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The 1COR Quarterly Medical Law Review

Updates and analysis of the latest legal developments

2020 | Special Issue

Welcome to this COVID-19 special issue of the Quarterly Medical Law Review, brought to you by the barristers at 1 Crown Office Row. Given the fast moving nature of this situation, we will likely produce a number of special issues, which will be emailed to subscribers and posted on the 1COR website, as per usual. This is the **third** version of our special edition, updating the April issue.

Each edition **builds on the last edition** and therefore we have kept earlier content as well as adding new articles.

As we move into the recovery phase, the courts and tribunals recovery plan has been published here. The associated message from the senior judiciary is here.

The first piece is by **Shaheen Rahman QC** and **Suzanne Lambert** and is a comprehensive review into the issue of excess BAME deaths from coronavirus, and what has been done to investigate the matter.

Our next two pieces are by **Dominic Ruck Keene,** in which he considers an application for adjournment of a clinical negligence trial and a review of the Civil Justice Council into the effect of COVID-19.

Rajkiran Barhey considers a recent judicial review of a decision by the Secretary of State to allow women to take medication inducing a termination at home.

Republished from previous COVID-19 special issues:

Jeremy Hyam QC and considers the calls for **legal immunity** for clinicians, particularly for volunteers.

We have two pieces on **coronavirus and custody**. The first is by **Gideon Barth** and looks at inquests and deaths in custody. The second is by **Suzanne Lambert** and considers immigration detention and coronavirus.

Dominic Ruck Keene considers **causation** and deaths from COVID-19. He then goes on to look at legal issues for employers arising from potentially **inadequate PPE provision**.

Darragh Coffey provides an analysis of the **Coronavirus Act**. It is split into two parts – the first considers why the Act was necessary and some more general aspects, whilst the second looks at more specific parts of the Act.

Rajkiran Barhey then looks at two decisions arising out of COVID-19. The first concerns an **order seeking possession of a hospital bed** from a patient who did not wish to be discharged. The second relates to an

application by a care home resident's daughter for his discharge, on the basis that a decision to ban all visitors breached his ECHR rights. She also considers an **application for adjournment** due to coronavirus.

Richard Mumford and **Caroline Cross** talk us through changes to **coroners' investigations**, updated to reflect the most recent Coroner's guidance.

Matthew Flinn has written a fitting tribute to **Sir John Laws,** who recently passed away due to coronavirus.

Towards the end, readers will find **links and extracts of new practice directions, protocols and guidance** relevant to the civil courts. There is a large amount of material which we have tried to collate in one place for readers.

Send us your questions, queries or concerns - at medlaw@1cor.com, or on Twitter at @1corQMLR.

Previous issues can be found on our website.

BEING BAME IS A MAJOR RISK FACTOR FOR DYING OF COVID-19 – WHAT CAN BE DONE ABOUT IT?

By Suzanne Lambert and Shaheen Rahman QC

Introduction

The Public Health England ("PHE") review into the disparities in risks and outcomes of COVID deaths was published on 3 June 2020. It was intended to address increasing concerns, notably voiced by the British Medical Association, about the disproportionate severity of infection and death rates from COVID-19 amongst Black, Asian and Minority Ethnic ("BAME") communities. The first ten doctors in the UK to die from COVID-19 all came from BAME backgrounds.

The review controversially omitted any recommendations to address the increased risk faced by BAME communities. A second report containing feedback and recommendations from BAME stakeholders was subsequently published. It remains to be seen if the recommendations will be embraced, if they will reduce BAME deaths from COVID-19, or if, in the longer term, they will have any impact upon the deeply rooted health inequalities identified by the review.

What were the objectives of the review?

PHE's press release published on 4 May 2020 indicated that the review was intended *"to better understand how different factors such as ethnicity, deprivation, age, gender and obesity could impact on how people are affected by COVID-19."* Professor Kevin Fenton, the London Director of Public Health at PHE and NHS London was tasked with leading the review. He acknowledged that *"increasing evidence and concern around the disproportionate impact of COVID-19 on black and minority ethnic groups highlights an important focus of this review. PHE is rapidly building robust data and undertaking detailed analysis to develop our understanding of the impact of this novel coronavirus on different groups which can inform actions to mitigate the risks it presents".* He added that PHE would be *"engaging a wide range of external experts and independent advisors, representing diverse constituencies including devolved administrations, faith groups, voluntary and community sector organisations, local government, public health, academic, royal colleges and others. We are committed to hearing voices from a variety of perspectives on the impact of COVID-19 on people of different ethnicities."*

The official terms of reference of the review noted that the *"emerging evidence from the United Kingdom and other countries"* was that some groups, including some ethnic minorities, were at increased risk and that *"this may exacerbate existing health inequalities*." The objectives of the review were then identified as follows, namely to:

- analyse and present disparities in COVID-19 infection, hospitalisation and mortality;
- describe the association between age and sex and COVID-19 cases and outcomes;
- quantify disparities in excess mortality by comparing against previous years;
- consider possible explanations for the findings such as the presence of obesity or underlying health conditions that are associated with increased risk of complications from COVID-19;
- determine the impact of occupation (including healthcare workers), where data are available, on hospital admissions and outcomes from COVID-19 infection;
- suggest recommendations for further action that should be taken to reduce disparities in risk and outcomes from COVID-19 on the population.

Accordingly, it was anticipated that recommendations would be made as to how to reduce any disparities that were identified, including those already noted to be emerging in relation to BAME communities. The terms of

reference concluded: *"PHE will work with external experts, independent advisors and stakeholders to consider the results of the review and any suggested recommendations".*

Controversy

From the off, the review was beset with controversy as a result of the announcement that the former Chair of the Equality and Human Rights Commission, Trevor Phillips, was to be involved. Critics suggested that his selection, given his suspension from the Labour party for alleged Islamophobia, would undermine the credibility of the review, particularly when the first four doctors who were known to have died from COVID-19 were Muslim. An open letter signed by one hundred Black women "*from the worlds of Media, Law, Criminal Justice, Health, Education and Publishing"* called for him to be replaced, given his "*recent history of discarding the very real issues and consequences of structural racism in the UK".* The letter called for "*courageous leadership"* for this *"pivotal investigation"* in order to make *"tough calls about reducing health inequalities by dealing with the reality of racism and its impact on healthcare"* as COVID-19 "*is a gamechanger, a life-taker and an illustrator of how underlying structures such as racism shape disparities in a number of institutions, including healthcare and the NHS"*. An open letter subsequently sent to PHE from tens of thousands of healthcare workers went further and recommended that the expert advice or support that Trevor Phillips was intended to provide to the review *"must involve someone who has authoritative knowledge of medicine, epidemiology, culture and discrimination"* and should be someone who has *"the trust of the communities [the] review seeks to understand and ultimately benefit".*

PHE defended his involvement, but shortly before the publication of the review it emerged that Trevor Phillips had in fact played no role in the review. The role of Professor Fenton also appears to have been the subject of a quiet reversal, which was less welcome to campaigners. Professor Fenton is a Black epidemiologist whose appointment had been touted by the Equalities Minister Kemi Badenoch as an example of *"diversity in leadership"*. It was reported in the press that at an event at the Royal Society of Medicine held in May Professor Fenton confirmed that he had consulted at least 1,000 individuals as part of the review and that *"The issues of racism, trust, discrimination and stigma are certainly coming up loud and clear from so many of our [community] stakeholders and partners"*. However, upon publication of the report it appeared that the report was led and written by a Professor John Newton, with Professor Fenton only making a contribution to it. Moreover, PHE stated that the work that Professor Fenton had completed by engaging with individuals and organisations within the BAME community would be taken forward by Kemi Badenoch. It was not addressed within the review.

A missed opportunity

The review itself was met with widespread criticism not because of its objective findings, but because of what it did not contain. The review confirmed that BAME groups were more likely to die of COVID-19, but did not identify an action plan to address the disparity. There were accusations that the review had been censored and "whitewashed", with none of the comments of the 1,000 BAME individuals and organisations with whom Professor Fenton had consulted included and none of the anticipated recommendations relating to race and ethnicity appearing in the final edit. Dr Chaand Nagpaul, BMA council chair, considered the review a missed opportunity and noted that it had failed to mention *"the staggering higher proportion of BAME healthcare workers who have tragically died from COVID-19 – with more than 90 per cent of doctors being from BAME backgrounds. The report has also missed the opportunity for looking at occupational factors; the BMA was clear we needed to understand how job roles, exposure to the virus and availability of PPE [personal protective equipment] were risk factors."*

Key Findings

Perhaps unsurprisingly, the review concludes that the impact of COVID-19 has *"replicated existing health inequalities and, in some cases, has increased them".* The review's key findings can be summarised as follows:

- Age was identified as the biggest risk factor, with the greatest disparity in death rates being seen in older people. Among people already diagnosed with coronavirus, people who were 80 or older were seventy times more likely to die than those under 40.

- Working-age males diagnosed with COVID-19 were twice as likely to die as females. Men made up 46% of diagnosed cases but almost 60% of deaths and 70% of admissions to intensive care units. These disparities exist after taking ethnicity, deprivation and region into account, though not occupation.
- The risk of dying among those diagnosed with COVID-19 was found to be higher in BAME groups than in white ethnic groups. After accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity were at most risk, with around twice the risk of death when compared to people of white British ethnicity. People of Chinese, Indian, Pakistani, other Asian, Caribbean and other Black ethnicity had between a 10% and 50% increased risk of death when compared to people of white British ethnicity.
- When adjusted for age the highest diagnosis rates of COVID-19 were amongst people of Black ethnic groups (486 in females and 649 in males) and the lowest were in people of white ethnic groups (220 in females and 224 in males).
- All-cause mortality was almost four times higher than expected among Black males during the period reviewed, with mortality rates being almost three times higher in Asian males and almost two times higher in white males. Deaths were almost three times higher in this period in Black, mixed and other females and 2.4 times higher in Asian females compared with 1.6 times in white females. Notably, in previous years, all-cause mortality rates were lower in Asian and Black ethnic groups than in white ethnic groups, which means that mortality risk for COVID-19 is a reversal of what has been seen in the past. Again, the study did not include the effect of occupation which was identified as an important shortcoming due to the high proportion of workers in key occupations from BAME groups.
- The mortality rates from COVID-19 in the most deprived areas were found to be more than double the least deprived areas, for both males and females. This was greater than the inequality seen in mortality rates in previous years.

