health law experts from the UK, USA, Scandinavia and the Republic of Ireland and helped form thinking and establish critical relationships at the outset of the review. In addition, two separate study trips to Sweden and Norway took place in September 2013 and September 2014 to examine the relevant legislative frameworks in those countries.

Throughout the review, discussions took place with a range of stakeholders including: a representative of the Bill Team involved in the amendments to the England and Wales 1984 Act; the Chartered Institute of Environmental Health in Wales; Business Services Organisation (BSO); policy officials in the Welsh and Scottish Governments; Institute of Public Health in Ireland; Department of Health, Republic of Ireland; Regulation and Quality Improvement Authority (RQIA); Public Health Agency (PHA); the Chemical, Biological, Radiological and Nuclear (CBRN) Committee; DOE; DARD; Chartered Institute of Environmental Health NI (CIEH NI) and the Chief Environmental Health Officers' Group (CEHOG).

The review project was managed through a project team comprising two principal legal officers; a working group also comprising the Director of Population Health, the Chief Environmental Health Officer and DHSSPS policy leads; and a Steering Group comprising the Chief Medical Officer, the Director of Development and Capacity Building, IPH, and the Director of Public Health/Medical Director, PHA.

A public consultation was launched on 29 September and ran for 12 weeks to 18 December 2015. During that process, a stakeholder event was held on 23 November 2015 to discuss the themes and issues raised in the consultation. In addition, two members of the Steering Group participated in a studio discussion programme hosted by local public service broadcaster, NVTV.

# 4 Consultation

## 4.1 Process

The consultation documents were issued to a wide range of stakeholders including people involved with the delivery of public health services, medical and legal professionals, as well as those concerned with the formulation of policy.

The consultation ran for 12 weeks from 29 September 2015 until 18 December 2015.

The consultation documents, including a questionnaire for responses, which can be accessed at https://www.dhsspsni.gov.uk/consultations/consultation-review-public-health-act-northern-ireland-1967-0 dealt with a wide range of public health issues. These were organised under four themes:

- structure and purpose,
- organisational responsibilities,
- public health powers and
- the protection of individuals.

A consultation event for stakeholders was held on 23 November 2015. The event explored questions based on the four themes.

While the primary purpose of the consultation event was to help participants to formulate their responses to the questions, the discussions at the event were valuable in helping the Department develop its knowledge and understanding of the issues.

The Department received 29 responses to the consultation, from a variety of sources including local government, medical professionals and academia.

A full list of those who responded is in the Annex to this report.

The Department would like to thank all those who participated in the process for their time and for their detailed views.

It should be noted that this consultation is intended as the first of two consultations. Subject to ministerial agreement to introduce a public health bill in the Assembly mandate beginning in May 2016, there will be a second consultation which will invite views on specific policy proposals for possible provisions to be included in the bill. Responses from the two consultations will inform the preparation by DHSSPS of new legislative proposals.

## 4.2 Summary and consideration of responses

The responses received have been considered and have helped the Department to understand the views of a varied section of respondents as to the need for a reform of the 1967 Act. They have also pointed to the shape of such reform.

The following paragraphs set out the questions posed in the consultation document; summarise the responses received, and set out the Department's responses.

## Theme 1 Structure and Purpose

### Q 1: Should new legislation include:

**(i) a set of principles**
**(ii) a statement of intent**
**(iii) a list of objectives**
**(iv) a combination of any of the above, or**
**(v) none of the above?**

**Please give reasons for your response.**

*Current position*

The 1967 Act does not contain a set of principles, a statement of intent or a list of objectives.

*Summary of responses*

Most respondents answered this question and supported the inclusion of a combination of principles, a statement of intent and/or a list of objectives, with the aim of providing clarity and a foundation for any new legislation, as well as outlining the scope of the legislation. One respondent set out the benefits of using *principles* (a help for decision-makers in practice), a *statement of intent* (clarifying the risks which the legislation is trying to mitigate) and a *list of objectives* (outlining how the mitigation of risk is to be achieved).

Several respondents were unable to give a definitive response to this question. One stated that a more comprehensive response would be provided in the future when decisions as to the legislative direction of travel had been decided. Another referred to the consequences of a governmental choice of legislative focus – health protection as opposed to '*a broader health promotion approach*' – for the question of how principles etc. would be framed and used in future legislation.

One response suggested that new legislation should be framed in similar terms to reforms passed in England & Wales, under the Health & Social Care Act 2008, and in Scotland, under the Public Health etc. (Scotland) Act 2008. Several responses referred to international legislation on public health, which had been discussed in the consultation document, such as those in Sweden, Norway and South Australia.

Other responses highlighted the importance of clarity regarding the purpose and scope of the legislation, for regulators, the Courts and ultimately the public. They also stressed the value of a set of principles, such as the Norwegian exemplar, in providing coherence, and of principles and objectives, such as those contained in the New South Wales Public Health Act and in the Swedish public health policy, in providing direction.

Some responses stated what a set of principles should cover, including:

- seeking to address the social determinants of health;
- reducing health inequalities;
- supporting the need for inter-sectoral and joined-up working;
- protecting health;
- striking a balance between individual rights, individual responsibilities and population health;
- responsibilities as well as rights of the individual;
- equality, prevention, improvement, protection, partnership and participation;
- the UN Sustainable Development Goals;
- a basis for future, as yet unspecified activities.

*Department's response*

The Department recognises the strong support for the inclusion of principles / objectives / a statement of intent in any new legislation, and how these could provide a foundation for legislative provisions. The Department agrees that their inclusion could enhance the clarity of a new bill, enabling regulators, the Courts and the public to understand the purpose of the legislation. The Department will consider the inclusion of a combination of principles, a statement of intent and a list of objectives in a new bill.

**Q2: How could new legislation best be future-proofed in order to protect the public's health against threats that are as yet unknown?**

*Current position*

The 1967 Act does not take an 'all hazards' approach, rather its main purpose is the notification and prevention of certain infectious diseases. Apart from a reference to 'contamination' (section 2A(1)(1A)), which was inserted in 2008 and is specifically tied to vessels or aircraft (section 2A(1)(c)), there is no broad provision for reacting to public health threats which may arise in the future.

*Summary of responses*

Most respondents provided comments on this issue, linking the adoption of a broad all-hazards approach with future proofing of the legislation. One response referenced the protection of public health as including a broad definition of 'infectious diseases', as well as 'contamination' and particularly, 'other such hazards' and a 'health risk state', as set out in the provisions of the Public Health etc. (Scotland) Act 2008. Another highlighted the need to ensure that the content of new legislation was at a sufficiently high level, with detail in subordinate legislation, which would allow flexibility as new issues emerged over time.

