

## Written evidence from Dr Jonathan Pugh, Dr Lisa Forsberg, and Dr Thomas Douglas (COV0255)

### Restrictions of Liberty in Public Health, Medical Treatment, and Human Rights in The COVID-19 Pandemic

We are a group of academics with expertise in medical ethics and law, and we have recently published legal analyses of the emergency Coronavirus legislation in peer-reviewed academic journals.<sup>1</sup> We are submitting this evidence note because our research in this area has enabled us to identify key areas in this legislation that raise human rights issues, and to develop three key recommendations for ensuring that liberty-restricting measures taken by the government to address the COVID-19 pandemic are human rights compliant.

The UK government has imposed significant restrictions of liberty of individuals in order to prevent the spread of the SARS-CoV-2 coronavirus (henceforth ‘the coronavirus’), raising concerns about potential human rights violations. Whilst the UK is a party to the European Convention on Human Rights (which is incorporated into domestic law via the Human Rights Act 1998), it is a well-established tenet of human rights law that restricting an individual’s liberty to prevent the spread of infectious disease need not amount to a human rights violation. Indeed, Article 5(1) of the European Convention of Human Rights (ECHR), which safeguards the individual’s right to liberty and security of the person, explicitly states that an individual may be deprived of their liberty to prevent the spread of infectious diseases, if that deprivation is in accordance with a procedure prescribed by law.

The European Court of Human Rights (ECtHR) judgment in the case of *Enhorn vs Sweden* (2005) further clarified the scope of this exception in two ways.<sup>2</sup> First, it noted that such deprivations must be necessary and proportionate to the benefit achieved if they are to be compliant with Article 5(1). Second, public health law in this area must be clearly defined and foreseeable in its application, thus satisfying a requirement for legal certainty.<sup>3</sup>

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<sup>1</sup> Thomas Douglas, Lisa Forsberg, and Jonathon Pugh, ‘The Covid-19 Response in England: A Conditional, Comparative Argument for Compulsory Medical Intervention’, *Journal of Medical Ethics*, 2020; Jonathan Pugh, ‘The United Kingdom’s Coronavirus Act, Deprivations of Liberty, and The Right to Liberty and Security of the Person’, *Journal of Law and the Biosciences*, 2020

<sup>2</sup> *Enhorn v. Sweden* (European Court of Human Rights 2005).

Prior to the Covid-19 pandemic, the Public Health (Control of Disease) Act 1984 (PHA 1984) already authorised local Justices of the Peace to impose certain restrictive measures in order to prevent the spread of infectious disease in England and Wales. Such measures include the imposition of quarantine, isolation, and medical examination. However, in response to the Covid-19 pandemic, the UK government passed emergency legislation to extend and centralise these powers, first in the Health Protection (Coronavirus) Regulations 2020, and then in Schedule 21 of the Coronavirus Act 2020 (which superseded the preceding Regulations).

In this evidence note, we shall highlight three key areas where important steps must be taken to ensure that the powers outlined in the new emergency legislation are exercised in a manner that is compliant with human rights law.

(i) Compulsory Medical Treatment

Part 2A, Section 45G(2) of the PHA 1984 lists 11 restrictions of liberty that a Justice of Peace may impose on potentially infectious individuals in order to protect public health. Notably, this list appears intended to be exhaustive, and the imposition of compulsory medical treatment or vaccination is not included amongst the interventions that a Justice of the Peace may authorize. Furthermore, section 45E of the PHA 1984 explicitly prohibits any future regulations that the Secretary of State may pass from including provisions to impose compulsory medical treatment (including vaccination).<sup>4</sup>

In contrast, the Coronavirus Act does not explicitly prohibit the imposition of compulsory medical treatment or vaccination. Furthermore, the wording of the Act suggests that the list of restrictions and requirements that it authorises is not intended to be exhaustive. Section 14(3) –(4) of Schedule 21 simply lists restrictions and requirements that may be *included* amongst those that may be considered necessary and proportionate to prevent the spread of

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<sup>3</sup> Robyn Martin, 'The Exercise of Public Health Powers in Cases of Infectious Disease: Human Rights Implications', *Medical Law Review* 14, no. 1 (20 March 2006): 132–43. See also Emma Cave, 'Voluntary Vaccination: The Pandemic Effect', *Legal Studies* 37, no. 2 (1 June 2017): 279–304, <https://doi.org/10.1111/lest.12144>.

<sup>4</sup> HM Government, 'Public Health (Control of Disease) Act 1984' (1984), 45L,

the coronavirus.<sup>5</sup> This wording leaves open the possibility that other interventions not listed could yet be lawful under the terms of the Act.

