



The United Kingdom's Coronavirus Act, deprivations of liberty, and the right to liberty and security of the person

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ABSTRACT

In response to the SARS-CoV-2 coronavirus pandemic the UK government has passed the Coronavirus Act 2020 (CA). Among other things, this act extends existing statutory powers to impose restrictions of liberty for public health purposes. The extension of such powers naturally raises concerns about whether their use will be compatible with human rights law. In particular, it is unclear whether their use will fall within the public health exception to the Article 5 right to liberty and security of the person in the European Convention of Human Rights. In this paper, I outline key features of the CA, and briefly consider how the European Court of Human Rights has interpreted the public health exception to Article 5 rights. This analysis suggests two grounds on which restrictions of liberty enforced some under the CA might be vulnerable to claims of Article 5 rights violations. First, the absence of specified time limits on certain restrictions of liberty means that they may fail the requirement of legal certainty championed by the European Court in its interpretation of the public health exception. Second, the Coronavirus Act's extension of powers to individuals lacking public health expertise may undermine the extent to which the act will ensure that deprivations of liberty are necessary and proportionate.

INTRODUCTION

The SARS-CoV-2 coronavirus (henceforth 'the coronavirus') outbreak has led to governments imposing strict restrictions on individual liberty in order to prevent the spread of this highly contagious and virulent pathogen. Such measures have included

the closure of businesses, travel restrictions, isolation of confirmed cases, and the quarantine of individuals who have been exposed to the virus.

The state's power to enforce such restrictive measures in order to protect public health is enshrined in the public health law of a number of jurisdictions. Prior to the coronavirus pandemic, the state's power to impose liberty-restricting measures for the purposes of public health in England and Wales was predominantly enshrined in the Public Health (Control of Disease Act) 1984 [as amended by the Health and Social Care Act 2008].¹ However, in the early months of 2020, the UK government supplemented this act, first with The Health Protection (Coronavirus) Regulations 2020 and then the Coronavirus Act 2020 (which revoked the aforementioned regulations). Both extended the powers of certain authorities to restrict the liberty of potentially infectious individuals.

While no one should doubt the urgency of the situation prompted by the coronavirus pandemic, the extension of emergency powers naturally raises concerns about whether their use will be compatible with human rights law.² Indeed, both national and international bioethical organizations have issued statements calling for the need to safeguard human rights while imposing restrictive measures in response to the coronavirus pandemic.³ Moreover, these concerns have relevance beyond the duration of the pandemic itself. As a statement from the European Group on Ethics in Science and Technologies (EGE) observes, a significant danger of any emergency legislation in this context is that it may create a new 'normal' of eroded rights and liberties in a post-pandemic world.⁴

Individuals who wish to raise a legal objection to the use of restrictive measures that are sufficiently severe to constitute a deprivation of liberty may be able to do so by appealing to human rights law. In Europe, for example, they may appeal to one of the various statutes that incorporate the European Convention of Human Rights (ECHR) into domestic law. However, even human rights law does not afford complete precedence to the individual's right to liberty in the context of public health. Although Article 5(1) of the ECHR states that every individual has the right to liberty and security of the person, the article goes on to state that the an individual may be deprived

1 For the Scottish and Northern Irish counterparts, see Scottish Government, Public Health etc. (Scotland) Act 2008. <http://www.legislation.gov.uk/asp/2008/5/contents>; Northern Ireland Government, Public Health Act (Northern Ireland) 1967. <http://www.legislation.gov.uk/apni/1967/36/contents> (accessed May 6, 2020).

2 Indeed, the UK Parliament Joint Committee on Human Rights issued a call for evidence on the human rights implications of the government's response to the coronavirus COVID-19 *Response Scrutinised to Ensure Human Rights Are Upheld—Committees—UK Parliament*. <https://committees.parliament.uk/committee/93/human-rights-joint-committee/news/145641/covid19-response-scrutinised-to-ensure-human-rights-are-upheld> (accessed May 6, 2020).

3 The Nuffield Council on Bioethics, *Guide to the Ethics of Surveillance and Quarantine for Novel Coronavirus*, 2020. <https://www.nuffieldbioethics.org/news/guide-to-the-ethics-of-surveillance-and-quarantine-for-novel-coronavirus>; UNESCO International Bioethics Committee and the UNESCO World Commission on the Ethics of Scientific Knowledge and Technology, *Statement on COVID-19: Ethical Considerations from a Global Perspective—UNESCO Digital Library*. <https://unesdoc.unesco.org/ark:/48223/pf0000373115> (accessed Apr. 17, 2020); European Group on Ethics in Science and Technologies, *Statement on European Solidarity and the Protection of Fundamental Rights in the COVID-19 Pandemic*, 2020. https://ec.europa.eu/info/publications/egs-statements_en (accessed May 6, 2020).