One response also pointed to broad definitions adopted in England & Wales and Scotland, as well as those in the IHR 2005 as suitable future-proofing models, enabling flexibility regarding emergent threats.

One respondent linked future proofing with a framework which included a set of principles, a statement of intent and/or a list of objectives. Two responses pointed out the need for legislative protection in the case of antimicrobial resistance, one of these linking future-proofing of a new bill with health in all policies/health impact assessment, enhanced cross-disciplinary, cross-border and international cooperation, as well as epidemiology, a focus on health inequalities, population ageing and globalisation.

Concerns, however, were also raised by respondents. One respondent stated that it was impossible to fully protect the public's health against threats that were as yet unknown, linking this problem with a need to routinely review and amend the legislation, while another commented that it was impossible to comprehensively future-proof any legislation. One respondent had concerns as to the inflexibility of legislation with regard to a list of health conditions and their vectors.

*Department's response*

The Department agrees that the adoption of an all-hazards approach, with legislative provisions drafted with this in mind, will provide a measure of future-proofing, in that threats to the health of the public, such as a bio-terrorist attack, an outbreak of new disease, or continuing antimicrobial resistance, would be covered. The Department is grateful for the suggestions about the most appropriate terminology to use in a new bill, with regard to the protection of public health, infectious disease and contamination. The specifics of any such legislative provisions will reflect the responses received to the second consultation.

**Q3: In new legislation, what categories of threat to human health should be grounds for state interventions? Such categories could include 'contamination', 'infectious diseases' and 'health risk state'.**

*Current position*

The 1967 Act establishes that those who are suffering from or are carriers of a 'notifiable disease' (schedule 1) or 'infectious disease' (section 32) may have orders made against them. The term 'contamination' is only mentioned in relation to vessels and aircraft (section 2A(1)(1A)). Both the Public Health (Ships) Regulations (Northern Ireland) 2008 and Public Health (Aircraft) Regulations (Northern Ireland) 2008 contain provisions for 'an infected person' and an infected ship or aircraft. There are no other clear categories of threat to human health in the 1967 Act.

*Summary of responses*

A large number of respondents gave suggestions in reply to this question. Almost half of those who responded supported the Scottish legislative model, incorporating a broad definition of infectious diseases, as well as a health risk state, which they

considered allowed for the most comprehensive definition of potential threats to public health. One response referenced how the Scottish legislation, by including expressions such as ‘health risk state’, extended the ability of the Act to deal with other hazards besides infectious disease, such as bioterrorism.

One respondent supported an all-hazards approach which would cover response, recovery and remediation.

Individual responses broadened the categories of threat to human health to include dangers caused by hydraulic fracking, gas extraction and exploration, as well as the health impacts of climate change caused by such hydraulic fracturing. Another response drew attention to the environmental contamination of air, soil and water from industrial sources and the consequences of such contamination for public health. This response also suggested a health impact assessment at pre-licensing stage for any potentially polluting industrial development, as well as the Health Minister and statutory bodies having the responsibility and authority to intervene in any contentious current or future development placing public health at risk.

One respondent drew attention to the risk posed by contaminants from chemical, biological, radiological and nuclear sources, stating that contamination should be a ground for state intervention, and drew attention to a lack of clarity as to roles and responsibilities and the fact that this could impact upon any response to the public health risk. External influences, such as migration and greater mobilisation of population globally, were also highlighted by one respondent.

Another response, which raised a concern about protection from medical radiation, referred to specific issues concerned with radioactive decontamination, such as nuclear medicine patients and radioactively contaminated casualties.

A number of responses expressed a desire to extend the scope of the legislation beyond health protection, into areas such as health improvement, health promotion and the reduction of health inequalities.

One respondent suggested that the legislation needed to clearly refer to mental health as well as physical health.

One respondent urged the Department to examine how new legislation could best support a system in which more people are enabled to access preventative services and fewer reach a point of health and social care crisis.

One response considered the focus of contemporary public health law and the consequences of choosing the concept of the management of risk as a category of health protection, comparing this broader term with what the respondent regarded as narrower categories such as infectious diseases and/or contamination. This response also referred to ‘*a broader legislative programme to promote population health in Northern Ireland, in conjunction with ‘Making Life Better*’’.

A respondent raised a concern that the use of ‘catch-all’ categories of threat, such as ‘health risk state’, could make it more difficult to balance individual rights with health

protection when seeking to make provisions in respect of specific future threats that are unknown or cannot be known.

*Department's response*

The Department notes the strong support from respondents for the adoption of a legislative model, similar to that of the Public Health (Scotland) etc Act 2008 with regard to categories of threat to human health that could be grounds for state interventions.

The Department notes also the arguments for extending the scope of public health legislation beyond health protection. The Department will take these into account when developing the policy for a public health bill.

## Theme 2: Organisational responsibilities

### Q 4: Should new legislation describe, for Ministers and for each of the statutory bodies concerned, their functions, duties and powers in relation to public health?

*Current position*

The 1967 Act remains limited by only setting out certain powers and duties. There is no overall framework regarding many of the public health functions in Northern Ireland.

*Summary of responses*

The majority of respondents agreed that legislation should contain specific organisational responsibilities for stakeholders as there was a '*need for clear accountability, governance and communication procedures'*.

A number suggested, further, that where functions of a statutory body require co-operation with partner statutory bodies, legislation should also include a provision to facilitate such cooperation, arguing that it is '*essential that legislation details information about the way in which these bodies are expected to work together and a duty to comply is included where appropriate'*.

Other respondents highlighted the benefits of setting out organisational responsibilities such as providing a clearer understanding of respective functions which would assist in emergency planning and response. One response argued that '*this approach would help establish clear lines of responsibility and accountability'* and would '*facilitate organisational responsibility to adopt a collaborative approach to tackling public health issues'*.

Clarity of legislation and clear lines of communication were raised as an important issue by respondents, with one in particular suggesting that legislation '*should also spell out exactly who is ultimately responsible',* whilst another stated that '*there*

*should be no confusion as to roles and responsibilities in dealing with a public health threat*'.

With regard to specific duties and powers, some respondents suggested that the public health roles and powers for local authorities, as set out in Scotland and England, should be adopted in Northern Ireland. Others stressed that any functions that are to be conferred in legislation should be subject to detailed consultation and agreement with stakeholders.

Some respondents noted that certain functions can be costly, such as disinfection, disinfestation and decontamination, and raised the need for regulations to give consideration to the resourcing required to carry out all works so that there was no additional burden placed unnecessarily on certain stakeholders. However, respondents commented that, given the relatively small geographical scale of Northern Ireland, resources and expertise should be shared in NI and other regions where it is cost-effective to do so.