Black Lives Matter

Accordingly, it is clear that being BAME is a major risk factor for dying of COVID-19. That fact emerged against the background of global protests prompted by the killing of George Floyd during his arrest by US police officers. The relevance of this context was acknowledged by Matt Hancock, when updating Parliament on the key findings of the review. *"Yes indeed, black lives matter but it is surely a call to action that black, Asian and minority ethnic people are more likely to die from Covid and more likely to be admitted to intensive care from Covid"*.

Structural racism, not race

Commentators have been at pains to emphasise that that the research into higher death rates and rates of diagnosis amongst members of the BAME community discloses no clear evidence for a biological or genetic reason for the disparity. Rather, the issue is one of structural racism and inequality.

Winston Morgan, reader in toxicology and clinical biochemistry, and the director of impact and innovation at University of London commented in an opinion piece:

"the reality is there is no evidence that the genes used to divide people into races are linked to how our immune system responds to viral infections.

[…]

Indeed race is a social construct with no scientific basis. However, there are clear links between people's racial groups, their socioeconomic status, what happens once they are infected, and the outcome of their infection. And focussing on the idea of a genetic link merely serves to distract from this.

[…]

In the absence of any genetic link between racial groups and susceptibility to the virus, we are left with the reality, which seems more difficult to accept that these groups are suffering more from how our societies are organised. There is no clear evidence that higher levels of conditions such as Type-2 diabetes, cardiovascular disease and weakened immune systems in disadvantaged communities are because of inherent genetic predispositions

But there is evidence they are the result of structural racism. All these underlying problems can be directly connected to the food and exercise you have access to, the level of education, employment, housing, healthcare economic and political power within these communities".

In the context of occupational factors, a survey of 2,000 BAME NHS workers carried out by ITV News found that they believed deployment in high risk roles and race discrimination were major contributing factors to their colleagues dying at a rate seven times higher than their non BAME colleagues. Further, forty percent of BAME doctors surveyed by the BMA said risk assessments recommended by NHS England at the start of May had still not been carried out.

A call to action

The difficulty with Mr Hancock's *"call to action"* was that the review did not come to any conclusions as to how the disproportionate adverse effect on BAME people might be addressed, in time to make an impact on deaths from COVID-19, or at all. In a chapter on *"Limitations"* the review expressed the caveat that the *"descriptive nature of the analysis therefore limits the conclusions that can be drawn about the reasons for the disparities shown".* It is stated that that the relationship between ethnicity and health is *"complex and likely to be the result of a combination of factors":*

"Firstly, people of BAME communities are likely to be at increased risk of acquiring the infection. This is because BAME people are more likely to live in urban areas, in overcrowded households, in deprived areas, and have jobs that expose them to higher risk. People of BAME groups are also more likely than people of White British ethnicity to be born abroad, which means they may face additional barriers in accessing services that are created by, for example, cultural and language differences.

Secondly, people of BAME communities are also likely to be at increased risk of poorer outcomes once they acquire the infection. For example, some co-morbidities which increase the risk of poorer outcomes from COVID-19 are more common among certain ethnic groups. People of Bangladeshi and Pakistani backgrounds have higher rates of cardiovascular disease than people from White British ethnicity, and people of Black Caribbean and Black African ethnicity have higher rates of hypertension compared with other ethnic groups (24). Data from the National Diabetes Audit suggests that type II diabetes prevalence is higher in people from BAME communities."

Crucially, despite analysis of 10,841 COVID-19 cases in nurses, midwives and nursing associates indicating that those from Asian ethnic groups were overrepresented amongst those diagnosed with the virus, the analysis did not look at the possible reasons behind these differences and did not identify a clear causal link between occupation and risk of infection. Rather, the review simply stated that the overrepresentation *"may be driven by factors like geography or the nature of individuals' roles",* and it cautioned that a *"more thorough analysis is required to fully understand the relationships between comorbidities including obesity, sociodemographic characteristics such as ethnicity and occupation and the risk of diagnosis and death to understand these disparities further".*

Earlier research by the Institute for Fiscal Studies had already found that occupational exposure may partially explain disproportionate deaths for some groups, with more than two in ten Black African women of working age employed in health and social care roles, Indian men 150% more likely to work in health or social care roles than their white British counterparts, a third of all working-age Black Africans employed in key worker roles (50% more than the share of the white British population) and Pakistani, Indian and Black African men being 90%, 150% and 310% respectively more likely to work in healthcare than white British men. The IFS research also found that many ethnic minorities are also more economically vulnerable to the current crisis than are white ethnic groups.

Against this background, the PHE review simply stated that the *"results improve our understanding of the pandemic and will help in formulating the future public health response to it"*. As noted above, this left commentators and those consulted disappointed that the review was conspicuously silent as to what that public health response should be and as to any recommendations for addressing existing health inequalities.

The second report

Following publication of the PHE review, an open letter to Matt Hancock and Kemi Badenoch from the BMA and thirty Black, Asian and minority ethnic medical organisations, representing tens of thousands of doctors and nurses, demanded urgent action to safeguard them from further deaths.

Material that was said to be an unpublished section of the PHE review was then leaked to the press, containing testimony received by Professor Fenton from approximately 4,000 stakeholders, including BAME groups and academics.

Although it was denied that there had been any censorship of the PHE review, a second report, Beyond the data: Understanding the impact of COVID-19 on BAME groups was subsequently published by PHE on 16 June 2020. It summarised the insights and feedback from more than 4,000 stakeholders, who provided comments and recommendations to Professor Fenton.

Some of the insights included in the second report are as follows:

- Stakeholders pointed to racism and discrimination experienced by communities and more specifically BAME key workers as a root cause to exposure risk and disease progression.
- Racism and discrimination experienced by BAME key workers was identified as a root cause affecting health and exposure risk. For BAME communities, lack of trust of NHS services resulted in reluctance to seek care.
- Historic racism and poorer experiences of healthcare or at work may mean that individuals in BAME groups are less likely to seek care when needed or as NHS staff are less likely to speak up when they have concerns about Personal Protective Equipment (PPE) or risk.

In a letter to Kemi Badenoch, the PHE Chief Executive, Duncan Selbie, acknowledged that the insights from BAME stakeholders made for *"humbling reading"* and contained a *"clear message from stakeholders [as to] the requirement for tangible actions, provided at scale and pace, with a commitment to address the underlying factors of inequality."*

PHE's recommendations

The second report contains seven recommendations to reduce inequality and to prevent the disparities in outcomes of COVID-19 for BAME communities:

- Mandate collection and recording of ethnicity data as part of routine NHS and social care data collection systems and from death certificates to inform actions to mitigate the impact of COVID-19 on BAME communities;
- Support community participatory research to understand the social, cultural, structural, economic, religious, and commercial determinants of COVID-19 in BAME communities, and to develop readily implementable and scalable programmes to reduce risk and improve health outcomes;
- Improve access, experiences and outcomes of NHS, local government and Integrated Care Systems commissioned services by BAME communities including: regular equity audits; use of Health Impact Assessments; integration of equality into quality systems; good representation of Black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users;

- Accelerate the development of culturally competent occupational risk assessment tools that can be used to reduce the risk of an employee's exposure to and acquisition of COVID-19, especially for key workers working with a large cross section of the general public or in contact with those infected with COVID-19;
- Fund, develop and implement culturally competent COVID-19 education and prevention campaigns, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability;
- Accelerate efforts to target culturally competent health promotion and disease prevention programmes for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma;
- Ensure that COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised.

Legal redress

The recommendations are clear, but whether those recommendations do in fact lead to *"tangible actions"* that have any measurable impact upon COVID-19 deaths or deep-rooted health inequalities remains to be seen.

There also remains the question of legal redress for those affected, particularly those who have died. Specific issues such as the provision of PPE in a specific healthcare context might be considered in the context of individual inquests into BAME deaths and civil actions could follow. There have been calls for a public inquiry into the issue and it is understood that at least one legal challenge has been initiated. The Equality and Human Rights Commission has already launched its own inquiry.

The Prime Minister has very recently committed to an independent inquiry into the coronavirus pandemic. However it is not clear when such an inquiry will take place, what its scope will be, and whether it will be a public inquiry under the Inquiries Act 2005. Disproportionate BAME deaths and the adequacy of efforts to combat health inequalities before the pandemic could – and we would argue should - form part of that.

For now, the PHE review and second report have identified and acknowledged that health inequality and structural racism increased the risk of death to BAME individuals from COVID-19. In many cases those who died were the very people who were being relied upon to protect everyone else from the disease, by working as key workers, nurses and doctors.

FAIRNESS OF A REMOTE HEARING

Dominic Ruck Keene

SC v University Hospital Southampton NHS Foundation Trust [2020] EWHC 1445 (QB)

The facts

The Defendant Trust applied a week before a clinical negligence trial for its adjournment on the basis that it would be unfair to hold the hearing remotely by video. The application was refused.

The Claimant had developed hemiplegic cerebral palsy as a toddler secondary to meningitis. The allegation was of a failure to diagnose a serious bacterial infection. The issues of fact included how the Claimant had presented, and what was said by her parents to the clinicians involved.

The trial had already been adjourned from January 2020 due to the ill health of the one of expert witnesses. There were 5 witnesses of fact – three clinicians and the Claimant's parents, and 3 expert witnesses. Counsel and solicitors on each side were "*ready, willing and (subject to the court being able to facilitate a hearing) able to attend court."* Most of the witnesses were also able to attend court next week. One expert witness was not able to attend court (because of health reasons) but was able to give evidence by video-link.

The application

Mr Justice Johnson noted that the application to adjourn was predicated on it being "*impossible"* for the hearing to place in court. The Defendant argued against a remote hearing on the basis that counsel would not be able *"visually to assess witness demeanour, judicial approach to evidence as it is given and the reactions of others at the same time as questioning in a way that occurs in a physical courtroom."* Further, the clinician witnesses would not be able to give their accounts *"face to face with the communication possible between multiple parties"* and it would not be possible for the legal representatives to take instructions from their clients, or discuss matters with the expert witnesses, during the course of evidence being given. It was also stated that the Defendant's leading counsel and witnesses did not have any experience of a virtual trial.

The Claimant resisted the application. She argued that the application had been made too late, and that if the trial was adjourned it was likely to be some considerable time before it was heard; the costs that would be incurred would be disproportionate; a trial in a court room ought to be possible but that, if it was not possible, a virtual trial would be fair (albeit there would be significant practical difficulties).