4 European Group on Ethics in Science and Technologies, *supra* note 3, at 3.

of their liberty to prevent the spread of infectious diseases, if that deprivation is in accordance with a procedure prescribed by law.⁵ Call this the ‘public health exception’. The scope of the public health exception has been further clarified by judgements in the European Court of Human Rights, as I shall explain below.⁶

In this paper, I shall use the Coronavirus Act 2020 (CA) as a case study of how emergency legislation enacted in the context of a pandemic may conflict with human rights law enshrined elsewhere in domestic law. I shall begin by briefly outlining the key powers outlined in different legal instruments that are (or have been) operative in the public health context in England and Wales. In the second half of the paper, I shall consider how these powers might interact with Article 5(1) of the ECHR (incorporated into domestic law in the UK by virtue of the Human Rights Act 1998). To do so, I shall first outline key criteria that the European Court of Human Rights takes to delimit the scope of the public health exception to Article 5 rights, as clarified by the Court’s Judgment in *Enhorn v Sweden*.⁷ These criteria concern whether the deprivation under considerations was (i) in accordance with domestic law, (ii) proportionate and necessary. I will conclude by considering some ways in which some restrictions of liberty that the CA might authorize may be susceptible to challenge on the basis of failing to meet these criteria. Throughout, I focus on powers to detain, quarantine, or isolate particular individuals that may in some cases engage Article 5(1) rights, and not on the less severe—though still significant—liberty restrictions that many governments have implemented at a population level, including what have been widely referred to as ‘lockdowns’.⁸

THE PUBLIC HEALTH (CONTROL OF DISEASE) ACT AND THE CORONAVIRUS ACT

Public Health (Control of Disease) Act 1984

From this point, I shall refer to The Public Health (Control of Disease) Act 1984 as amended by the Health and Social Care Act 2008 as ‘the PHA’. The PHA lays much of the responsibility for controlling the spread of infectious disease at the door of Justices of the Peace (JoPs), magistrates (often laypeople) who are appointed by the crown. Section 45G of the PHA gives a JoP the power to impose various restrictions on an individual, ‘P’ if the JoP is satisfied that the following are true:

- (a) P is or may be infected.

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- 5 European Court of Human Rights, Council of Europe, European Convention on Human Rights (1950), Article 5(1)[e]. https://www.echr.coe.int/Documents/Convention_ENG.pdf (accessed May 6, 2020).
 - 6 For instance, see *Enhorn v Sweden* (European Court of Human Rights 2005). European Court of Human Rights, Council of Europe, European Convention on Human Rights (1950).
 - 7 HUMAN RIGHTS ACT 1998. <http://www.legislation.gov.uk/ukpga/1998/42/introduction> (accessed Mar. 30, 2020).
 - 8 For an insightful discussion of the lawfulness of these interventions, and the distinction between liberty restrictions and deprivations of liberty in this context, see JEFF KING, *The Lockdown Is Lawful: Part Two*. UK Constitutional Law Association, Jan. 4, 2020. <https://ukconstitutionallaw.org/2020/04/02/jeff-king-the-lockdown-is-lawful-part-ii/>; ALAN GREENE, *States Should Declare a State of Emergency Using Article 15 ECHR to Confront the Coronavirus Pandemic*. Strasbourg Observers (blog), Jan. 4, 2020. <https://strasbourgobservers.com/2020/04/01/states-should-declare-a-state-of-emergency-using-article-15-echr-to-confront-the-coronavirus-pandemic> (accessed May 6, 2020).

- (b) The infection or contamination is one which presents or could present significant harm to human health.
- (c) There is a risk that P might infect or contaminate others.
- (d) It is necessary to make the order in order to remove or reduce that risk⁹.

The PHA also makes it clear that there should be some evidentiary basis for the JoP's belief that these things are true. Although the precise level of evidence is not stipulated, subsection (7) states that 'The appropriate Minister must by regulations make provision about the evidence that must be available to a justice of the peace before the justice can be satisfied'.

Section 45G(2) outlines 11 'special restrictions' that a JoP may impose. For my purposes in this paper, the first four restrictions listed are particularly relevant. A JoP may order that:

- (a) P submit to medical examination;
- (b) P be removed to a hospital or other suitable establishment;
- (c) P be detained in a hospital or other suitable establishment; and
- (d) P be kept in isolation or quarantine.¹⁰

While section 45G outlines the powers that JoPs have to impose restrictions of liberty on particular individuals in the name of public health, other sections of Part 2A give the Secretary of State the power to make other general regulations for this purpose. However, such regulations are subject to certain limits. Notably, one such limit delineated in 45D(3) is that domestic regulations (issued under 45C) may not include provisions for the direct imposition of any of the restriction 45G(2)(a), (b), (c), or (d) (ie the measures outlined above).¹¹ Thus, compulsory medical examination, hospital detention, quarantine, and isolation cannot be imposed directly at a population level under new regulations, although they might potentially be imposed indirectly following a case-by-case assessment by a designated authority under new regulations.¹² Furthermore, section 45E prohibits regulations from including provisions to directly impose mandatory medical treatment (including vaccination).¹³