While many responses were positive in nature, a number of respondents raised concerns.

Some respondents felt that to set out functions, duties and powers would be risky as legislation may exist relatively unaltered for a long time, during which functions and the statutory bodies themselves may be radically altered. This view was mirrored by one respondent who was not convinced that specific responsibilities and accountabilities need to be defined in primary legislation. Instead, they suggested that guidance for the DHSSPS and all relevant statutory agencies should be addressed in secondary or subordinate legislation or in an associated code of practice, to minimise the extent to which administrative reforms can render the legislation out-of-date.

One respondent recognised that the definition of organisational responsibilities may ultimately depend upon the scope of the new act. If public health legislation remains concerned exclusively with health protection, then clarity about organisational responsibilities would facilitate the work of public bodies and would provide reassurance to the public. However, if the legislation were to take a broader approach, such as 'health in all policies', then specific functions and responsibilities would become more problematic as a large number of areas of government and society will be engaged in meeting these goals. In that instance a more useful approach would be to impose a general duty on Ministers and bodies to collaborate with each other and with other actors.

*Department's response*

The Department agrees with the majority of respondents in recognising the importance of establishing public health legislation that clearly defines organisational responsibilities, as well as transparent accountability and communication structures.

The Department agrees that further consideration should be given to the use of subordinate legislation in strengthening organisational responsibilities to ensure legislation is sufficiently future-proofed.

## Theme 3: Public Health Powers

### Q 5: What powers should statutory agencies have to investigate public health risks?

*Current position*

The 1967 Act has a limited framework for investigative powers which has not been systematically updated or modernised.

*Summary of responses*

A number of respondents commented that the current powers of investigation in the 1967 Act are limited in scope and their extent is no longer adequate for properly assessing public health risks and protecting the public. Some suggested that new regulations should provide for the powers necessary to deliver the desired functions.

Examples of suggested investigatory powers included:

- adequate provision for obtaining warrants and establishing offences in the event of obstruction;
- the wide range of powers available in Scotland, England and Wales, such as directing that premises be left undisturbed, taking measurements or photographs; making recordings; requiring a person to answer questions or dismantling any article or substance;
- the use of reasonable force to enter premises when necessary.

There were different views about enabling public authorities to authorise another person to act on their behalf. While it was recognised that such a provision would be beneficial, concern was expressed about using a term such as '*any other person'* in relation to the role of the authorised officer, with a recommendation that the Department should determine precisely what is meant by the term '*authorised officer'*.

One respondent addressed the issue of responding to incidents that have a cross-border impact and recommended that new legislation and proactive response strategies should enable the consistent implementation of agreed control measures.

While a number of respondents were of the view that investigatory powers needed to be improved, some respondents stated that protection measures should be included in legislation as many of the investigatory powers may impinge upon human rights, liberty and property.

The following examples of protections were suggested:

- a clear framework for the use of investigatory powers;
- a code of practice to ensure correct and consistent use of powers of entry;

- a requirement for legislation and protocols to govern the sharing of information, particularly given the sensitive nature and personal details involved;
- ensuring compliance with the Data Protection Act 1998, particularly regarding the processing or sharing of sensitive personal data including health information;.
- the need for the surveillance of individuals, covert or otherwise, or any intrusion into privacy, to be justified and proportionate and to reflect human rights considerations;
- ensuring a balance is struck between powers available to statutory agencies and the rights of those affected by the exercise of such powers.

A large number of respondents recommended that powers should be developed in consultation with regulators and should be comprehensive but limited to those necessary.

*Department's response*

The Department believes that the current investigatory powers may be too limited in scope and may need to be modernised. The Department acknowledges that if changes are made to investigatory powers it will be necessary to ensure that new legislation incorporates sufficient measures to protect individuals against the misuse or inappropriate or disproportionate use of such powers as regards human rights, liberty and property. The Department recommends that investigatory powers in public health legislation should be strengthened and recommends further consultation on specific investigative powers that will enable statutory agencies to effectively investigate public health risks whilst respecting the rights of those affected.

**Q 6: What powers should statutory agencies have to enter premises?**

*Current position*

The 1967 Act provides limited powers regarding the right to enter premises, along with limited prescribed duties, which have not been systematically updated or modernised.

*Summary of responses*

There was general agreement that statutory agencies should have power to enter premises if there was concern about a risk to the health of the public.

As regards the extent of such powers to be included, respondents recommended consistency with powers of entry in other UK countries, and that legislation should enable appropriate enforcement actions to be carried out, including by officers located in one organisation, but acting on behalf of another.

A concern was raised that granting intrusive powers to '*any other person'* could be unnecessarily broad, therefore primary legislation needs to be specific about who should be given such powers.

Several respondents were of the view that powers available to statutory agencies should not be limited to situations where a threat to public health has been confirmed by medical examination, but should also include the investigation of potential threats where incidents have not yet been confirmed. However, other respondents stressed the need for such powers *'to be proportionate to the risk and only available where reasonable grounds exist'*. Respondents acknowledged that the details were a matter for the second consultation.

One response highlighted the need for adequate provision for obtaining warrants, and suggested that the obstruction of officers be made an offence. The use of reasonable force to enter premises when necessary was raised, with a recommendation that '*a code of practice be developed to sit alongside powers of entry to ensure correct and consistent use of powers'.*

A number of respondents recognised the importance of ensuring that clear powers of entry were provided, as these are likely to impinge on human rights, liberty and property.

One respondent concluded that '*it will be important that any potential intrusion on privacy is justified and proportionate*' while supporting the provision that '*any intervention contains the least invasive and least intrusive procedures*'.

*Department's response*

The Department recognises the need for statutory agencies to have the power to enter premises in certain circumstances and recommends that such powers should be firmly established and modernised in new legislation. However, the Department recommends that such powers should be limited and controlled to ensure that entry powers are used in required circumstances and are proportionate to the risk. The second consultation will include detailed proposals about provisions for powers of entry.

**Q 7: What powers, if any, should statutory agencies have to quarantine individuals, and how should such powers be limited and controlled?**

*Current position*

The 1967 Act does not mention quarantine. While the Public Health (Ships) Regulations (Northern Ireland) 2008 mentions quarantine, it is referenced only in relation to ships infected or suspected of carrying plague.

*Summary of responses*

There was general agreement that certain events and circumstances require the availability of quarantine powers, and that such powers need to be constrained, with

a set of criteria governing their use, e.g. the principle of a specified maximum period, and that these powers should be used proportionately, seeking a balance between powers and individual rights.