The decision

Mr Justice Johnson began by holding that any costs necessitated by adjournment would not be disproportionate given the high value of the claim. The case was fully prepared for trial. The question of costs would not therefore be determinative.

With regards to the lateness of the application (made on 28 May, i.e. some weeks after the COVID-19 restrictions on court hearings were imposed), Johnson J held that while the application had been made at a late stage, that had enabled more informed and focussed inquiries to be made as to the possible mechanisms for holding the trial. The Defendant also had argued that it was waiting and hoping that a hearing in court would be possible. The timing of the application was therefore also not determinative.

Johnson J held that any further delay would be highly undesirable – noting that it was 14 years since the events in question, and there were factual issues which could turn on the oral recollection of witnesses. He stated that "*If it were possible to be certain that any further delay could be limited to a matter of a very few weeks – and if there were no alternative in order to secure fairness – then the overriding objective might compel the grant of a further adjournment."* However, there was no certainty as to when the case would be heard if adjourned.

He noted that both the clinicians and also the Claimant, and her family, would have the continued stress and uncertainty of the case hanging over them. Accordingly, provided a hearing could be heard fairly, the overriding objective militated against adjournment.

With respect to fairness, Johnson J held that:

"There are circumstances in which a remote hearing would not be fair. An example is where one of the parties is unable to access or effectively utilise the technology necessary to conduct a remote hearing.

Conversely, there are many cases where a remote hearing can, with careful case management, take place in a way that is fair to the parties. As a result of the Covid-19 pandemic there have been no hearings in court in the Queen's Bench Division since late March. However, hearings have continued to take place, being conducted remotely rather than in court …

A number of witness trials have taken place remotely. Others have been adjourned, and, so far, only one clinical negligence trial has taken place remotely. That is not surprising. First, so far as clinical negligence trials are concerned, there was a compelling need to ensure that practising medical professionals were not diverted from

their primary clinical responsibilities by the need to give evidence in civil proceedings. Second, other types of case (for example where liberty or the right to housing was at stake or there was a need for an immediate injunction) took a higher priority. That does not, however, mean that it would be unfair to try a clinical negligence claim remotely.

In this case, both parties are legally represented. All witnesses have access to the technology required to conduct a remote hearing. The disadvantages of a remote hearing would impact on all parties, but it has not been shown that they would do so in a way that is unequal or unfair to the Defendant…

I consider that the risk of unfairness can (if necessary) be sufficiently addressed and managed by the trial judge. The clinicians are experienced professionals who are well-used to communicating in difficult and stressful conditions (if not by video conference in a court hearing). Case management directions… can be imposed which ensure that the disadvantages of a remote hearing in this case are reduced as far as is possible."

Having concluded that it was possible to have a fair remote hearing, Johnson J went on to consider whether it should be conducted remotely. He noted that there were many reasons why it was not desirable: the solemnity, formality and focus of a courtroom could not easily be replicated remotely; and more significantly *"the complex multi-layered human communications and observations that take place during a substantial witness trial are significantly impeded when the hearing is conducted remotely."*

He concluded that *"In this case, a remote hearing would be possible. However, having regard to the likely length of hearing, the nature of the issues, the volume of written material and the complexity of the lay and expert evidence, a remote hearing would be undesirable*." One key factor was that one of the clinicians did not consider that he could give as full and effective an account of his actions as in a face to face hearing, and would not be able to communicate effectively with his legal representatives. His *"professional reputation, medical competence and, potentially, personal integrity are in issue."* Accordingly, the case should not be held remotely unless a court hearing was simply not possible.

With regards to practicality, Johnson J noted that there would be no risk to the safety of participants through giving evidence (save for the one witness who would give evidence by video link) following the HMCTS measures to ensure the safety of court users with appropriate social distancing.

Accordingly, the application was dismissed. It was predicated on the hearing being conducted remotely but there was no reason why it had to take place remotely. If there was an insurmountable obstacle to a physical hearing, then a fair remote hearing could be heard.

Comment

This decision makes it clear that parties will have to approach applications to adjourn clinical negligence trials simply on the basis of the COVID-19 restrictions with great caution – this is likely to be particularly so given the recent relaxation of those restrictions. Further, and with wider application in the post COVID-19 world where there may be a push to increase the number of remote hearings more generally, the decision also demonstrates that arguments against a remote hearing will need to be grounded in the facts of the particular case and be based on more than the inherent drawbacks of remote hearings generally.

THE CIVIL JUSTICE COUNCIL RAPID REVIEW

Dominic Ruck Keene

The Review

The Civil Justice Council was requested by the Master of the Rolls (Sir Terence Etherton) to conduct a rapid review between 1 and 15 May 2020 on the impact of COVID-19 on the civil justice system. The specified aims of the review were to examine (1) the impact of arrangements (in particular the widespread adoption of remote

hearings) on civil court users, (2) to make practical recommendations for the short to medium term, and (3) to inform thinking about a longer term review.

The review acknowledged that due to the short time scale there had been a relatively limited response from lay court users, which only emphasised the importance of collecting better data to understand their experience. Judges and court staff were also not asked to participate due to pressures on their time.

Context

The review noted that successive announcements by the senior judiciary at the start of 'lockdown' emphasised their commitment to continuing the work of the courts wherever possible. The rapid expansion of the use of remote hearings had been central to facilitating the continued operation of the justice system with few civil hearings being conducted face-to-face. Judges had been required to consider the suitability of remote hearings on a case-by-case basis and asked to proceed remotely *"where a fair resolution could be achieved."*

The review identified that this had led to a proliferation of practice across the civil justice system with the move to remote hearings being swifter and easier in the senior and commercial courts, where resources are greater and levels of legal representation are higher, and more problematic in the County Court. Multiple respondents to the survey had also noted the variation in clarity and content of the various court guidance documents and working practices, leading to an inconsistency of approach. Overall, restrictive and inconsistent interpretation of listings guidance had therefore further reduced the number of hearings taking place at the county and district court level.

The Findings

It was noted at the outset that "A combination of factors brought about by COVID-19 have fundamentally altered the work conducted across the civil justice system." These factors include policy decisions as to which types of cases should be prioritised or stayed; pressures on County Court time due to the continued need for family law hearings; and a reduced number of litigants in person engaging with hearings.

Respondents registered significant concerns that the combination of the pandemic-related economic changes and the backlog created by the stay in possession hearings would create very serious pressure on the civil justice system in the short to medium term. Professional court users also raised repeatedly as a concern the high rate of adjournments, with a particular impact on members of the junior bar. Further, the use of remote hearings had a disproportionate impact on lawyers with caring responsibilities.

In respect of remote hearings that had taken place within the time period of the review, 46.5% had taken place in London and only 58.8% in county courts outside London. Nearly 40% were personal injury hearings. The vast majority of all hearings were less than 3 hours, and only 31% were trials as opposed to interlocutory hearings. Less than a third were by video rather than by phone. Nearly half the hearings had technical difficulties of some kind, especially in video hearings, both with joining calls and conducting the actual hearings. In many cases, the technical issues lay with the technology available to the judiciary. There were also inconsistencies in the ability of courts, particularly county courts, to manage remote hearings and electronic files. Unsurprisingly, in 44% of hearings there were issues with parties interrupting each other, particularly in telephone rather than video hearings, which was not helped by time lags caused by technology.

The review concluded that there was "tentative support for reserving remote hearings for matters where the outcome was likely to be less contested, where the hearing was interlocutory and where both parties were legally represented."

Respondents felt that audio hearings were more efficient, due to reduced travel and waiting time, and offered tangible benefits for work/life balance and the environment. However, the majority of respondents felt remote hearings were less effective for facilitating participation, and were more tiring due to the impact that video hearings have on the ability to communicate with clients and other legal teams. Respondents felt that dialogue was less fluent when hearings proceeded by video, and that it was harder to gauge reactions and respond appropriately. The prevalence of technical issues was commonly cited as a reason for thinking that video

hearings were worse than hearings in person: many respondents stated that the information technology provided for video hearings was counter-intuitive and prone to failure. Frustration with connection problems, delays and time lags was also commonly expressed. Further, they were not necessarily cheaper than hearings in person. The main factor increasing preparation time was the extra work involved in preparing electronic bundles and documents.

There were a number of concerns noted about the impact on lay clients and court users: in particular the lack of communication and reduced administrative support available from and with court staff had a disproportionate effect on lay clients and litigants in person; the challenge of accessing technology and using e-bundles; and that the practices adopted by lawyers to communicate with their clients during hearings relied on lay parties having access to multiple devices and good standards of written comprehension, creating barriers to effective participation. The review noted that significant multi-tasking was required to communicate with clients during remote hearings and this had presented considerable challenges for both audio and video hearings. Communication with clients had to happen privately and simultaneously as the hearing took place. Respondents described difficulties concentrating on the hearing and making submissions, whilst also dealing with emails or texts.

Overall, the review concluded that "a combination of restricted access to legal advice due to COVID-19 and difficulties with navigating unfamiliar technology alongside unfamiliar legal processes compounded pre-existing practical and emotional barriers to effective participation." The review highlighted that given the low participation of lay users in the review and the kind of hearings that had been heard during the review period, the problems experienced by lay users and litigants in persons were likely to be amplified if remote hearings were expanded to include matters more likely to involve litigants in person and vulnerable parties, such as housing.

Recommendations suggested by respondents

The review noted that there was a clear willingness and enthusiasm for commercial firms to expand the use of remote hearings in commercial litigation. In other practice areas, respondents to the review recommended maximising the use of remote hearings in preliminary matters, interlocutory hearings and trials without evidence, particularly where both sides were represented. The majority of costs disputes were also felt to be suitable for remote determination. Respondents also emphasised the important role of continuing to list trials in encouraging parties to settle.

Practical suggestions

A number of practical recommendations were made as to how to address identified technical issues with remote hearings. Those particularly relevant to professional users were:

Preparation:

- Conducting dry runs to test the technology in advance of the hearing;
- Providing sufficient notice of format so all participants can ensure suitable technology is in place;
- Allocating more time before the start of each hearing to deal with connectivity issues;
- Having direct contact details of parties and judge in advance of hearing;
- Having a backup line of communication;
- Ensuring the quality of e-bundles.