The Coronavirus Act 2020

The CA is an extensive piece of legislation forged in response to the coronavirus outbreak. It outlines various provisions that aim to enable the UK to respond to the pandemic across a wide range of domains. These provisions include (among others)

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- 9 HM Government, Public Health (Control of Disease) Act 1984, Part 2A, Section 45G(1). <http://www.legislation.gov.uk/ukpga/1984/22/part/2A>.
 - 10 HM Government, Public Health (Control of Disease) Act 1984, Part 2A, Section 45G(2). <http://www.legislation.gov.uk/ukpga/1984/22/part/2A>. See Section 45C 6(a) for the relevant definition of a 'special restriction'.
 - 11 HM Government, Section 45D(3). Notably, a similar limit does not pertain to regulations governing international travellers, which are provided for under Section 45B.
 - 12 Jeff King, *The Lockdown Is Lawful: Part Two*. UK Constitutional Law Association, Jan. 4, 2020. <https://ukconstitutionallaw.org/2020/04/02/jeff-king-the-lockdown-is-lawful-part-ii/>
 - 13 HM Government, Public Health (Control of Disease) Act 1984, Part 2A, Section 45E.

schedules pertaining to the emergency registration of healthcare professionals¹⁴ and schedules pertaining to the use of live links in criminal proceedings.¹⁵ The Act will expire 2 years after it is enacted (unless certain conditions are met, as outlined in section 90),¹⁶ and its provisions will be subject to parliamentary review at 6-month intervals.¹⁷

Schedule 21 of the CA extends the existing PHA powers to control infectious disease in the specific context of the coronavirus. In doing so, it expands upon the government's initial extension of these powers issued in The Health Protection (Coronavirus) Regulations on February 10, 2020. Since the CA later revoked these regulations,¹⁸ I shall focus my discussion on the CA. However, I shall raise two notable differences between the extension of powers initially issued in the Regulations and those that are now in force by virtue of the CA at the end of this section. Furthermore, in the interests of brevity, I shall focus only on the powers that schedule 21 of the CA grants in relation to potentially infectious persons 'in England' (as outlined in Part 2 of the schedule).

The powers with which I shall be concerned here all share in the fact that they are subject to three conditions. First, the powers are only authorized in a declared 'transmission control period'. Such a period may be declared when the transmission of coronavirus constitutes a serious and imminent threat to public health in England, and the powers outlined in the schedule will be an effective way of delaying or preventing significant further transmission.¹⁹ The UK declared the beginning of a 'transmission control period' on February 10, 2020 [in accordance with the extant Health Protection (Coronavirus) Regulations at that time].²⁰ This condition should go some way to mitigating the EGE's concern that the state's extended power to restrict liberty in emergency coronavirus legislation may potentially come to constitute a 'new normal'. However, I shall return to this point in the conclusion.

Second, the individual exercising the power in question over a person must have 'reasonable grounds to suspect that the person is or potentially infectious.'²¹ Finally, the powers must only be exercised if it is considered to be both necessary and proportionate to do so, either in the best interests of the person, for the protection of other people, or for the maintenance of public health.²² Notice that this echoes key criteria of the European Court of Human Rights' interpretation of the scope of the public health exception, which I shall explore further in the next section.

The CA extends the power to control infectious diseases in relation to the coronavirus beyond local JoPs (as per the PHA), thereby centralizing an important set of powers in the current pandemic. Under the CA, 'public health officers' now have the

14 HM Government, The Coronavirus Act, Schedule 1'.

15 *Id.*, Schedule 23

16 *Id.*, s89–90

17 *Id.*, Section 98.

18 HM Government, Schedule 21, s24(1). Notably, the government supplemented Schedule 21 of the CA with new regulations, in the form of HM Government, The Health Protection (Coronavirus, Restrictions) (England) Regulations 2020. <http://www.legislation.gov.uk/ukxi/2020/350/contents/made> (accessed May 6, 2020). These regulations authorize notable restrictions on freedom of movement and gatherings.

19 HM GOVERNMENT, *supra* note 12, Schedule 21, (4)–(5).

20 *Id.*, 24(3).

21 *Id.*, Schedule 21, s6(1); s7(1); s8(1b); s13(1b); s14(1b); s15(5a).

22 *Id.*, Schedule 21, s6(3); s7(3); s8(2); s13(6); s14(2); s15(2b)

power to impose restrictive measures. I shall discuss the definition of such officers below, having first outlined their powers.