Some respondents highlighted difficulties about quarantine, referring to the medical and scientific expertise required to ensure human rights compliance. One respondent referred to the interference with fundamental rights and freedoms and recommended '*strong procedural safeguards'* for individuals.

A number of respondents stressed that quarantine powers need to be used sparingly and as a last resort. There was recognition also that statutory agencies would need a margin of discretion when assessing the need to exercise the powers in a particular scenario.

Other respondents highlighted:

- the need for clear communication with individuals affected, regarding the reasons for quarantining, decontamination etc;
- that interventions should involve the least invasive and least intrusive procedures, and appeal processes should be accessible;
- the quarantine powers should be subject to regular review whilst enacted, and a mechanism to challenge post event independently;
- a need for effective and speedy access to legal advice.

*Department's response*

The Department notes the general acceptance of the need for properly constrained powers of quarantine and notes the associated complexities in seeking to balance individual rights with the need to protect the public's health.

There were a number of suggestions for specific ways to circumscribe quarantine powers and to control their use so that individuals' rights are as fully protected as possible by the legislation. These will be reflected in the second consultation.

**Q 8: What powers, if any, should statutory agencies have to isolate individuals, and how should such powers be limited and controlled?**

*Current position*

The 1967 Act does not mention isolation. However, there are specific references in the Public Health (Ships) Regulations (Northern Ireland) 2008 and the Public Health (Aircraft) Regulations (NI) 2008 with regard to ships and aircrafts.

*Summary of responses*

The responses to this question raised broadly the same issues as the responses to Q7 on quarantine, including matters of balance; the sensitive nature of this intrusion;

the need for clear limits and controls on the powers of authorities, including a robust protocol and approval process; access to appeal, challenge and review mechanisms.

There was general acceptance that in certain circumstances it may be necessary to isolate individuals against their will if this is necessary to protect the public's health. Such power should be available only if all other reasonable efforts fail, and should be used only as long as the effect or impact of the risk persists.

There were specific suggestions as to how isolation powers could be limited, controlled, and used proportionately, including:

- a set of criteria for using the power, possibly set out in the primary legislation, but in any case established in advance;
- triggering of timely, automatic review;
- clear communication as to reasons for isolating a person;
- the need for transparency and accountability;
- a mechanism to challenge post-event independently;
- a specific risk assessment, conducted in line with independent expert advice.

*Department's response*

As with the powers of quarantine, the Department notes the general acceptance of the need for properly constrained powers of isolation and notes the complexities involved in balancing individual rights with the need to protect the public's health.

The suggestions for ways to circumscribe quarantine powers and to control their use so that individuals' rights are protected will be reflected in the second consultation.

**Q 9: What powers, if any, should statutory agencies have to detain individuals, and how should such powers be limited and controlled?**

*Current position*

The 1967 Act provides limited detention powers. Reference is made to detention powers in relation to vessels or aircraft; persons on board them (section 2A (1A)(3)(d)); and the detention of an in-patient attempting to leave hospital where there is serious risk of infection to others (section 3B(1)).

*Summary of responses*

As with quarantine and isolation, responses tended to focus on the need to balance powers with people's rights, and various means of achieving this. The practical suggestions mirrored those made in relation to quarantine and isolation.

One respondent recommended that the Department consider a list of powers to be contained in subordinate legislation, in order to better enable regular review.

*Department's response*

The Department acknowledges the points raised in relation to powers of detention, and the issues common to detention, quarantine and isolation.

Whilst the Department recognises the difficulties surrounding detention powers, it takes full cognisance of the views expressed by many of the respondents that where severe and imminent risk to public health is posed, it may be necessary to apply such powers.

The suggestions for ways to constrain and control powers of detention will be reflected in the second consultation.

**Q 10: Are there any circumstances in which compulsory medical treatment would be justified? Please provide reasons for your response.**

*Current position*

The 1967 Act does not require anyone to undergo medical treatment (section 2A (1)(a)).

*Summary of responses*

There was some agreement that in certain circumstances compulsory medical treatment may be justified if an individual's refusal to have medical treatment would pose a sufficiently serious threat to the public's health, and that such an intervention should be strictly constrained, including its duration.

A common theme which emerged was the need to balance individuals' rights with the need to protect the public, and the need for especially careful consideration to be given to this issue, including putting in place appropriate safeguards.

One respondent referred to the need to protect the public against new or emerging diseases.

Another respondent referred to the possible use of iodine tablets prophylactically in the event of a large scale release of radiation, and stated that this would need to be considered fully.

One respondent urged that consideration be given to the importance of relevant education and public information in helping to reduce the perceived need for compulsory medical treatment.

The contentious nature of these powers was recognised by many respondents, with recommendations that legal advice should be sought in respect of the appropriate checks and balances which should be contained in the legislation.

Again, the need for proportionality was stressed, with authorities being required to use the least invasive and least intrusive interventions.

Respondents noted that the legislation should state clearly how such decisions are taken and by whom. One respondent commented that councils were unlikely to have the skills or expertise to exercise such powers.

One respondent stated that this power should be expanded to include compulsory medical investigation where this is justified for the protection of the public's health, suggesting, as an example, that food handlers could be required to submit their own stool samples in the context of an outbreak of gastrointestinal illness associated with their place of work.

*Department's response*

The Department recognises that compulsory medical treatment is an issue that is particularly sensitive for respondents and will consider the matter further. If, in the second consultation, the Department brings forward specific proposals for compulsory medical treatment, these will be accompanied by proposals for ensuring that adequate safeguards are in place for any person affected by such powers.

**Q 11: Where it is deemed necessary to place employment restrictions on a person or premises, in order to protect the public's health, what restrictions would be legitimate and proportionate?**

*Current position*

The 1967 Act provides limited powers for:
- placing employment restrictions on certain types of work (section 6 and 19);
- bringing sanctions against a person who knowingly suffers from a notifiable disease and engages in a trade or occupation which has risk of spreading the disease (section 4) and
- allowing the Director of Public Health to ask a person to discontinue a trade, business or occupation (section 15).

These provisions contain no rights to review or appeal and contain many outdated references.

*Summary of responses*

There was general agreement that such powers should be available to protect the public's health.

One respondent suggested that such powers would be consistent with the all-hazards approach.

Some respondents commented that '*the use of such restrictions must be balanced against the potential risk and a clear rationale for the imposition for a restriction as well as a review date and appeal mechanism should be included'.*

Respondents raised the need for balance and proportionality, with one recommending that restrictions should cease when the threat to the public's health has passed.

Some respondents were of the view that statutory agencies '*should be indemnified against any claims for costs associated with such restrictions where they have acted in good faith'*.