Technology

- Investing in remote access areas for clients with no access to technology and broadband
- Ensuring parties have more than one screen to participate in hearing and view documents

Comment

Many of us in the medical legal world will, by now, have been faced with the challenge of conducting remote hearings in the current COVID-19 context to a far greater extent than any had previously anticipated could be possible, given the civil court system's pre-existing shortcomings and difficulties. Arguably, the courts have been dragged (un-)willingly into the 21st Century – in particular in the use of e-bundles. Aside from technology, the two greatest difficulties have been the variation in practice between courts as to what hearings are held remotely, and in how they are they heard.

What the CJC review makes clear is that there is a significant potential for remote hearings to be used to good effect to reduce time and expense for all parties involved. However, there is a need for significant investment of time and effort by both court users, and perhaps most of all by the court system, to acquire the necessary commonality of technology, expertise and familiarity with the different issues posed by accessing and conducting remote hearings. Further, remote hearings are certainly not appropriate for all types of hearings, and there is a real issue over access to justice and meaningful participation in cases for the unrepresented and even for lay clients who are represented.

The real question is whether in the brave new world after COVID-19 there is the political will, and perhaps more importantly the funds available, to implement the lessons learnt during the current pandemic in order to increase the availability and usability of remote hearings wherever they are suitable. The judiciary will have a key role in driving their wider implementation.

In the meantime we will have to continue to navigate the ever lengthening lists of guidance, and protocols and hope that over time there will be a sensible convergence around common best practices.

ABORTION AND A WOMAN'S HOME

Rajkiran Barhey

R (on the application of Christian Concern) v Secretary of State for Health and Social Care [2020] EWCA 1546 (Admin)

The High Court refused the Appellant permission to bring a judicial review against the decision of the Secretary of State to approve 'the home of a woman' as being a place where treatment for the termination of pregnancy could take place.

Background

Early medical abortion involves the taking of two drugs – Mifepristone and Misoprostol – with a gap of approximately 24-48 hours in between. Since 2018, it has been legal for the second of those drugs to be taken at home.

With the onset of the COVID-19 pandemic, many abortion providers were worried that women would not be able to access their services or would delay accessing services, potentially necessitating abortions later into a pregnancy (with higher risk of complication). There was also fear that delays would lead to services being swamped when people felt more comfortable to travel to providers and/or that some women may turn to 'backstreet' abortion providers. There was also particular concern about women trapped in abusive relationships.

It was therefore argued that women should be allowed to take both medications at home.

The decision

After some debate, the Secretary of State (1) approved the home of a doctor as an approved place, such that they could prescribe treatment for termination of pregnancy from home (2) prescribed the home of a woman as an approved place, such that the woman could take treatment for termination of pregnancy from home (3) with the conditions that the pregnant woman has attended an approved place, had a consultation with an approved place via video link, telephone etc. or has had a consultation with a doctor via video link, telephone, etc. and (4) that the pregnancy has not exceeded 9 weeks and 6 days.

Grounds of challenge

There were 8 grounds of challenge. Permission was refused on all 8.

1. Ultra vires – It was argued that the decision was ultra vires the 1967 Abortion Act, as s.1 of the Act states that a pregnancy must be terminated by a registered medical practitioner.

The Appellant sought to rely, via *Pepper v Hart*, on parliamentary statements made at the time of amendment to the Act in 1990 (which granted the power to approve places where termination of pregnancy could take place) in which a Minister was asked whether the amendments would pave the way for terminations of pregnancy at home. The Appellant argued that the Minister had given a categorical assurance that the powers granted would not be used to allow home abortions.

The court rejected this suggestion. First, it noted that *Pepper v Hart* was concerned with the interpretation of words used in legislation and not with statements about the ways in which powers conferred by legislation might be used in the future. In the latter situation, a statement might only be admissible if a minister had given a categorical assurance. The court rejected the Appellant's argument that the Minister had given a categorical assurance, finding that the words used by the Minister were more open-ended than had been argued.

It was further argued that the requirement that the termination must be carried out 'by a medical practitioner' would not be met if a woman took the drugs at home. This was rejected on the basis that the Act did not require the doctor to administer the drugs themselves. Provided that the doctor 'remains in charge throughout' it did not matter whether the drugs were administered by, for example, a nurse or the woman herself.

2. Contrary to legislative purpose – it was argued that the decision permitted the whole process of abortion to take place at home, where there was no guarantee that the home would be safe or hygienic or that the woman would not be put under undue pressure. The court rejected this argument on the basis that there was nothing in the 1967 Act to support the submission. Furthermore, part of the purpose of the 1967 Act was to discourage 'backstreet' abortions and the decision in question was consistent with that purpose.

3. Irrationality – it was argued that the decision was irrational and that the effect of the decision on the epidemic would be 'evidently minimal.' This ground was rejected as it was plainly open to a reasonable Secretary of State to conclude that women may not be able to access legal abortions unless this decision was made.

4. Constitutional impropriety - it was argued that the proposed reform in question had already been debated in Parliament and rejected, that ministers had assured Parliament no such reform would take place, and that Parliament had been in recess and therefore unable to scrutinise the Executive. An analogy was drawn to the *Miller* cases. This was rejected on the basis that the decision made was within the scope of the power conferred by the 1967 Act and was consistent with the purpose of the Act. The extent to which the Minister was open to criticism for exercising that power is not a matter for the courts.

5. Legitimate expectations – it was argued that there were two substantive legitimate expectations generated by ministerial assurances given in Parliament, namely that the Defendant would not designate a woman's home as a place where termination of pregnancy would take place and/or that the change would not be introduced without the Defendant satisfying himself that there were adequate safeguards in place to protect vulnerable women/women in abusive relationships. It was further argued that a procedural legitimate expectation had been generated, namely that the Minister would not introduce any such changes without either a wide

Parliamentary consensus or adequate Parliamentary scrutiny or debate. These assurances were said to have been given both in the 1990 debate referred to above, and in the more recent debate in March 2020.

The submissions were rejected. As noted above, the court found that the statements made in 1990 did not amount to a categorical assurance and, by extension, were not sufficiently clear, equivocal and/or without qualification such that a legitimate expectation could be generated. Furthermore, the statements were made in 1990 and outside the context of the COVID-19 pandemic. As to the more recent statements, they contained qualifications; it was made clear that discussions would continue with the relevant bodies and those discussions might give rise to changes in position.

6. Failure to take into account relevant considerations/conduct sufficient enquiries: It was argued that there was a failure to take into account relevant considerations, for example the risk that drugs would be re-sold on the black market, or prescribed before the 10 week cut-off but taken after the cut-off.

The court noted that ministerial submissions would never ordinarily include every piece of background information and that: *"the omission of particular details will cause a submission to be "misleading" only if those details are so critical that, without them, the court cannot be confident that the Minister took into account every legally mandatory consideration. In that regard, it is well established that it is for the public authority to decide on the manner and intensity of the enquiry to be undertaken; and the court should intervene if, and only if, no reasonable authority could have been satisfied on the basis of the enquiries it made that it possessed the information necessary for its decision."* [66] The court noted that delaying a decision to gather more information could also have an impact on the public interest.

7. Failure to carry out public consultation – it was argued that the Secretary of State was under a common law duty to carry out a consultation with various stakeholders and/or the public prior to making the decision.

This was rejected on the basis that there was no statutory duty to consult and no common law duty to consult (save where a legitimate expectation had been generated). As to legitimate expectation, the Appellant had not established that there was a past practice of consultation which would give rise to an expectation of a consultation in the present context. In any event, the court found that the circumstances of the pandemic would have been sufficient to override past practice.

8. Breach of s.6 of the Human Rights Act – the court rejected the submission that the Claimant was a 'victim' within the meaning of the Act. In any event, the court went on to find at [77] to [78] that: "*the Claimant is in any event not able to point to anything in the Convention or the case law which would prevent the Secretary of State from designating a woman's home as an approved place for the purposes of the 1967 Act.*

It is not necessary to decide whether the Convention might ever confer rights on the unborn. Even if it does, it is impossible to see how the decision under challenge infringes any such rights. The decision was taken in 2018 to permit at least one aspect of an early medical abortion to take place in a woman's home. All that the decision now under challenge does is to permit the woman concerned to take the other pill at home as well. There is no arguable breach of the ECHR in deciding to permit this to happen."

Permission was refused but an appeal against this decision to the Court of Appeal is outstanding.

LEGAL IMMUNITY IN THE COVID-19 PANDEMIC?

Jeremy Hyam QC

It was reported over the weekend of 18-19 April 2020 that the Medical Defence Union ("MDU"), which provides legal support to around 200,000 doctors, was calling for a debate on the need for emergency legislation to protect doctors from negligence claims arising from the COVID-19 emergency.

The particular concerns raised by the MDU were that retired doctors have been called back to the wards and medical students sent out before they have finished training. Even though the UK government has promised to cover the cost of any future legal actions by providing indemnities [see ss.11-13 Coronavirus Act 2020 and Darragh Coffey's article below], this will, as the MDU says, cost the country vast sums and expose those who have volunteered to "extremely distressing" and potentially career damaging hearings.

It is worth for a moment pausing to reflect on this justifiable concern and the extent to which the courts and or the legislature may be required to remedy it.

The default common law position is that there is currently one objective standard of care that looks at the activity being carried out rather than the specific actor – see *inter alia*, *Nettleship v Weston* [1971] EWCA Civ 6 where it was held that a learner driver should be judged by the standard of an ordinarily competent driver. This single standard applies - for policy reasons - across the professions to avoid the risk of complicated shifting standards. Thus the standard of a reasonably competent doctor carrying out e.g. "heart surgery" will be judged by the standards of the ordinarily competent heart surgeon, not some special standard altered for the specific circumstances.

One recent case which looked at the possible blurred lines between the roles performed and the persons who perform them was the Supreme Court's judgment in *Darnley v Croydon Health Services NHS Trust* [2018] UKSC 50. *Darnley* was a case involving the negligence of hospital receptionist, where Lord Lloyd-Jones focussed on the role performed by the individual in question:

"The particular role performed by the individual concerned will be likely to have an important bearing on the question of breach of the duty of care. As Mustill LJ explained in Wilsher v Essex Area Health Authority [1987] QB 730 , 750-751, the legitimate expectation of the patient is that he will receive from each person concerned with his care a degree of skill appropriate to the task which he or she undertakes. A receptionist in an A & E department cannot, of course, be expected to give medical advice or information but he or she can be expected to take reasonable care not to provide misleading advice as to the availability of medical assistance. The standard required is that of an averagely competent and well-informed person performing the function of a receptionist at a department providing emergency medical care."