The restrictions that public health officers may impose under the CA include (among other things) the removal of a person to a place suitable for screening and assessment.²³ Once a person has been taken to a suitable place for screening and assessment, public health officers may also require that the person remains at that place for a period not exceeding 48 hours²⁴ and that they be screened and assessed.²⁵

If screening either confirms that (i) the individual is infected or contaminated with the coronavirus, or (ii) if the screening was inconclusive, or (iii) if there are reasonable grounds for believing that the person remains infectious, then public health officers may exercise further powers.²⁶ Among others, they may (under paragraph 14(3)) detain a person in a specified place for a specified period and keep them in isolation from others during that period.²⁷ In exercising these particular powers, the public health officer must have regard to the person's well-being and personal circumstances,²⁸ and the period of detention cannot exceed 14 days.²⁹

However, under paragraph 15 (5), if a public health officer suspects that the person will be potentially infectious at the end of that 14-day period, then they may extend the time for which that person will be detained for a further 'specified period'.³⁰ Any form of detention beyond the initial 14-day period must be reviewed at least once daily by a public health officer and revoked if the individual is no longer found to be infectious.³¹

Furthermore, this further 'specified period' may not exceed 14 days if the restriction in question is simply detaining someone in a specified place. Crucially though, the act explicitly states that this supplementary 14-day limit to the extension of a restriction does not apply to a requirement that a person remains in a specified place 'in isolation' from others.³²

In addition to extending the above powers to designated public health officers, the CA also extends considerable powers to police constables and immigration officers in the course of exercising any of their functions (although they must consult a public health officer prior to exercising these powers, to the extent that it is practicable to do so).³³ A police constable or immigration officer may direct or remove a potentially infectious person to a place that is suitable for assessment and screening.³⁴ They may also detain a person at that place until a public health officer can exercise the functions outlined above.³⁵ A police constable may detain a person for 24 hours (extendable by a

23 *Id.*, Schedule 21, s6(2–3).

24 *Id.*, Schedule 21, s9(1).

25 *Id.*, Schedule 21, s10(1).

26 *Id.*, Schedule 21, s14(1).

27 *Id.*, Schedule 21, s14(3)[d–e].

28 *Id.*, Schedule 21, s14(6).

29 *Id.*, Schedule 21, s15(1).

30 *Id.*, Schedule 21, s15(5).

31 *Id.*, Schedule 21, s15(7–8).

32 *Id.*, Schedule 21, s15(6). This states 'Except in the case of a requirement referred to in paragraph 14(3)(e) (requirement to remain in isolation), the further period specified under sub-paragraph (5) may not exceed 14 days'.

31 *Id.*, Schedule 21, s15(7–8).

34 *Id.*, Schedule 21, s7.

35 *Id.*, Schedule 21, s13(2).

further 24 hours if it is not reasonably practicable for a public health officer to exercise their function within the initial period, and if authorized by a senior officer), while an immigration officer may detain a person for 3 hours (extendable by a further 9 hours if comparable conditions are met).³⁶

There are two particularly noteworthy aspects of the CA's extension of these powers. First, it extends the power to detain individuals to authorities who may lack professionally recognized public health expertise. This is most obviously true of police constables and immigration officers who may impose time-limited detentions. However, it is also striking to consider the definition of public health officers under the CA in this context. A public health officer can be

- (i) an officer of the Secretary of State designated by the Secretary of State for any or all of the purposes of this Schedule, or
- (ii) a registered public health consultant so designated.³⁷

Notice that 'public health officers' under the CA need not be registered public health consultants or acting under their guidance. This constitutes a significant departure from the approach adopted in the Regulations that preceded the CA. Under the previous Regulations, a public health officer was defined as either a professionally registered public health consultant working within Public Health England or a person working within Public Health England acting under the supervision of a registered consultant.³⁸ Moreover, in the Regulations, only the former kind of public health officer had the power to impose significant restrictions of liberty³⁹ —under the CA, all public health officers have these powers.

I shall suggest below that this first feature of the CA arguably raises concerns about the proportionality and necessity of the restrictions that it might authorize, despite its ostensible commitment to these criteria. The second point I wish to highlight here pertains to another feature that may also jeopardize the extent to which certain significant restrictions of liberty authorized by the CA might fall within the public health exception, as understood by the European Court of Human Rights. The feature in question is that there is no clear limit to the period of time for which an individual may be isolated under the CA. This is a significant departure from the PHA, which, by virtue of section 45L, imposes a 28-day time limit on detention, isolation, and quarantine orders that a JoP may impose.⁴⁰ As detailed above, under the CA, if it is considered necessary to detain a person for a period exceeding 14 days (which is the current estimate of the incubation period of the SARS-CoV-2 coronavirus),⁴¹ then the public health officer must review the continuation of that restriction at least once every

36 *Id.*, Schedule 21, s13(1–5).

37 *Id.*, 3(2)[a].

38 HM Government, The Health Protection (Coronavirus) Regulations 2020, s2(1). <http://www.legislation.gov.uk/uksi/2020/129/introduction/made> (accessed May 6, 2020).

39 *Id.*, s5–8. Public health officers under the regulations who were not registered consultants could not impose restrictions, but they could help carry out certain requirements (such as performing screening tests). *Id.*, 6.