This is significant, as it leaves open a potential avenue for the imposition of compulsory medical treatment and/or vaccination in order to prevent the spread of the coronavirus. Indeed, if an effective vaccine were to be discovered, there may be considerable political pressure to consider this avenue, particularly if there were also grounds for doubting that a voluntary vaccination programme would achieve sufficient uptake to ensure herd immunity.<sup>6</sup>

Yet, the prospect of compulsory treatment and/or vaccination raises human rights issues that go far beyond the Article 5(1) rights raised by the restrictions of liberty already authorized by the PHA and the emergency coronavirus legislation. Indeed, in *X v Austria*, the EctHR held that compulsory medical intervention, must be considered an interference with the right to respect for private and family life protected by article 8 ECHR, even if the intervention itself is of minor importance.<sup>7</sup> However, like article 5 ECHR, the protection that article 8 ECHR offers is not absolute, and compulsory medical treatment may be compatible with Article 8 ECHR in some circumstances, if it is in accordance with domestic law, proportionate, and necessary to achieve a legitimate aim. The EctHR has previously accepted the use of non-consensual blood tests, vaccinations, and screening programmes as justified on grounds of the protection of the rights and freedoms of others,<sup>8</sup> and public safety.<sup>9</sup> However, it is not clear that compulsory vaccination or medical treatment in the context of Covid-19 would similarly satisfy the criteria of being both proportionate and necessary.<sup>10</sup>

**Recommendation 1:** The government should clarify whether compulsory medical treatment and/or vaccination would be lawful under the terms of the Coronavirus Act, and the issue should be subjected to Parliamentary scrutiny, particularly of how the restrictiveness of

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<sup>5</sup> HM Government, 'The Coronavirus Act' (2020), Schedule 21, 14(3)-(4),

<sup>6</sup> Cave, 'Voluntary Vaccination'.

<sup>7</sup> *X v Austria*. (1979) 8278/78: ECmHR, 1979.

<sup>8</sup> *Ibid.*

<sup>9</sup> *Acmanne v Belgium*. (1984) 10435/83: ECmHR, 1984.

<sup>10</sup> For further discussion, see Douglas, Forsberg, and Pugh, 'The Covid-19 Response in England: A Conditional, Comparative Argument for Compulsory Medical Intervention'.

compulsory medical treatment/vaccination should be balanced against that of detention, when either would be effective in preventing the spread of the coronavirus.

(ii) Necessity and Proportionality of Restrictions of Liberty

Fine-grained, evidence-based assessments of whether it is necessary and proportionate to detain a potentially infectious individual in the context of an emerging pandemic requires considerable public health expertise. For this reason, the Regulations issued in February 2020 limited the power to authorise deprivations of liberty (following a proportionality/necessity assessment) to registered public health consultants and the Secretary of State.<sup>11</sup> However, the Coronavirus Act further extended these powers to individuals who may lack relevant public health expertise, including police officers and immigration officers, as well as individuals designated as public health officers by the Secretary of State.<sup>12</sup> Crucially, under the Coronavirus Act, individuals who have been designated as ‘public health officers’ need not be professionally registered public health consultants.<sup>13</sup>

Of course, non-experts will make judgments about when restrictions of liberty are necessary and proportionate to the best of their abilities. However, this does not mean that restrictions based on such assessments will be necessary and proportionate in the sense that is relevant for Article 5(1) rights, if they are not grounded by a sound public health rationale.<sup>14</sup>

**Recommendation 2:** The extension of powers to restrict liberty to individuals other than registered public health consultants should be accompanied by extensive training programs that will enable police officers, immigration officers and individuals designated as public health officers by the Secretary of State to make evidence-based assessments of when a restriction of liberty is necessary and proportionate.

(iii) Legal Certainty and Isolation Orders

One way in which the emergency legislation departs from the PHA 1984 is that it does not specify specific time limits for certain restrictions of liberty. Following amendments

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<sup>11</sup> HM Government, ‘The Health Protection (Coronavirus) Regulations 2020’ (2020), section 5 and section 8.,

<sup>12</sup> HM Government, The Coronavirus Act, Schedule 21, sections 8-14.

<sup>13</sup> HM Government, Schedule 21, section 3(2)[a].

<sup>14</sup> Pugh, ‘The United Kingdom’s Coronavirus Act, Deprivations of Liberty, and The Right to Liberty and Security of the Person’.

introduced by the Health and Social Care Act 2008, the PHA 1984 imposes a 28-day time limit on detention, isolation, and quarantine orders that a JoP may impose.<sup>15</sup> Strikingly, although the Health Protection (Coronavirus) Regulations 2020, and the Coronavirus Act 2020 incorporate extensive procedural safeguards regarding the imposition of deprivations of liberty (including daily review, and a simple appeals process), they do not specify time limits for certain deprivations. The Regulations failed to do so for any form of detention;<sup>16</sup> in contrast, although the Coronavirus Act specifies an overall 28-day limit for detaining a person in a place for screening and assessment, it explicitly excludes isolation orders from the scope of this limit.<sup>17</sup>

Irrespective of whether it would be necessary and proportionate to detain a potentially infectious individual in isolation beyond 28 days, the absence of a specified time limit raises doubts about whether this particular power is clearly defined and foreseeable in its application in the manner that legal certainty requires, as emphasised by the ECtHR in *Enhorn vs Sweden* (2005) . This is particularly striking in light of the explicit 28-day limit on restriction of liberty introduced by the 2008 revision of the PHA 1984.<sup>18</sup>

**Recommendation 3:** The Coronavirus Act should be amended to include a specific time limit for isolation orders.

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<sup>15</sup> HM Government, Public Health (Control of Disease) Act 1984, section 45L.

<sup>16</sup> HM Government, The Health Protection (Coronavirus) Regulations 2020, section 9.

<sup>17</sup> HM Government, The Coronavirus Act, Schedule 21, s15(6).

<sup>18</sup> For further discussion, see *Ibid.*