That is not to say that the circumstances of an emergency may not affect the standard of care.

In Wilsher v Essex AHA in the Court of Appeal Mustill LJ explained at 749: *"….full allowance must be made for the fact that certain aspects of treatment may have to be carried out in what one witness (dealing with the use of a machine to analyse the sample) called "battle conditions." An emergency may overburden the available resources, and, if an individual is forced by circumstances to do too many things at once, the fact that he does one of them incorrectly should not lightly be taken as negligence. Here again, however, the present case is in a different category, for none of those accused of negligence who were called to give evidence on their own behalf suggested that, if mistakes were made, this happened because their attention was distracted by having to do something else at the same time, or because they had to take a difficult decision on the spur of the moment."*

However, as the authors of Clerk and Lindsell 22nd Edition point out: *"some emergencies can be anticipated and planned for, especially in a professional context, and it may be negligent to fail to make appropriate arrangements to deal with an emergency".*

In support of that proposition the authors cite *Bull v Devon Area Health Authority* [1993] 4 Med LR 117, a case in which there was a prolonged delay in providing medical assistance at the birth of a child. There the court rejected the "resources" argument of the Defendant who said they were trying to do the best job possible with the limited resources available.

Thus while some leeway may be given to health bodies, it is possible that the "*full allowance*" mentioned by Lord Justice Mustill may in fact be watered down to not very much allowance at all, since it can be argued that the COVID-19 emergency could have been (at least in some key respects PPE, provision of ventilators etc.) planned for and anticipated by healthcare bodies in proper planning.

Volunteers/Rescuers?

Insofar as the MDU raise the question of volunteers and whether a different standard should apply to them, the current state of the law is that the English courts have rejected the arguments that a different standard of care should apply to the volunteer helper. For example, a householder repairing a door has been required to conform to the standards of a reasonable carpenter see Wells v Cooper [1958] 2 QB 265 and the same applies in the medical or first-aider field, thus in Cattley v St John Ambulance Brigade (1999) (unreported) the judge held that:

"[The volunteer rescuer in question] or any other person holding himself out as a first-aider trained in accordance with [the First Aid Manual] would be negligent if he failed to act in accordance with the standards of the ordinary skilled first-aider exercising and professing to have that special skill of first-aider' and went on to say 'the true test for establishing negligence in a first-aider is whether he has been proved to be guilty of such failure as no first-aider of ordinary skill would be guilty of, if acting with ordinary care."

The position in England is in contrast to many other jurisdictions, where the concern that potential good Samaritans might refrain from helping others for fear of liability, has led to the replacement of the standard of reasonable care with a lesser standard i.e. of gross negligence or recklessness. German law, for example, employs a standard of gross negligence (and Australia and US laws have rules to similar effect). Closer to home, the Irish Law Reform Commission proposed (in 2014) that a gross negligence standard for good Samaritans be incorporated into the Irish Civil Liability Act 1961. This document is illuminating because it sketches out what a piece of domestic legislation might look like if the Government were to make amendments to existing legislation to cater specifically for the COVID-19 emergency:-

"Protection of good Samaritans from liability for negligence.

51D.— (1) A good Samaritan shall not be personally liable in negligence for any act done in an emergency when providing—

(a) assistance, advice or care to a person who is—

(i) in serious and imminent danger, or apparently in serious and imminent danger, of being injured or further injured,

(ii) injured or apparently injured, or

(iii) suffering, or apparently suffering, from an illness,

or

(b) advice by telephone or by another means of communication to a person (whether or not the person is a person referred to in paragraph (a)) who is at the scene of the emergency.

(2) The protection from personal liability conferred on a good Samaritan by subsection (1) applies even if the emergency is caused by an act of the good Samaritan.

(3) The protection from personal liability conferred on a good Samaritan by subsection (1) shall not apply to—

(a) any act done by the good Samaritan in bad faith or with gross negligence, or

(b) any act done by the good Samaritan when providing assistance, advice or care in circumstances where the good Samaritan has a duty (whether imposed by or under any enactment or any other rule of law) to provide such assistance, advice or care."

Overall

The call for legislation creating complete immunity from suit to volunteer healthcare workers is probably a step too far. If amendment to protect volunteering retired healthcare professionals assisting with the COVID-19 emergency is contemplated, then the Irish Law Commission's draft provides a clear blueprint for setting a gross negligence or recklessness test for the establishment of liability. In the absence of such legislative change, it is likely that, while some allowance will be made by the courts for the emergency situation brought on by COVID-19, the allowance will be tempered by the consideration that the state is responsible (under its target duties under ss.1 and 3 of the NHS Act 2006) to provide a comprehensive system of healthcare and, that if that system fails and results in injury to patients or staff (even in the current emergency situation), then, absent cogent mitigating circumstances explaining the failure, liability is likely to follow.

More generally, the courts and Parliament have historically resisted attempts to move to shifting standards of care in the field of negligence, and the Government's provision of indemnity (see ss.11-13 Coronavirus Act 2020) would seem to suggest it is not currently part of the Government's plans to change tack now. For Claimant and Defendant solicitors considering the extent to which "*emergency*" will provide a defence to claims in negligence the answer for the time being would seem to be that, while "*full allowance*" may be given to "*battle conditions*", that allowance will be tempered by considerations of the degree to which the COVID-19 emergency was in fact relevant to the breach of duty alleged, and the degree to which any lack of resources (e.g. PPE, ventilators etc.) could be anticipated or guarded against in the overall provision of the healthcare system. Absent legislative change, it is unlikely that the fact that the person or "*actor*" carrying out the impugned task is a volunteer or rescuer, will be of any relevance to the standard of care.

INQUESTS INTO DEATHS IN CUSTODY DURING THE COVID-19 PANDEMIC

Gideon Barth

Following the sad news of the first death in custody from COVID-19, one question arises: what are likely to be the issues at inquests into the deaths in custody from COVID-19?

Article 2 and the central issues

Not all deaths in custody mandate an Article 2 inquest (see *R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] EWHC 1396 (Admin); *R (Tyrell) v HM Senior Coroner for County Durham and Darlington* [2016] EWHC 1892 (Admin)). An Article 2-compliant inquest must be undertaken when there has been an arguable breach of the substantive obligation to protect life. When a death occurs in custody, Article 2 will be engaged if there have been any arguable failings in the care provided.

The new Coronavirus Act 2020 will not change this. The real questions will be whether the Deceased died as a result of failings on the part of the prison. There will undoubtedly be questions asked about the steps taken by the prison to protect prisoners, especially those identified to be at risk, whether because of an underlying health conditions or their age.

The Government recently issued guidance on the steps being taken in prisons and other state detention centres to isolate prisoners and staff who develop symptoms. For example, any prisoner or detainee with a new, continuous cough or high temperature should be placed in protective isolation for 7 days. Where necessary, if there are multiple cases, 'cohorting' or gathering a number of potentially infected cases together may be appropriate. Staff who become unwell with the symptoms are to go home. A prima facie failure to comply properly with this medical guidance is likely to lead to an Article 2 inquest. For example, if an individual is not

isolated after showing symptoms, and another prisoner or detainee develops symptoms having come into close contact with them, this may represent a failing by the prison.

One interesting question is how far Coroners will be willing to go in Article 2 inquests in considering whether the steps taken in prisons and detention centres were sufficient to protect prisoners and detainees. There has been a wealth of criticism about the sluggishness of the Government's response to the crisis, and there remain questions about the discrepancy between the World Health Organisation ("WHO") recommendation of 14 days self-isolation compared to the Government's advice of only 7 days. It seems unlikely that any coroners would be willing to call evidence looking at the timing of the Government's decisions or the appropriateness of this advice. The Government has also responded to calls for prisons to release some prisoners early, or release remand prisoners, to combat overcrowding, by releasing up to 4,000 'low-risk offenders' on licence. If a death occurs as a result of prisoners being required to share cells with those who have tested positive for the virus, serious questions may be asked at an inquest.

Nevertheless, establishing any causative link between any decision/care and the death is likely to be incredibly difficult. It might be necessary to rely on the power to leave to the jury *potentially causative* factors (per *R (Lewis) v HM Coroner for the Mid and North Division of Shropshire* [2009] EWCA Civ 1403).

Jury

Section 30 of the Coronavirus Act 2020 provides that, for the purposes of an inquest, COVID-19 is not a notifiable disease so that a jury is not mandatory for a COVID-19 related death under section 7(2)(c) of the Coroners and Justice Act 2009.

This should not make a difference to deaths in custody. An inquest into a death from COVID-19 in prison will not, of itself, require a jury. However, if there are concerns that there were failures which resulted in the individual dying from COVID-19, such that the death could not be considered a 'natural death', then the obligation to empanel a jury will still arise under section 7(2)(a).

Delay

Inquests into deaths in custody normally take some time before the hearing is listed. This is because investigations by the Prisons and Probation Ombudsman ("PPO") and other organisations normally take place in advance. The article by Richard Mumford and Caroline Cross deals with how long hearings will be adjourned for. It is likely that this pandemic will delay these cases even further.

This article also appears on the UK Human Rights Blog.

COVID-19 AND IMMIGRATION DETENTION CENTRES

Suzanne Lambert

At the start of the year, some 1,200 immigrants were being held in immigration detention in the UK. The power to detain immigrants is separate from detention of individuals as part of a criminal sentence. There is a presumption against detention of immigrants, and immigration detention can only be in accordance with one of the statutory powers (the majority of which are contained in the Immigration Act 1971 and the Immigration and Asylum Act 2002), and where it is in the interests of maintaining effective immigration control, for example, to effect removal; to establish a person's identity or the basis of their immigration claim; or where there is reason to believe that the person will fail to comply with any conditions attached to a grant of immigration bail.

In order to be lawful, not only must immigration detention be in accordance with one of the statutory powers, but it must also be in accordance with the limitations implied by the domestic common law and Strasbourg case law (ECHR Article 5), as well as with stated Home Office policy.

Under the common law and ECHR Article 5, the statutory powers to detain are to be strictly and narrowly construed, i.e. if detention is not for a statutory purpose (or is no longer for that purpose) it will become unlawful. Additionally, the power to detain is impliedly limited to a period that is reasonably necessary for the statutory purpose to be carried out and must be justified in all the circumstances of the individual case, requiring an assessment of individual factors such as the risk of absconding, the likelihood of imminent removal, and the impact on the detainee.