40 HM Government, *supra* note 9, s45L.

41 Lauer et al., *The Incubation Period of Coronavirus Disease 2019 (COVID-19) From Publicly Reported Confirmed Cases: Estimation and Application*. ANN. INT. MED. DOI: 10.7326/M20-0504 (accessed Mar. 10, 2020).

24 hours. However, while the CA stipulates a 14-day limit for this further period of detention, this limit explicitly does not apply to a requirement to remain in isolation.⁴²

Interestingly, the CA improves upon the preceding Regulations in this regard. Although the Regulations similarly required daily review for detention beyond an initial period of 14 days, it failed to specify time limits to any form of detention beyond this initial period.⁴³ Notably, this was compatible with provisions limiting the new regulations that the Secretary of State may make under the PHA. The relevant PHA provision in this regard merely requires that if a detention, quarantine, or isolation order authorized by such regulations is capable of remaining in force beyond 28 days, then a specified person may require that its continuation is reviewed at specified intervals (of 28 days or less).⁴⁴

THE SCOPE OF THE PUBLIC HEALTH EXCEPTION: ENHORN V SWEDEN AND ARTICLE 5(1)

The Human Rights Act 1998 requires that legislation passed in the UK must be compatible with the ECHR.⁴⁵ There is considerable scope for tension between the Human Rights Act and the CA powers outlined above. However, whether these powers fall afoul of the Human Rights Act with respect to Article 5 rights will depend on at least two things.

First, it will depend on whether the restrictions imposed are sufficiently severe to constitute a deprivation of liberty of the sort that engages Article 5 rights. The determination of whether a particular restriction amounts to such a deprivation of liberty is not simply a matter of the form and duration of the restriction. Indeed, in its judgment on *Austin v UK* (a case of a detention for several hours in a non-public health context), the European Court of Human Rights stated that the mere fact that detention has been imposed for a significant period is ‘... not in itself sufficient to trigger a deprivation of liberty.’⁴⁶ Rather, case law suggests that such determinations must proceed from consideration of the detained person’s concrete situation and accommodate a wide range of considerations, including the ‘type, duration, effects, and manner of implementation of the measure in question.’⁴⁷

This is relevant in the current context, because the CA permits detention for relatively short periods of time (although isolation is not subject to a specific time-limit, as discussed above). Although the maximum period of 28 days authorized by the CA for other forms of detention is far longer than the period of detention considered in the *Austin* judgment, it is quite possible that not all detentions authorized by the CA would be sufficient to constitute a deprivation of liberty.⁴⁸ This is particularly true of the short restrictions that may be imposed by police officers and immigration officials.

However, even if a deprivation of liberty has occurred, there is still the further question of whether it might fall within the public health exception to Article 5 rights

42 HM Government, *supra* note 12, Schedule 21, 15(6).

43 HM Government, *supra* note 36, Section 9.

44 HM Government, *supra* note 9, s45F (7–8).

45 HUMAN RIGHTS ACT 1998, *supra* note 7, Section 3.

46 *Austin and others v. The United Kingdom*, App. No. 39692/09 [2012], Eur. Ct. H.R. 459, at 41 (2012).

47 *Guzzardi v. Italy*, 7367/76, Chamber Judgment [1980], Eur. Ct. H.R. 5, at 92 (1980).

48 I thank an anonymous reviewer for urging me to clarify this point.

mentioned in Section 1. Recall that this exception states that an individual may be deprived of their liberty to prevent the spread of infectious diseases, if that detention is in accordance with a procedure prescribed by law. The European Court of Human Rights clarified the scope of this exception in the case of *Enhorn v Sweden* (2005).⁴⁹ The case concerned an individual known to be infected with human immunodeficiency virus (HIV) who was subjected to involuntary isolation. As Robin Martyn explained in an insightful commentary on the case, the applicant argued that this restriction violated his Article 5(1) rights on two bases. First, it was not in accordance with the substantive and procedural requirements of domestic law, and second, it did not constitute a proportionate response to the need to prevent the spread of infectious disease, thus failing to meet the substantive provisions of Article 5.⁵⁰

Although the first argument failed to convince the court, the second succeeded. However, the reasoning behind each verdict is relevant to our discussion here. With regards to the first, although the court held that the restrictions were in accordance with the requirements of domestic law in Sweden, it also stressed in its discussion of this argument that legal certainty is paramount in cases of deprivations of liberty; public health law must thus be clearly defined and foreseeable in its application.⁵¹ With regards to the second argument, the court emphasized that deprivations of liberty under public health law must satisfy a principle of proportionality, and that the restrictions imposed must be necessary: other less restrictive measures must have been considered and found wanting.⁵² The applicant's second argument succeeded on the basis that compulsory isolation had not been used as a last resort measure and that the seven-year extension of the isolation order (which included almost 18 months in which the applicant was detained in hospital) was disproportionate to the reduced risk of transmission that the measure achieved, relative to less restrictive alternatives.⁵³