Specific suggestions included the following:

- The current legislation allows for the exclusion of food handlers infected with food poisoning organisms; these restrictions should be extended to include 'all hazards' should this approach be adopted.
- Consideration should be given to excluding individuals presenting a potential severe risk to public health pending medical investigations, to allow fuller risk assessment. For example, the screening of food handlers for food borne infectious agents during an outbreak investigation.
- There should be robust clear process and approval mechanism and provision for review.
- When excluding or restricting work practices proportionately to the hazard indentified, all actions should be based on the best available evidence and assessment of risk to the public's health.

*Department's response*

The Department recognises the need to modernise, limit and control the power for statutory agencies to place employment restrictions on premises and persons in certain circumstances. Specific proposals on this will be in the second consultation.

**Q12(a): Should new legislation contain provisions for public health measures in relation to premises and things, with powers to disinfect, disinfest and decontaminate?**

**Q12(b): Should equivalent provisions apply to persons?**

*Current position*

The 1967 Act contains limited powers to clean or disinfect premises (section 21). There are no provisions to disinfest or decontaminate premises, things or persons.

*Summary of responses*

There was general agreement that the legislation should contain such provisions, with some respondents strongly in favour, and that the exercise of such powers had to be evidence-based, justified and proportionate.

One respondent suggested that the power to destroy things/articles in premises could be extended to the premises themselves.

One respondent, addressing the question of radioactive contamination, noted that it would be necessary to consider who would be carrying out this work and at what trigger level of contamination would this occur. This respondent stated that at present in Northern Ireland there are policies, procedures and arrangements in place to deal with decontamination issues which should be considered, and that there should be further consultation with the Public Health Agency as regards the decontamination of people.

A number of respondents recognised that this would be an area in which local councils would be most active, with some suggesting that it would be important to '*ensure that any provisions are agreed following detailed consultation with local government and that there is no additional cost burden'*.

The costs associated with such powers were highlighted by some respondents and the need to make adequate budgeting arrangements in advance.

One respondent identified that applying equivalent provisions to persons may be problematic. '*If such processes would ordinarily form part of an overall package of medical care and treatment, then provisions relating to compulsory medical treatment should cover any such associated procedures*'. The respondent added that '*if the individual is not consenting to such processes and it is not certain that they have been infected, infested or contaminated, then it would be more proportionate to rely on quarantine until their status is clarified'*.

One respondent argued that, where possible, individuals should have a statutory footing to be informed about any such intrusive actions and be able to access clear information on how to appeal decisions or actions taken, in a human rights context.

*Department's response*

The Department recognises the general support for legislation to contain powers to disinfect, disinfest and decontaminate premises and things and recommends that such powers should be established and modernised in new legislation. The Department also recognises the concerns that have been raised about resourcing this function.

The Department acknowledges that extending such powers to persons is a more complex matter, requiring judgement as to whether, in an actual situation, the risk to the population is so serious that it should outweigh the rights of the individual.

Specific proposals on such powers will be included in the second consultation.

**Q 13: Should new legislation include provision for emergency subordinate legislation? Please provide reasons for your response**

*Current position*

The 1967 Act does not contain any provision for emergency subordinate legislation.

*Summary of responses*

Several respondents thought that the provision of emergency subordinate legislation would seem appropriate, on grounds of enabling a speedy and appropriate response to unforeseen circumstances or an emerging threat, and also that this could be a means of future-proofing.

One respondent stated the public health framework should support a comprehensive approach to emergency response that includes preparedness, response and recovery.

A number of reservations were expressed:

- the all-hazards approach could help to future-proof the legislation and thereby obviate the need for emergency subordinate legislation;
- there had to be assurances that it would be as easy to revoke as to bring into operation;
- such provisions should only be exercised *in extremis*;
- adequate checks and balances had to be established;
- the circumstances in which such a procedure can be invoked should be clearly spelt out in the primary legislation.

The current England & Wales legislation was suggested as a model to replicate in Northern Ireland.

One respondent highlighted in their response that there are currently policies, procedures and arrangements in place to deal with radioactively contaminated casualties, as well as regulations such as the Radiation (Emergency Preparedness and Public Information) Regulations 2001 which should also be taken into consideration when drafting matters regarding an emergency situation.

*Department's response*

The Department recognises the advantages that the provision of emergency subordinate legislation could offer in responding quickly to circumstances that could arise during a serious public health incident. The Department recognises also the importance of setting out clearly in the primary legislation the terms that would govern how such provisions would be invoked, operated and revoked.

Detailed proposals will be included in the second consultation.

**Q 14: What powers should be conferred upon a statutory agency to restrict the removal of the body of a deceased person from any place?**

*Current position*

The 1967 Act contains limited provisions restricting the removal of the body of a person who has died in hospital from a notifiable disease (section 17) and ordering

that a deceased person be removed from any building to a mortuary or buried (section 14).

*Summary of responses*

Several respondents agreed that controls may need to be applied when deceased persons pose a threat to public health. They suggested that powers conferred should be comprehensive in prescribing how the body is handled or treated.

One respondent suggested that, as with Scottish law, where a body poses significant risk to public health, an explanation of the risk and associated precautions should be provided. The same respondent went on to identify several key issues that should be considered further such as '*defining who would have a right to do this, what constitutes 'significant' in this respect, and how this power related to the statutory role of the coroner*'.

Other respondents recommended consideration of powers around handling and/or preparing bodies, movement to a mortuary, arrangements for interment/disposal and repatriation of bodies from abroad. It was acknowledged that such requirements should be based on a robust risk assessment. Furthermore, there were suggestions that any controls should be recommended, assessed or endorsed by a medical professional.

It was noted that it would be helpful to include the term 'any place' rather than restrict legislation to buildings or specific locations.

It was also noted that while the dignity of the deceased person and the wishes of the family were important, so too is any wider risk to health.

An all hazards approach was recommended, recognising that contamination may come, not only from infectious diseases, but also from CBRN sources.

One respondent commented on the fact that guidance already exists in dealing with radioactive patients who have died in a hospital following treatment. They recommended that Medical and Dental Guidance Notes produced by the Institute of Physics and Engineering in Medicine (2002) could be used to help inform drafting of relevant sections of the Public Health Act regarding radioactively contaminated bodies.

*Department's response*

The Department recognises that there may be circumstances in which controls may need to be applied when handling deceased persons. The Department recognises the difficulties in balancing the wishes of the deceased person's family with any risk to the public's health. Specific proposals on such powers will be included in the second consultation.