Since news of the first immigration detainee testing positive for COVID-19, there has been increasing concern about the risk of COVID-19 deaths in immigration detention and about the legality of continued detention of immigrants. Detention Action Group sought to challenge the continued detention of some 736 immigrants in a judicial review advanced on two main bases: first in relation to vulnerable detainees such as those who are suffering from serious medical conditions or who are aged 70 and over; and secondly in relation to those whose removal is not reasonably imminent as a result of the global pandemic and the consequential travel bans and restrictions around the world.

Vulnerable detainees

The Home Office's *Adults at risk in immigration detention* policy confirms the presumption against the detention of those adults who are particularly vulnerable to harm in detention except in very exceptional circumstances.

Adults at risk include those who have serious physical health conditions or illnesses and those aged 70 or over. Age disputes are not uncommon in the immigration context, particularly if formal documentation (such as passports and birth certificates) are not available or not accepted as genuine. However, there is even greater scope for dispute in relation to the question of whether someone with a health condition such as asthma, diabetes, or a heart condition is considered to have a serious physical health condition severe enough so that they should not be detained. Given that those with asthma and heart conditions are considered to be vulnerable in the context of COVID-19 in open conditions within the wider community, it seems to follow that immigrant detainees with those same conditions would also be deemed vulnerable, particularly in conditions where social distancing may be difficult or impractical, or where access to appropriate medical care may be more limited.

Detention Action Group commissioned a scientific report from Professor Richard Coker, Professor of Public Health, which indicated that prisons and detention centres provide ideal incubation conditions for the rapid spread of the coronavirus, and it was "credible and plausible that 60% of immigration detainees will soon become infected with COVID-19". The continued detention of such vulnerable immigrants is therefore subject to challenge on the grounds that it would be in breach of the *Adults at risk* policy.

Detainees with physical conditions or illnesses that place them at high risk if they contract COVID-19 will need to be identified and Rule 35 of the Detention Centre Rules, which requires medical practitioners in detention centres to ensure that particularly vulnerable detainees are brought to the attention of those with direct responsibility for authorising, maintaining and reviewing detention, will need to rigorously applied to ensure that such vulnerable immigrants are released from detention.

Detainees liable to removal to countries with travel restrictions

A separate consideration is the likelihood that removal of those in immigration detention will no longer be reasonably imminent with no realistic prospect of removal or the likelihood of an unreasonable delay in effecting removal to those countries where there is a travel ban in place.

The question of how long it is reasonable for an immigrant to be detained pending deportation or removal is one that has been given detailed consideration in case-law, most notably in *R(ota I v SSHD)*, and *R v Governor of Durham Prison ex parte Hardial Singh*. The fact that travel restrictions and bans are in place in several countries throughout the world is likely to pose an insurmountable obstacle to the removal or deportation to those countries, so challenges to detention by those facing removal to such countries can be pursued successfully if decisions to release are not made following review of detention in those cases.

The need for case-by-case reviews of continued detention

Although Detention Action Group's recent application for urgent interim relief for the release of the 736 immigrants in detention was rejected by the High Court last week, in the week leading up to the hearing 350 detainees were released, and the Home Office provided an undertaking to review proactively the detention of all those held under immigration powers in accordance with updated Public Health England guidance.

Although the Home Office has not been compelled to empty the immigration detention centres, like in other European countries, continued detention will now be reviewed carefully on a case-by-case basis and it is also likely that bail applications, Habeas Corpus applications and individual judicial review claims will be brought where the detainee is deemed vulnerable in accordance with the guidance from Public Health England, or where the detainee is liable to removal to a country where travel restrictions are in place. It remains to be seen whether detainees considered at risk or vulnerable on the grounds of COVID-19 will be subject to "shielding" measures in solitary confinement rather than be released, however, as suggested in a leaked G4S letter.

In the unfortunate event that there is a death in immigration detention as a result of COVID-19, the adequacy of any detention review and the application of Rule 35 in such a case are likely to attract significant attention in the inquiry into the death in custody and the decision to continue to detain.

This article will also appear on the UK Human Rights Blog.

COVID-19 AND CAUSATION

Dominic Ruck Keene

One key factor that is driving the Government's response to COVID-19 is the number of deaths. Those are deaths 'from' COVID-19, the number of deaths 'with' COVID-19, and the number of those who have died with or from COVID-19 who are 'likely' to have died within a certain period of time in any event. That information is clearly critical to determining whether the drastic current interventions in social and economic life are necessary and proportionate to the risk, and whether the current restrictions on social interaction are proving effective and sufficient.

The Public Health England ("PHE") dashboard states (as at 21 July) that there have been 271,063 'laboratory confirmed' cases of COVID-19 and 42,265 'COVID associated deaths' in England and Wales. The number of deaths comprises those where the deceased had tested positive from COVID-19 and died in hospital, without any distinction being made between deaths 'from' vs. deaths 'with' COVID-19 i.e. deaths where COVID-19 caused or contributed to death, or where COVID-19 was merely present.

The Office of National Statistics ("ONS") separately compiles statistics of the number of deaths where COVID-19 has been 'mentioned' on the death certificates, which includes deaths in the community (including hospices and care homes). In the period ending 10 July there were 50,946 deaths registered in England and Wales 'involving the coronavirus.' The ONS statistics distinguish between deaths where the 'underlying cause' was respiratory disease from those where COVID-19 is mentioned. In the most recent week for which statistics were available, 9.08% of all death certificates listed influenza or pneumonia as the underlying cause and 4.21% of death certificates mentioned COVID-19, however, the ONS notes a death can be registered with both COVID-19 and influenza and pneumonia mentioned on the death certificate, and if a death had an underlying respiratory cause and a mention of COVID-19 then it would appear in both counts. The current guidance on completing medical certificates of death has been updated in light of COVID-19.

It notes "*Information from death certificates is used to measure the relative contributions of different diseases to mortality. Statistical information on deaths* ***by underlying cause*** *is important for monitoring the health of the population, designing and evaluating public health interventions, recognising priorities for medical research and*

health services, planning health services, and assessing the effectiveness of those services." [Emphasis in the original]

The guidance further states:

"*COVID-19 is an acceptable direct or underlying cause of death for the purposes of completing the Medical Certificate of Cause of Death…*

Medical practitioners are required to certify causes of death "to the best of their knowledge and belief". Without diagnostic proof, if appropriate and to avoid delay, medical practitioners can circle '2' in the MCCD ("information from post-mortem may be available later") or tick Box B on the reverse of the MCCD for ante-mortem investigations. For example, if before death the patient had symptoms typical of COVID19 infection, but the test result has not been received, it would be satisfactory to give 'COVID-19' as the cause of death, tick Box B and then share the test result when it becomes available. ***In the circumstances of there being no swab, it is satisfactory to apply clinical judgement…***

You are asked to start with the immediate, direct cause of death on line 1a, then to go back through the sequence of events or conditions that led to death on subsequent lines, until you reach the one that started the fatal sequence. If the certificate has been completed properly, the condition on the lowest completed line of part I will have caused all of the conditions on the lines above it. This initiating condition, on the lowest line of part I will usually be selected as the ***underlying cause of death, following the ICD coding rules. WHO defines the underlying cause of death as "a) the disease or injury which initiated the train of morbid events leading directly to death, or b) the circumstances of the accident or violence which produced the fatal injury". From a public health point of view, preventing this first disease or injury will result in the greatest health gain….***

You should also enter any other diseases, injuries, conditions, or events that contributed to the death, but were not part of the direct sequence, in part two of the certificate. The conditions mentioned in part two must be known or suspected to have contributed to the death, not merely be other conditions which were present at the time." [Emphasis in the original]

There is therefore a clear and unsurprising parallel between the circumstances in which COVID-19 will be 'mentioned' on a death certificate (and therefore tracked by the ONS) as either being the underlying cause of death or another contributory disease or condition, and the test of contribution in the context of coronial conclusions – whether an event or omission more than minimally, negligibly or trivially contributed to death.

On the face of it, the ONS data may therefore be more accurate than the PHE numbers as a way of distinguishing between deaths from vs. deaths with COVID-19 (as well as also capturing deaths in the community as well). It would perhaps be helpful if the ONS data made the further break down of deaths where COVID-19 was a Part 1 underlying cause, as opposed to a Part 2 contributory condition. However, what cannot currently be known accurately from either set of data is the number of deaths where the deceased was infected but asymptomatic for COVID-19. It appears that hospital patients are only being tested for COVID-19 if they are symptomatic, and there is of course very limited community testing. Of particular concern has been the lack of reporting of deaths in care homes.

Neither set of data is therefore accurate as to the true mortality rate (even if only on a contributory basis) of those who are infected with COVID-19. Further, without an in-depth investigation (for example including post-mortem, which is unlikely to be performed for the vast majority of COVID-19 related deaths) it cannot be known how many deaths would have occurred in any event. I.e. the number of deaths that would not have occurred on the balance of probabilities but for infection of COVID-19 - applying the conventional test of causation in clinical negligence outside of circumstances where the material contribution exception applies. Arguably, that continues to be a key information gap when assessing the requirement for the continuation of the present 'lockdown' and one that is unlikely to be filled by either the PHE or ONS statistics, or indeed by such inquests as do take place under the current restrictions on the coronial system.

One final issue is that it is not clear whether the statistics we have would be sufficiently reliable as to mortality rates to satisfy the tests for the use of statistical information as evidence of the cause of death at an inquest. As explained in *R (Chidlow) v HM Senior Coroner for Blackpool and Fylde* [2019] EWHC 581 (Admin), general statistical evidence alone is unlikely to be sufficient, because being a figure in a statistic did not of itself prove causation. In most cases there would be other evidence as to whether the deceased probably would have fallen within the statistical group of survivors or not. Where there was apparently credible additional causation evidence which, if accepted, together with general statistical evidence could properly lead the jury to find on the balance of probabilities that the event or omission more than minimally, negligibly or trivially contributed to the death, it would usually be proper and safe to leave causation to the jury.

PPE PROVISION

Dominic Ruck Keene

One of the totemic issues that has emerged over recent weeks as part of the COVID-19 pandemic is the provision of 'appropriate' and 'sufficient' Personal Protective Equipment ("PPE"), above all to those providing hands-on care to patients in hospital and to residents in care homes.