Having outlined the court's reasoning on these matters, Martin goes on to assess the implications of this judgment for the extant version of the Public Health Act in England and Wales at that time, identifying important shortcomings in the Act. However, two years after the publication of her analysis, the Act underwent significant revisions, including the repeal of sections that were the focus of much of her analysis. Furthermore, Part 2A, which was included in the 2008 revisions of the PHA, addresses some of the shortcomings that Martin had previously highlighted. For instance, Martin argued that the absence of time limits on compulsory detention in the previous version of the act restricted the foreseeability of the application of this power, meaning that its use would likely fall foul of the requirement of legal certainty emphasized in the *Enhorn* judgment.⁵⁴ Yet, as noted above, the revised PHA incorporates a 28-day limit for some section 45G orders.

Rather than rehearse Martin's analysis for the PHA revisions, I shall instead use her analysis of the two strands of the *Enhorn* judgment as a springboard to focus on the

49 *Enhorn v. Sweden*, 34–56, *supra* note 6.

50 ROBYN MARTIN, *The Exercise of Public Health Powers in Cases of Infectious Disease: Human Rights Implications*. 14 MED. LAW REV. 132–43, at 133 (2006). DOI: 10.1093/medlaw/fwi038

51 MARTIN, *supra* note 50, at 134; *Enhorn v. Sweden*, *supra* note 6, at 36.

52 MARTIN, *supra* note 50, at 134; *Enhorn v. Sweden*, *supra* note 6, at 36 and 44.

53 MARTIN, *supra* note 50, at 135.

54 MARTIN, *supra* note 50, at 138.

extent to which the restrictions of liberty that would be authorized by the CA would be compatible with Article 5(1) rights.

ARTICLE 5(1) AND THE CORONAVIRUS ACT

Compliance with Domestic Law

The question of whether deprivations of liberty authorized by the CA would be in accordance with requirements of domestic law might appear moot; as long as the procedures for such deprivations outlined by the CA are followed, then the use of such measures would thus be in accordance with domestic law.⁵⁵ However, elements of the CA might be challenged on the grounds that they may run the risk of failing the principle of legal certainty championed in the *Enhorn* judgment's exploration of the applicant's argument regarding compliance of his detention with domestic law. The reason for this is that the CA does not specify a limit to the period for which a potentially infectious person may be detained in isolation (albeit subject to daily review after 14 days).

Of course, we should not fetishize time limits—the foreseeability of the application of a power should be assessed in the broad context of the legislation as a whole, including its procedural safeguards. So, even if Martin was correct to raise this objection with respect to the lack of time limits in the version of Public Health Act that was operative in 2006, the CA outlines extensive procedural safeguards regarding the imposition of any restriction that might plausibly constitute a deprivation of liberty, including daily review, a simple appeals process that can occur in a magistrate court (rather than requiring judicial review), and indeed, specified time limits for many such restrictions.⁵⁶ Furthermore, there may also be good reasons for refraining from specifying a specific time period for such deprivations in the case of an emerging pandemic. There is a great deal that we currently do not know about the SARS-CoV-2 coronavirus, including how long an individual may remain infectious after recovery.⁵⁷

Nonetheless the fact that the CA (and the Regulations before it) neglect to include a specified limit on isolation is particularly striking for two reasons. First, isolation is treated as an exceptional kind of detention under the CA in this regard, and second, in this respect, the CA overturns the explicit 28-day limit to isolation orders (in addition to general quarantine and detention orders) introduced by the 2008 revision of the PHA in section 45L. Even in view of the mitigating factors noted in the previous paragraph, the absence of a specified time limit arguably leaves open the prospect that the prolonged imposition of isolation by the CA could be challenged as violating article 5(1), in view of the European court's high regard for legal certainty in this context.

Proportionality and Necessity

As detailed above, the CA makes explicit reference to the need for restrictions of liberty to be both necessary and proportionate. It is therefore important to first acknowledge

55 Owen Bowcott, 'Man Wrongly Convicted under Coronavirus Law, Met Police Admit', *The Guardian*, 14 April 2020, sec. UK news, <https://www.theguardian.com/uk-news/2020/apr/14/man-wrongly-convicted-under-coronavirus-law-met-police-admit>. (accessed on May 6, 2020).

56 HM GOVERNMENT, *supra* note 12, schedule 21, s17.

57 LAN et al., *Positive RT-PCR Test Results in Patients Recovered From COVID-19*, *JAMA*. DOI: [10.1001/jama.2020.2783](https://doi.org/10.1001/jama.2020.2783) (accessed Feb. 27, 2020).

that the CA includes provisions for weaker measures that might be implemented prior to the imposition of compulsory quarantine or isolation. For instance, paragraph 14(3) of the CA authorizes (*inter alia*) the imposition of requirements to provide information and/or contact details to a public health officer. Accordingly, Martin's concern that the 1984 Public Health Act restrictions might fail the European Court's necessity condition, because it afforded few opportunities for less restrictive measures than quarantine and isolation, is at least partly mitigated in the CA (not to mention the revised PHA).⁵⁸

Nonetheless, despite its commitment to proportionality and necessity, features of the CA raise doubts about whether potential deprivations of liberty imposed in its name will always satisfy these conditions. To see why, it is important to acknowledge that a number of things must be the case if a deprivation of liberty is to be both necessary and proportionate.