**Q 15: If a person is restricted from removing the body of a deceased person, should that person have a statutory right to a timely explanation as to why they may not remove the body?**

*Current position*

The 1967 Act does not provide a statutory right to a timely explanation as to why a person may not remove the body of a deceased person.

*Summary of responses*

A majority of respondents agreed that it was reasonable that such a statutory right would exist and that any restriction should be applied for the minimum time possible until the appropriate public health controls can be determined.

Other respondents suggested that decision-making must be open, transparent and accountable and suggested that clear records regarding the nature of any public health threat should be kept.

Only one respondent did not believe that such a right needs to be statutory and instead proposed that guidance should cover it.

*Department's response*

The Department agrees that such a statutory right would be reasonable and that such a requirement should be set out in primary legislation.

## Theme 4: Protecting Individuals

**Q.16: 'What powers, if any, should statutory agencies have to subject individuals to compulsory medical examination, and how should such powers be limited and controlled'?**

*Current position*

The 1967 Act contains a provision for a person suffering from, or a carrier of, a notifiable disease to undergo a medical *investigation*, which arguably amounts to a medical *examination* (section 3).

*Summary of responses*

Few respondents gave a full reply to this question. Of those who did respond, one commented that such powers would be highly contentious and would require detailed consultation and consideration, and raised issues about informed consent.

Others stressed the importance of safeguards to ensure that any actions taken would be necessary, proportionate and subject to review.  It was pointed out that every effort should be made to attempt to gain voluntary submission to medical

examinations and that any steps taken should be the least invasive and intrusive procedures practicable, as with the Scottish legislation.

One respondent pointed to the need for a robust risk assessment to determine the existence of a severe and imminent risk to public health to justify any intervention.

It was suggested that a framework or clear criteria and processes, such as automatic review, triggered at early and agreed time intervals, should be set out in advance as a further safeguarding measure.

*Department's response*

The Department recognises respondents' concerns and the need to balance health protection and personal freedom. The Department acknowledges that actions taken to submit individuals to compulsory medical examination should be necessary, proportionate and have clear review processes detailed.

**Q 17: 'How should new legislation safeguard a person's rights of review and appeal from public health orders'?**

*Current position*

The 1967 Act does not contain any rights of review or appeal, apart from a right to apply to a District Judge to have an order discontinuing a trade etc. revoked (section 15(3)).

*Summary of responses*

Respondents expressed strong support for safeguarding a person's rights of review and appeal.

It was noted that any actions taken should be necessary and proportionate with good communication and that the rights of the individual must be considered alongside Human Rights legislation and must be balanced by public interest/public health considerations.

One respondent suggested that decisions should not be vested in one person, but should be judicially ratified, while another pointed to the need for independent expert advice.

Another respondent quoted a WHO report which highlighted major roles for the law in advancing public health, one of which referred to authorising and limiting public health actions with respect to protection of individual rights.

Other specific points included the following.

- In order to safeguard the public the order could be deemed to stand until the review and/or appeal is heard.
- There should be an early and automatically triggered review of the use of each or any aspect of statutory powers.

- There should be a pre-specified appeals process.

*Department's response*

The Department recognises the respondents' support for safeguarding a person's rights of review and appeal from public health orders as well as concerns around balancing individual rights and the exercise of statutory powers designed to protect public health. The Department acknowledges suggestions for obtaining independent expert advice to assist with decision-making.

The Department recognises the need for any new legislation to comply with the Human Rights Act 1998.

**Q 18: 'Whenever a person is being detained, quarantined, isolated or required to undergo compulsory medical examination or treatment, should they have a statutory right to a timely explanation of the interference with their rights'?**

*Current position*

The 1967 Act does not provide a statutory right to a timely explanation of the interference with a person's rights.

*Summary of responses*

A majority of respondents gave a definitive answer to this question, supporting a statutory right to a timely explanation of interference with a person's individual rights.

One respondent emphasised that a voluntary approach was preferable in all circumstances and every effort should be made to achieve this before resorting to statutory powers.

Some respondents placed this right in the context of the broader need to safeguard individual rights and to ensure that basic rights and values are included in legislation and that any actions are necessary and proportionate.

*Department's response*

The Department recognises the strong support from many respondents for a person having a timely explanation of any interference with their rights. This is in accordance with the Human Rights Act 1998 and the European Convention on Human Rights ('ECHR'). The responses will inform the second consultation, where human rights compatibility will be reflected in the drafting of specific legislative proposals.

**Q 19: 'The Department would welcome your ideas on**

**(a) how best to balance, on the one hand, the need to protect the public's health, and, on the other hand, the rights, needs and dignity of the individual, and**

**(b) how best to ensure that, where an intervention impinges on a person's rights, the interference is proportionate to the threat to public health'.**

*Current position*

The 1967 Act contains only one reference to where the interests of a person, his family or the public interest are to be considered (section 3(1)(b)). The Act does not require a balance to be struck between the state acting to protect public health and an individual's needs and dignity. The Act contains no requirement for orders made to be proportionate.

*Summary of responses*

In relation to 19(a) several respondents expressed the view that action by regulators had to be proportionate to the risk to public health, recommending the development of a detailed risk assessment procedure, supported by necessary training and guidance.

One respondent referred to the development of an enforcement procedure and a detailed code of practice through consultation, while another considered that the ECHR presented a satisfactory framework in which to work.

One respondent felt that awareness-raising and cooperation with neighbouring jurisdictions and others would be important when considering balancing health protection and individual rights. Another referred to health protection in its international context, both in relation to examining and learning from legislative models, such as those in Sweden and Norway and suggesting that, to be effective, legislation should align with the IHR 2005 and give appropriate powers.

One respondent suggested that a compensation scheme, such as already exists in Scotland, should be introduced.

One response referred specifically to radioactive contamination and the need to consult with the appropriate experts according to the nature of the risk.

In thinking about the balance between the role of the State and individual responsibility, one respondent commented that '... *the state has a fundamental duty of protection which should in most cases override individual autonomy, provided that the threat is of a degree of severity that state action is needed. Insertion of a word like 'significant' to qualify the nature of the risk should be adequate to cover this concern'*.

In relation to 19(b) suggestions for ensuring that any intervention is proportionate to the threat included:

- an open, transparent and independent review process;
- periodic reassessment of what is perceived to be proportionate;
- robust processes for decision-making in place;
- the need for compliance with human rights legislation; and

- the inclusion of proportionality as a general statutory principle.

One respondent also pointed to the need to protect individuals' privacy and to ensure that only information which is relevant, adequate and necessary should be shared.

One respondent suggested that these matters should be the subject of further detailed discussion and consultation with relevant stakeholders.