Leaving aside criminal liability for any breach of Health and Safety Regulations (in particular, the Personal Protective Equipment at Work Regulations 1992), all employers have common law duties towards their employees. The tortious liability of an employer to an employee is a duty, which is personal to the employer, to "*exercise due care and skill to provide a competent staff of men, adequate plant and materials, a proper system of work and effective supervision*": *A(a Child) v MOD* [2003] PIQR P33 at [27] citing *Wilsons and Clyde Coal Co v English* [1938] AC 57 and particularly Lord Wright at p.78 where the duty was stated to be "*to take reasonable care for the safety of his workmen*."

In *Smith v The National Farmers Union Mutual Insurance Society* [2019] NICA 63, the Court of Appeal in Northern Ireland held at [25] that:

"*As we have indicated a feature of the employer's duty of care to his employee is its non-delegable nature. That is an aspect of the special responsibility of an employer to its employee which provides a policy reason for the employer to retain responsibility. As a result the employer can delegate the performance of the duty to others, such as an independent contractor, but not responsibility for its negligent performance. The duty of care is not fulfilled simply by entrusting its performance to another even if reasonable care is taken in selecting that other*."

In *Kennedy v Cordia Services LLP* [2016] 1 WLR 597, the Supreme Court noted at [110-112] that:

"*…in more recent times it has become generally recognised that a reasonably prudent employer will conduct a risk assessment in connection with its operations so that it can take suitable precautions to avoid injury to its employees. In many circumstances, as in those of the present case, a statutory duty to conduct such an assessment has been imposed. The requirement to carry out such an assessment, whether statutory or not, forms the context in which the employer has to take precautions in the exercise of reasonable care for the safety of its employees…*

…It follows that the employer's duty is no longer confined to taking such precautions as are commonly taken or, as Lord Dunedin put it, such other precautions as are so obviously wanted that it would be folly in anyone to neglect to provide them. A negligent omission can result from a failure to seek out knowledge of risks which are not in themselves obvious…

In the present case, Cordia were aware of a history of accidents each year due to their home carers slipping on snow and ice, and they were aware that the consequences of such accidents were potentially serious. Quite apart from the duty to carry out a risk assessment, those circumstances were themselves sufficient to lead an employer taking reasonable care for the safety of its employees to inquire into possible means of reducing that risk."

Each and every NHS Trust and care home has, therefore, a duty to assess the relevant risk to its employees from COVID-19 and to provide adequate materials, including PPE, in order to ensure a safe system and place of work. It should be noted that the test is not one of strict liability, but of the usual tortious duty to take reasonable steps. Nevertheless, as the Supreme Court noted in *Kennedy* in respect of the PPE Regulations, as to whether there had been a breach of the common law duties of an employer:

"*The expansion of the statutory duties imposed on employers in the field of health and safety has given rise to a body of knowledge and experience in this field, which, as we explain later in this judgment, creates the context in which the court has to assess an employer's performance of its common law duty of care*."

Possible issues that might be relevant to any claim where an employee argued that they were not given adequate protection leading to infection with COVID-19 include:

1. The extent to which employers were or ought to have been aware as a result of prior planning for possible pandemics that a very large quantity of specialised PPE would be required across the country.

2. The extent to which employers have been following external guidance from NHS England, Public Health England or indeed the World Health Organisation, and the extent to which it was reasonable for them to rely on such guidance rather than their own individualised risk assessments taking into consideration the local aspects of the general threat from COVID-19 particular to their own place and systems of work.

3. Whether reasonable measures have been taken in recent weeks to acquire, distribute, and manage supplies of PPE.

One potentially difficult area will be the tension between the fact that each NHS Trust (rather than 'the NHS' generally) is likely to be seen as the relevant 'employer' for the purpose of employment law (and other aspects of tort such as vicarious liability) but might not be deemed to be the relevant (or the only) employer for the purpose of employer's liability in the context of COVID-19. When it comes to the assessment of risk for PPE and the consequent provision of PPE either pre-pandemic or during the pandemic (i.e. who has had responsibility for assessing and responding to the particular risk of infection from an infectious disease such as COVID-19) there does appear to be an extent to which there has been national level input into what is currently happening within individual NHS trusts. For example, the most recent detailed revised guidance from Public Health England and NHS England has set out the PPE requirements deemed necessary in healthcare contexts. Further, the distribution of PPE has become a national effort, assisted by the MOD. As noted by the Court of Appeal in *Lane v The Shire Roofing Company* [1995] PIQR 417, 421, the fundamental issue in employer's liability claims is that they must be considered in "*the context of who is responsible for the overall safety of the men doing the work in question*."

Finally, it should also be noted that where an employer is a public authority under Article 2 ECHR, the State can be required to take reasonable preventative operational measures to safeguard lives of those within its jurisdiction against real and immediate risks to life. Breaches of that duty can be a result of 'systemic' or 'operational' failings. In the context of environmental disasters over which States have no control, the obligation of the State to take preventive operational measures comes down to adopting measures to reinforce the State's capacity to deal with the unexpected and violent nature of natural phenomena in order to reduce their catastrophic impact to a minimum: *M. Özel and Others v Turkey* (Application no 14350/05).

The relevance of Article 2 in the context of COVID-19 potentially lies in two areas in particular:

(1) in general whether prior to 2020 the State took appropriate measures in light of its actual or constructive knowledge to deal with the potentially catastrophic impact of a pandemic such as COVID-19; and

(2) specifically whether appropriate planning and procurement was implemented prior to the onset of the pandemic with respect to the provision of PPE to NHS and other 'frontline' key workers (see the reference in *Smith v MOD* [2013] UKSC 41 to both the systemic and operational duties potentially applying to the procurement of protective military equipment).

THE CORONAVIRUS ACT 2020: WHEN LEGISLATION GOES VIRAL (PART ONE)

Darragh Coffey

Introduction

At this point, it is almost trite to say that we are living through unprecedented events. The global spread of the coronavirus pandemic poses serious challenges to society. So far, the global death-toll has exceeded 21,000 and life as we know it in the UK has changed dramatically. In response to this crisis the Government has announced drastic measures in order to curb the spread of the virus and to support those who may be affected. Indeed, it seems that Cicero's famous injunction to let the welfare of the people be the highest law has gained a new relevance in the age of COVID-19.

As readers will probably know, a significant plank of the Government's legislative response is the coronavirus Act 2020, which received royal assent on 25 March having been fast-tracked through Parliament. This substantial piece of legislation –which consists of 102 Sections, 29 Schedules and runs to just under 360 pages– is intended to deal with the various challenges that may be posed by the coronavirus epidemic. As a result, its provisions are broad ranging, touching on areas as diverse as powers to disperse gatherings, pensions, sick pay, inquests and investigatory powers to name but a few.

Given the scope of this legislation, it would be folly for me to try and consider it comprehensively in one article. Therefore, this is the first of two articles on this subject. In this article I explore why this legislation was considered necessary and consider some general aspects of the Act. In a second article, I will explore some of the more interesting/controversial aspects of the Coronavirus Act 2020.

Why Legislate?

When the Government first produced an outline of the legislative proposals before the Bill was introduced to the Commons, at least one law and policy commentator cautioned against knee-jerk legislation and urged that consideration be given to whether existing powers may already be sufficient to deal with the challenges that might arise. In certain respects, the point is well made. For example, the Public Health (Control of Diseases) Act 1984 (as amended) allows for wide ranging regulations and orders to be made for the purpose of preventing, protecting against or controlling the spread of an infection.

However, as alluded to above, the 2020 Act encompasses far broader powers than those in the 1984 Act and appears to create powers of more general rather than specific application. Importantly the 2020 Act also creates a unitary legislative scheme for dealing with the pandemic across all of the nations of the UK or, to use what seems to be a popular political term, 'levels up' the response. An interesting constitutional point that arises from this is that, despite the extraordinary nature of the legislation, the drafting appears to preserve the Sewell convention, whereby most changes that may be made under the Act to any legislation dealing with devolved matters will require the consent of the relevant devolved administration.

Another option for dealing with the crisis without the need for new legislation may have been to use the powers under the Civil Contingencies Act 2004 . Under this Act, a senior Minister of the Crown (Prime Minister, Secretary of State or Lord Commissioner of the Treasury) is empowered in certain circumstances –which are likely to be deemed met at present– to make very broad ranging emergency regulations. However, regulations under the 2004 Act must be ratified by Parliament within seven days of being made. Furthermore, such regulations expire after 30 days. Thereafter they must then be renewed and re-ratified. This means that for any power granted under the Civil Contingencies Act 2004 to remain in force for the duration of the crisis, Parliament would have to meet at least every 30 days. In the context of an epidemic, this simply may not be possible. On this basis, the Government appear to have decided that more enduring legislation was necessary.

The Sunset Clause

Turning to the Coronavirus Act 2020 itself, the first point to note is that, while it has more longevity than regulations made under the Civil Contingencies Act, it is still clearly intended as temporary emergency legislation. As will be seen in part two, this legislation makes fundamental changes to a range of areas of law and grants very significant powers to the authorities. However, due to the urgency of the situation the legislation could only receive the most cursory of parliamentary scrutiny before being passed. Ordinarily, legislation making some of the changes proposed would be expected to be subjected to significant scrutiny in both houses of Parliament. In this case the Bill was introduced on Monday and received Royal assent on Wednesday.

In these circumstances it was clearly necessary to place a limit on the duration of most of the Act's provisions. To this end, Section 89 of the Act, creates a sunset clause, under which the majority of the provisions will expire after two years. However, this period may be extended by six months or shortened in accordance with Section 90. In the Bill as drafted, these were the only limitations on the longevity of the Act. In circumstances where such significant legislation would be nodded through Parliament, an unchecked legislative lifespan of two – perhaps up to two and a half– years is a very long time. Particularly, considering the Prime Minister's ambition to 'turn the tide on the disease in 12 weeks'.

Understandably, this raised significant concerns among human rights groups, lawyers and MPs from across the political spectrum. To its credit, the Government was receptive to these concerns and ultimately accepted an amendment, which introduced the requirement that the operation of the Act must be reviewed by Parliament every six months (see Section 98). This appears to strike an appropriate balance between the need to maintain parliamentary oversight of the significant powers created by this Act, and the concerns that Parliament may not be able to operate as normal during the crisis. Indeed, a six month review period appears to be more in line with approaches to such legislation taken in other common law jurisdictions.