Assessments of proportionality in this context aim to establish whether there is a 'fair balance' between the cost of depriving an individual of their right to liberty (both in terms of the subject's Article 5(1) rights, and potentially others) and the need to ensure the outcome that has been achieved by doing so.⁵⁹ In *Enhorn*, the European Court further claimed that in assessing the lawfulness of detaining a person to prevent the spread of infectious disease, a deprivation will only be proportionate if that infectious disease is dangerous to public health or safety.⁶⁰ The view that is implicit here is that it is only in such circumstances that will there be a public health benefit of sufficient magnitude to outweigh the moral cost of depriving an individual of their right to liberty. Notice that the public health benefit may include safeguarding various rights of other member of the public.⁶¹

Notably, the *Enhorn* judgment does not explicitly incorporate considerations of the effectiveness of the deprivation for achieving the public health benefit into its assessment of proportionality. However, if there is to be fair balance between the deprivation of liberty and the benefit that is to be achieved by it, it is clear that the deprivation must have some degree of effectiveness in achieving the benefit.⁶² Yet, as Martin notes, this itself raises a considerable epistemic challenge given the paucity of evidence regarding the effectiveness of public health deprivations of liberty.⁶³ This is particularly true in a novel pandemic, although international differences in the severity

58 MARTIN, *supra* note 50, at 139.

59 Vasileva v. Denmark, 52792/99 [2003], Eur. Ct. H.R. 457 (2003) (accessed Apr. 17, 2020).

60 Enhorn v. Sweden, *supra* note 6, at 44.

61 Space here does not allow for a substantive discussion of the relevant rights that would be necessary for a comprehensive proportionality assessment. See GREENE, *supra* note 8, for a discussion of other ECHR rights that may be operative in this context.

62 Domestic law comes close to incorporating considerations of effectiveness into assessments of proportionality. Following Lord Bingham of Cornhill's suggestion in *Huang v. Secretary of State for the Home Department* [2007] UKHL 11 (21 March 2007) (accessed Apr. 17, 2020), The UK Supreme Court ruled that assessments of proportionality must (among other things) consider 'whether the measures which have been designed to meet the legislative objective are *rationally connected* to it' in *R (Quila and another) v Sec of State for the Home Dept* [2011] UKSC 45 at 45(b) (UK Supreme Court 2011).

63 MARTIN, *supra* note 50, at 140. However, see JULIA E. ALEDORT et al., *Non-Pharmaceutical Public Health Interventions for Pandemic Influenza: An Evaluation of the Evidence Base*, 7 BMC PUBLIC HEALTH 208 (2007). DOI:\ignorespaces10.1186/1471-2458-7-208, for some evidence in this regard.

of national outbreaks may give us some limited evidence of the effectiveness of different public health measures in this context.

Accordingly, the question of whether a deprivation of liberty is proportionate primarily concerns whether the public health benefits of the deprivation outweigh its various moral costs. In contrast, the question of whether the deprivation of liberty is 'necessary' concerns whether there are other alternative measures that could have been employed to achieve those benefits. For instance, in *Enhorn*, necessity was understood by the European Court of Human Rights to concern the question of whether there was an 'absence of arbitrariness', such that detention was considered to be the last resort measure in order to prevent the spreading of the disease, because less severe measures had been considered and found to be insufficient to safeguard the public interest.⁶⁴

In order to assess whether a deprivation of liberty is necessary in this way, we must be able to assess whether the imposition of weaker restrictions would fail to sufficiently safeguard public health. As such, we must be able to assess whether the putative subject of a deprivation of liberty will likely pose a transmission risk that could lead to significant harm in the absence of that deprivation. Crucially, in the case of *Enhorn*, the applicant was a confirmed carrier of HIV, so a significant epistemic obstacle to assessments of necessity was not present in that case. In contrast, this obstacle remains in place in the context of the CA powers, since they can be invoked to detain individuals who are merely 'suspected' of being potentially infectious, and it is possible that asymptomatic individuals may pose an infection risk for the coronavirus. This makes the application of the *Enhorn* judgment to interpreting the interaction of the coronavirus powers with Article 5(1) rights less straightforward.⁶⁵

In view of the above considerations, it is clear that sensitive, evidence-based assessments of the necessity and proportionality of deprivations of liberty in the context of a novel pathogen require a great deal of public health expertise. To some extent, this was implicitly acknowledged in the Regulations, which limited the power to authorize significant restrictions of liberty (following a proportionality/necessity assessment) to registered public health consultants (and the Secretary of State), either of which would need to have 'reasonable grounds' for their beliefs regarding the necessity and proportionality of these matters.⁶⁶