*Department's response*

The Department acknowledges respondents' suggestions as to how best to balance the public's health against the rights, needs and dignity of the individual.

The requirement for actions to be proportionate is an essential part of the achievement of this balance. A second consultation will take place which will explore these issues in more detail.

**Q20: 'The Department has identified a number of apparent or possible gaps and deficiencies in the Public Health Act (Northern Ireland) 1967. The Department would welcome your views on what issues or gaps - whether identified in this document or not - should be considered for future possible reforms to the 1967 Act'.**

*Current position*

The 1967 Act has a number of gaps, already set out in the answers to the questions above, which relate both to structure and content. Perhaps the most serious relate to the lack of an 'all hazards' approach and to the failure to protect individual rights, thus causing the Act to be incompatible with human rights legislation.

*Summary of responses*

Most respondents pointed to the need to widen the scope of the legislation to include all hazards. One stressed the importance of monitoring, managing and controlling future hazards, while another noted that global pandemic threats and antimicrobial resistance should remain core components of the public health function.

One respondent referred specifically to the emerging range of cosmetic treatments being offered to the public. This respondent felt that a licensing scheme for businesses offering these treatments would be stronger than the current Northern Ireland system of registration.

A common theme was the need to draft legislation which reaches beyond health protection alone and deals with the issues of health improvement and promotion and the prevention of ill health. Some respondents referred to the emergence of non-communicable diseases and their impact on population health, with one requesting a range of interventions in relation to the use of tobacco, alcohol misuse and unhealthy nutrition and another suggesting that legislation should encompass mental as well as physical health. Several respondents felt that extending the scope of legislation

could help tackle health inequalities. One response referred to the focus on health protection in the consultation documents as a gap in the vision for public health law in Northern Ireland.

One respondent suggested that an act could be divided into two distinct parts - part one for health protection, and part two for health promotion and improvement.

Respondents also mentioned a need for health impact assessments as a core component of legislation as well as suggesting the need for a 'whole of government/society' approach. Some respondents referred to the strategic framework for public health, *Making Life Better,* as a suitable approach for legislation.

A respondent body concerned with upholding information rights identified the need to ensure compliance with the Data Protection Act 1998, particularly with regard to the processing or sharing of sensitive personal data, in this case health information. Another suggested that consideration should be given to provisions relating to the mandatory sharing of confidential health information in the context of a significant public health threat, as well as setting out the necessary criteria for the sharing of such information.

Other possible gaps suggested for consideration were:

- risks to a child or minor with a non-compliant parent or guardian;
- access to preventative community support services;
- issues relating to radioactive contamination;
- the enablement of enforceable activity to prevent risks to public health;
- compulsory vaccination for healthcare workers in the face of a significant threat to public health;
- specific issues arising in connection with education premises and settings such as hospitals and care homes where risks of spread of infectious disease are high;
- possible restrictions on freedom of assembly, and
- alignment with IHR 2005.

*Department's response*

The Department recognises the main gap in the current legislation in relation to an all hazards approach.

The Department recognises the support expressed for legislative provision which extends beyond health protection alone, to an approach that would include ill health prevention more broadly and health improvement.

Additional suggested gaps will be considered further by the Department and may be included for discussion in the second consultation.

**Q 21: 'Should a public health bill for Northern Ireland be in the form of an amending bill, i.e. one that would make multiple amendments to the 1967 Act, or a**

**'fresh start' bill that would be a combination of new provisions and 'savings' from the 1967 Act'?**

*Summary of responses*

Respondents showed strong support for a new/fresh start bill with one respondent citing the Public Health etc. (Scotland) Act as a possible template.

Another respondent stressed the importance of a new bill forming part of a suite of public health legislation which would include e.g. laws relating to use of tobacco and alcohol. One respondent favoured the introduction of two bills, one to focus on health protection and the other on health improvement and promotion.

*Department's response*

The Department notes the general strong support for a new/fresh start bill.

**Q 22: 'The Department would welcome any observations on the two options for reform'.**

*Summary of responses*

Most respondents reiterated their preference for a new/fresh start bill.

Others took the opportunity to again stress their preference that a new bill go further than health protection, citing the significant impact that legislation can have on public health and requesting that the opportunity be taken to consider the impact of non-communicable disease.

One respondent body saw a new bill as *' ...a unique opportunity to influence and shape the direction of public health law in Northern Ireland in order to reflect the changing nature of public health and the impact of wider issues such as globalization, conflict and climate change'.*

The same respondent favoured a clear link with and reflection of Northern Ireland's public health strategy, *Making Life Better*.

*Department's response*

The Department has again noted the considerable support for a new/fresh start bill reiterated in these responses. The Department also notes those responses that restated a preference for a bill that extends beyond health protection to health improvement/promotion.

**Other matters**

The Department invited respondents to raise any other relevant matters that were not prompted by the consultation questions.

*Summary of responses*

The subjects raised in the responses ranged from broad discussions of the purposes and scope of public health law, including how it has developed and could be further developed, to specific issues such as enforcement, types of regulation, and the need for communication and engagement.

*The purposes and scope of public health law*

Some respondents were of the view that the scope of the consultation was too narrow, and by that token was at odds with *Making Life Better*, arguing that tackling health inequalities is a proper function of public health law, and that public health law can deliver a wide range of benefits to society and can promote equity in health. This raised a more basic philosophical and political question about different views of the proper role of the state, and where the boundaries should be drawn between state intervention and individual autonomy. One commented:

> '*Many contemporary public health lawyers, ethicists and policy analysts would regard the role of the state as appropriately more interventionist than the consultation appears to do....there appears to be a disjuncture between the ambitions expressed for government in 'Making Life Better' and the more restricted role outlined here. This seems...a matter which is worthy of public debate in the course of drawing up any programme for further legislative action'*.

In this context the Department was invited to consider the 'stewardship' model discussed in the 2007 Nuffield Council Report: *Public Health – Ethical Issues.*

Some respondents pointed to the development of new types of public health law in other jurisdictions, with legislation being used to involve local communities in decisions affecting their health and well-being, as well as the prevention of ill health and early lifestyle approaches to the improvement of public health.

One response suggested that the political history of Northern Ireland could have been a factor in determining the scope of the consultation.

Partnership and community participation emerged as a theme, echoing the principles outlined in the South Australian Public Health Act. Some responses highlighted the potential value of collaborative working at district council level as part of the community planning process.

*Specific issues raised*

More specific points were made in relation to:

- the use of enforcement powers as a last resort, in the context of balancing the exercise of powers to protect public health with individual freedoms and human rights obligations;
- radiological contamination, and the transporting of radioactive material;

- the need for robust communication and training for public health professionals when considering the implementation of new legislation;
- the lack of a cross-cutting Civil Contingencies Bill;
- the role of first aid education in public health, and
- the regulation of emerging cosmetic treatments.