However, the CA potentially extends this authority to individuals who may lack the relevant degree of public health expertise to make such complex judgments accurately; recall that public health officers who may authorize restrictions of liberty under this act need not be registered public health consultants working within NHS England (in stark contrast to the Regulations), and that the CA also extends considerable powers in this regard to police constables and immigration officers. Crucially though, the circumstances that might give an individual lacking public health expertise 'reasonable grounds' for believing that depriving a given individual of their liberty would be necessary and proportionate for achieving a public health benefit may not provide such grounds for someone with a high degree of relevant professional expertise.

64 *Enhorn v. Sweden*, *supra* note 6, at 36 and 44.

65 Alan Greene, States Should Declare a State of Emergency Using Article 15 ECHR to Confront the Coronavirus Pandemic. Strasbourg Observers (blog), Jan. 4, 2020. <https://strasbourgobservers.com/2020/04/01/states-should-declare-a-state-of-emergency-using-article-15-echr-to-confront-the-coronavirus-pandemic>

66 HM GOVERNMENT, *supra* note 36, s5–8.

Of course, it might be claimed that there can be an ‘absence of arbitrariness’ in the determinations of individuals lacking high degrees of expertise in this context, in so far as they make their judgments about what constitutes such reasonable grounds to the best of their ability. However, while this may plausibly lead us not to sanction non-expert individuals who make inaccurate assessments of these matters, this does not entail that deprivations of liberty based on non-expert assessments should be regarded as necessary and proportionate in the sense that is relevant for Article 5(1) rights. Poorly informed assessments of necessity and proportionality performed by individuals who lack relevant expertise about how to make such judgments can only be said to involve an absence of arbitrariness in only a significantly attenuated sense. Accordingly, the greater vigilance that the CA affords by extending the power to impose significant restrictions of liberty, beyond the public health consultants authorized by the previous regulations, arguably evinces a tension with its commitment to ensure such deprivations are both necessary and proportionate.

CONCLUSION

Extraordinary times can call for emergency legislation with extraordinary measures. However, it is crucial that the measures we invoke to battle the coronavirus pandemic are compatible with human rights.

Following the judgment in *Enhorn*, I have suggested that there are two bases upon which extended powers in the CA might potentially be challenged as threatening Article 5 rights. First, the failure to include specified time limits on isolation means that the use of this measure may fail the requirement of legal certainty stressed by the European Court in its judgment on *Enhorn*. Second, despite echoing the European Court’s interpretation of the public health exception to Article 5 rights in emphasizing a commitment to ensure that deprivations of liberty under the CA are both necessary and proportionate, the Act’s extension of powers to individuals potentially lacking sufficient public health expertise may undermine the extent to which the Act will ensure accurate assessments of necessity and proportionality.

I shall conclude with two future-oriented observations. The extended powers of the CA are limited by the two-year expiration date of the bill itself and by the fact that they are only operative in a declared transmission control period. However, this does not wholly obviate the concern articulated in the EGE’s statement on the ethical implementation of restrictive measures in the present pandemic (as quoted in the introduction of this paper). More specifically, we must be vigilant to ensure that the precedent set by the extension of powers necessitated by the present pandemic in the CA does not automatically translate to a ‘new normal’ of eroded rights and liberties in the aftermath of the current crisis in future legislative change.⁶⁷ The extended powers that are now in place are far less likely to be justifiable in the absence of the imminent threat posed by the coronavirus.

Finally, we may observe that the various legal instruments discussed here do not engage with what may prove to be a human rights question that public health responses to the coronavirus pandemic may soon provoke. A great deal of research is currently being performed to search for a vaccine that will afford protection against the devastat-

67 I thank an anonymous reviewer for raising this point about post-pandemic restrictions.

ing effects of Covid-19. Indeed, the development of an effective vaccine is a possible contender for an exit strategy from the widespread public health restrictions that are currently enforced across the world. In that context, it is important to note that neither the Regulations nor the CA authorize the imposition of compulsory treatment, including vaccination, in response to the coronavirus. Moreover, the PHA does not authorize a JoP to order such treatment and explicitly prohibits future regulations from including provisions mandating medical treatment (including vaccinations).

The question of compulsory vaccination raises salient human rights questions that I cannot address here, potentially engaging the right to freedom of religion (Art 9), freedom of expression (Art 10), right to private life (Art 8), and possibly the right to freedom from inhuman and degrading treatment (Art 3). However, if a vaccine proves to be the most viable exit strategy from our current predicament, the pandemic may yet require us to confront the question of whether compulsory vaccination could be a necessary and proportionate response to this public health threat, and how far we might be willing to revise existing limits to regulations that the Secretary of State may make in response to a pandemic threat.

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