*Department's response*

The Department is grateful to all those who took the time to respond to the consultation, and will continue to consider the points made including the matters raised in this final part of the consultation.

## 5 Conclusions and recommendations

The review of the Public Health Act (Northern Ireland) 1967, including the public consultation, has led the Department to the following conclusions and recommendations.

| Conclusions | Recommendations |
|---|---|
| 1. The 1967 Act is deficient in a number of respects. | 1. The Executive should include a public health bill in its legislative programme for the next Assembly mandate. |
| The remaining recommendations assume that the Executive will agree to do so. | |
| 2. The 1967 Act is concerned almost exclusively with infectious diseases, whereas the International Health Regulations 2005 and a number of jurisdictions have adopted the all-hazards approach to health protection legislation. | 2. The Public Health Bill should be based on the all-hazards approach and be consistent with the WHO International Health Regulations. |
| 3. There is support for the inclusion of a statement of principles or a statement of intent or a list of objectives or a combination of any of these. | 3. The Public Health Bill should include a statement of principles or of intent, or objectives, or a combination of these. |
| 4. The 1967 Act does not require authorities to act in ways that are proportionate to the threats to the public's health. | 4. The Public Health Bill should aim to strike a balance between the state's responsibility to protect the public's health, and the autonomy, rights and dignity of the individual. The Bill should be compliant with the state's duties in respect of human rights. |
| 5. Given the infrequency with which this legislation is reviewed, there is a particular need to future-proof new legislation. | 5. The Department should aim to future-proof the legislation by a combination of: the all-hazards approach; careful choices of terminology in the legislation including the categories of threat to population health; judicious use of subordinate legislation. |
| 6. Many categories of threat to | 6. In preparing instructions to OLC |

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| population health are used in different jurisdictions. | the Department should consider in particular the categories of threat used in the Scottish legislation. |
| 7. One of the shortcomings of the 1967 Act is a lack of clarity or completeness as regards the roles and responsibilities of different authorities. | 7. The Department should aim to ensure that the new legislation provides greater clarity regarding the roles and responsibilities of the bodies concerned. |
| 8. The current powers of statutory agencies to investigate public health risks appear to be inadequate. | 8. Investigatory powers should be strengthened, and the Department should give further consideration to specific investigatory powers. |
| 9. Powers of quarantine, isolation, detention, and compulsory medical examination need to be updated. | 9. The Public Health Bill should include provisions to update these powers. |
| 10. Opinion is divided as to whether there should be a power to impose medical treatment on an individual. | 10. The Department should give further consideration to the ethical and practical aspects of this, and should consult on any specific proposals. |
| 11. There is general agreement that there is a need to modernise powers to place employment restrictions on persons and premises. | 11. The Public Health Bill should modernise such powers and the associated constraints and controls. |
| 12. Powers to disinfect, disinfest and decontaminate premises, things and persons need to be modernised. | 12. The Department should give further consideration to these powers, particularly in relation to persons, and should consult on specific proposals. |
| 13. There is support for the creation of powers to introduce emergency subordinate legislation to deal with certain scenarios, subject to necessary constraints and controls. | 13. The Department should give further consideration to whether the Public Health Bill should include powers to make emergency subordinate legislation, and should consult on specific proposals. |
| 14. There is support for controls to be applied when a deceased person poses a threat to public health. | 14. The Department should give further consideration to such powers and should consult on specific proposals. |
| 15. There is general support for rights of review and appeal in the event of certain interventions. | 15. The Public Health Bill should enshrine such safeguards. |
| 16. There is strong support for a right to a timely explanation for certain interventions including restrictions on the removal of a body; and the imposition of quarantine, isolation, | 16. The Public Health Bill should enshrine such rights. |

| | |
|---|---|
| detention or medical examination. | |
| 17. There are differing views as whether the legislation should continue to be limited to health protection, or also include provisions relating to other domains of public health. | 17. The Department should consider further the scope of the new legislation. |
| 18. The current legislation needs to be modernised in many respects and particulars, including the language used in the Act. The necessary amendments are so numerous that an amending bill would be significantly more complex to produce, to understand and to interpret than a fresh start bill. This could have adverse operational consequences in the event of a public health emergency. | 18. The Public Health Bill should be an entirely new piece of legislation which would re-enact provisions from the 1967 Act as necessary. |

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## Annex 1: Members of the Steering Group and Working Group for the review

Steering Group

Dr Michael McBride, Chief Medical Officer (Chair).
Dr Carolyn Harper, Director of Public Health/Medical Director, Public Health Agency.
Dr Elizabeth Mitchell, Director of Development and Capacity Building, Institute of Public Health in Ireland.

*Alternates*

Dr Anne Kilgallen, Deputy Chief Medical Officer.
Dr Lorraine Doherty, Assistant Director of Public Health (Health Protection), Public Health Agency

Working Group

Dr Gerry Mulligan, Director of Population Health, DHSSPS (Chair)
Seamus Camplisson, Health Protection Branch, DHSSPS
Diane Drennan, legal team, DHSSPS
Bernie Duffy, Emergency Planning Branch, DHSSPS,
Elaine Lawson, Emergency Planning Branch, DHSSPS, until May 2015
Professor Nigel McMahon, Chief Environmental Health Officer, DHSSPS
Anne McNally, Health Protection Branch, DHSSPS
Sheena Mairs, Emergency Planning Branch, DHSSPS, from August 2015
Rob Warnock, legal team, DHSSPS

## Annex 2: List of consultation respondents

Antrim and Newtownabbey Borough Council
Armagh, Banbridge and Craigavon Borough Council
Belfast City Council
Belfast Health & Social Care Trust
Belfast Healthy Cities
British Medical Association
British Red Cross
Cardiff University
Charted Institute of Environmental Health
CBRN (Chemical, biological, radiological and nuclear) Steering Group
Community Development and Health Network
Derry City and Strabane District Council
Fermanagh and Omagh District Council
Information Commissioners Office
Institute of Physics and Engineering in Medicine
Institute of Public Health Ireland
Little, Dianne
McCarron, Dr Geralyn
Mid and East Antrim Borough Council
Mid Ulster District Council
Newry, Mourne and Down District Council
Northern Ireland Affairs Committee of UK Faculty of Public Health
Northern Ireland Local Government Association
Parkinson's UK
Police Service Northern Ireland
Queen’s University Belfast
Royal College of Nursing
Royal College of Physicians
South Eastern Health and Social Care Trust