Human Rights

Before the Bill was published Barrister, Adam Wagner produced a detailed twitter thread in which he set out his observations on any potential legal response to the coronavirus. In the thread, he very compellingly emphasised the importance of keeping human rights values at the centre of any such response.

An important general point arises in this context. Under Article 15 of the ECHR, in times of war or other emergency threatening the life of the Nation, a Contracting State may derogate from many of its human rights obligations under the Convention. Such a course of action appears to be contemplated by at least six Council of Europe Member States as a result of the coronavirus. In contrast, the UK Government has not yet signalled any such intention. Therefore, any action taken under the Coronavirus Act 2020 must necessarily be compatible with all of UK's ECHR obligations in accordance with the Human Rights Act 1998. In Part 2, I will explore certain aspects of the legislation for which this requirement will be of particular relevance.

In general, the drafters of the legislation demonstrate an acute awareness that any measures adopted under the Act must be proportionate. Indeed, the phrase "necessary and proportionate" appears no fewer than 48 times throughout the Act. Furthermore, the Government has explicitly stated:

> *The measures in the coronavirus bill are temporary, proportionate to the threat we face, will only be used when strictly necessary and be in place for as long as required to respond to the situation.*

To support this aim, Section 88 of the Act creates an 'on/off switch' whereby the operation of any provision of the Act may be suspended and revived by regulations as and when the measures are considered necessary throughout the life of the legislation.

As it stands most of the provisions of the Act have been brought into force as of 25 March. The exceptions to this are provisions relating to: Emergency volunteers; modifications to Mental Health legislation; changes to the powers and duties of local authorities in relation to the provision of care and support; changes in relation to the registration of deaths and still births; and provisions relating to food supply. These provisions will be brought

into force as and when they are deemed necessary. In the next post, I will consider the substantive provisions of the Act and highlight some aspects that are particularly interesting or controversial, or indeed both.

This article also appears on the UK Human Rights Blog.

THE CORONAVIRUS ACT 2020: WHEN LEGISLATION GOES VIRAL (PART TWO)

Darragh Coffey

Note:

In Part One (above), I set out what I considered to be the Government's rationale in enacting the Coronavirus Act 2020 rather than relying on existing legislation. In a piece for *Law Society Gazette* Dr Andrew Blick and Professor Clive Walker have sought to rebut this rationale and argued that the Government should more appropriately have used the Civil Contingencies Act 2004.

Introduction

In Part One, I considered the background to the Coronavirus Act 2020 and some general aspects of the legislation. Here, I focus on some of the substantive provisions of the legislation and briefly explore the role that human rights law has to play in the management of the COVID-19 crisis.

At this point it bears repeating that the UK Government has not derogated from the ECHR under Article 15. Thus, any measures introduced in response to the coronavirus must be compatible with the UK's full human rights obligations under the Convention as transposed into domestic law via the Human Rights Act 1998. Jeremy McBride has produced an excellent piece on the ECHR Blog, in which he analyses the range of various responses to the COVID-19 crisis through the lens of the Convention obligations. Such an exercise is not possible here due to constraints of space. However, towards the end of this piece I will briefly consider the compatibility of the lockdown restrictions on movement with the UK's ECHR obligations.

Aims of the Legislation

According to the Explanatory Notes that accompanied the legislation as it proceeded through Parliament, the aims of the Coronavirus Act 2020 are to support the Government's efforts in five broad areas:

1. increasing the available health and social care workforce;
2. managing the deceased with dignity and respect;
3. supporting people;
4. easing the burden on frontline staff; and
5. containing and slowing the spread of the virus;

As I have commented in Part One, the Coronavirus Act 2020 is a substantial piece of legislation. Readers may perhaps be relieved that considerations of space prevent me from engaging in a detailed analysis of each and every effective provision. Rather, I will provide an overview of the substantive measures, focusing in more detail on certain aspects.

Increasing the Available Health and Social Care Workforce

In order to increase the manpower available in the health and social care sectors, Sections 2 to 7 and their associated schedules provide for the emergency temporary registration of various regulated healthcare professionals and social workers for the duration of the emergency. Importantly, sections 11 to 13 of the Act make arrangements to provide indemnity against clinical negligence claims for healthcare professionals assisting in the response to the crisis, who would not otherwise be so indemnified.

Another mechanism by which the legislation seeks to increase the pool of personnel who can assist with the response to the crisis, is by providing for Emergency Volunteering Leave. When Sections 8 and 9 of the Act are brought into force, workers will be entitled to unpaid statutory leave in order to act as Emergency Volunteers in

the health or social care sectors. These Emergency Volunteers may also be compensated for loss of earnings and for travel and subsistence.

Managing the Deceased with Dignity and Respect

The Act also introduces measures to manage the increased number of deaths caused by the pandemic. Temporary changes are made to the procedures for registering deaths and still births (Sections 18 to 21) and temporary arrangements are made in Section 58 and Schedule 28 in respect of the transportation, storage and management of the bodies of the deceased.

Temporary changes are also introduced to coronial law under the legislation. For the purposes of any inquest opened after the coming into force of the legislation (25 March 2020), COVID-19 is not a notifiable disease. This means that a jury inquest is not required to be held if there is reason to suspect that a death was caused by the virus. This measure is eminently sensible when one considers that, at the time of writing there have been over 16,000 deaths as a result of COVID-19.

Supporting People

In order to fulfil the aim of supporting people, the Act introduces measures in respect of statutory sick pay (Sections 39 to 44). Included in these measures is the power to disapply the three day waiting period, so that those who are off work sick will be entitled to statutory sick pay from the first day upon which they are absent. The Act also introduces certain protections in respect of tenancies by effectively increasing the notice period for evictions to three months across the board (Sections 80 to 84). Furthermore, under the Act designated authorities may be granted powers to request information that can be used to avoid or mitigate any potential disruption to the food supply chain (Sections 25 to 29).

Easing the Burden on Frontline Staff

Mental Health Law

Section 10 and its associated schedules make temporary modifications to mental health legislation to reduce the demands placed on medical professionals as a result of various administrative procedures. Ordinarily an application for the compulsory detention of a person under the Mental Health Act 1983 must be supported by the opinion of two doctors. However, when these provisions are brought fully into force, if it is impractical to obtain the advice of two doctors or if this would cause undue delay, the opinion of one doctor will suffice. Other modifications include the extension of various periods for which a person may be detained or held on remand under the Mental Health Act; and amendments to procedures for the administration of medication to a detained patient without their consent. Clearly, if brought into force, these changes would represent dilutions of important safeguards that are currently in place in respect of potentially vulnerable individuals. The effects of such changes will require careful monitoring in order to ensure that the interests of vulnerable patients are protected.

Adult Social Care

Sections 14 to 17 of the Act make significant changes in respect of the adult social care regime. The changes essentially suspend the duty placed on local authorities to make an assessment in respect of an adult who may have needs for care and support, or who is receiving NHS Continuing Healthcare but is no longer eligible for such. Furthermore, the general duty to meet the eligible needs of certain adults becomes a power, with a duty only arising if a failure to do so would breach the Human Rights Act. As Mary-Rachel McCabe and Jamie Burton explain these changes are significant and may have very serious impacts on adults with social care needs.

Oversight of Investigatory Powers

Section 22 and 23 of the Act allow for temporary changes to be made to the Investigatory Powers Act 2016. These changes relate to the appointment of Judicial Commissioners, who are required to carry out certain oversight functions under the 2016 Act; and to certain time-limits in respect of warrants issued pursuant to that legislation –including the ex-post facto 'urgent-warrant' process. Section 24 of the Act allows for regulations to

be made extending the time period for which biometric material, such as fingerprints and DNA profiles may be held by the police. Each of these changes represents an erosion – however slight – of the safeguards placed on important and potentially intrusive investigatory powers. While it is of course important that police and other resources are appropriately deployed during the crisis, we should not downplay the trade-offs that may be needed to facilitate this.

Containing and Slowing the Spread

Perhaps the suite of measures under the Act that may have the greatest impact across wider society are those aimed at containing and slowing the spread of the virus. These include: powers in respect of the provision of education, training and child-care (sections 37 and 38 and schedules 16 and 17); powers to suspend port operations (Section 50 and Schedule 20); allowing for the use of video and audio technology by courts and tribunals to facilitate remote hearings (Section 53 to 57); and the postponement of upcoming elections (Sections 59 to 70).

Section 51 and Schedule 21 of the Act contain certain coercive powers in respect of potentially infectious persons. Under these provisions, Public Health Officers are empowered to require a potentially infectious person to submit to screening and assessment and to impose certain restrictions and requirements on such persons. Constables and Immigration Officers are also empowered to direct or remove a person to a suitable place to undergo screening and to hold them there for a period of time in order to hand them over to a Public Health Officer.

In respect of more generally applicable powers, Section 52 and Schedule 22 create powers to issue directions in relation to events, gatherings and premises. Under these provisions, events and gatherings may be prohibited and orders can be made in respect of specified premises imposing prohibitions, requirements or restrictions in relation to the entry into, departure from, or location of persons within them. These are clearly very broad powers with the potential to impinge significantly on the freedom of movement of large sections of the population.

Despite these broad powers in the Coronavirus Act 2020, the current lockdown restrictions – contained in the Health Protection (Coronavirus, Restriction) (England) Regulations 2020 and their Scottish, Welsh and Northern Irish counterparts – were not made under that Act. Rather they were made under the Public Health (Control of Diseases) Act 1984. There has been significant debate throughout the blogosphere – including on the UK Human Rights Blog – in relation to the lawfulness or otherwise of these regulations. The arguments have focused on the question of whether the regulations are ultra vires the 1984 Act. As my focus here is the Coronavirus Act 2020, I do not propose to enter into that particular fray. But it is perhaps worth examining briefly the compatibility of the lockdown restrictions with the Human Rights Act 1998.

The UK has not signed up to the Fourth Protocol to the ECHR, Article 2 of which guarantees the right to freedom of movement. The compatibility of the UK's lockdown provisions with the State's ECHR obligations, therefore, falls to be judged by reference to Article 5 of the Convention. Importantly, Article 5 is concerned with *deprivations* of liberty rather than 'mere restrictions.' As the Grand Chamber has pointed out in *De Tommaso v. Italy,* when deciding whether a measure constitutes a deprivation or merely a restriction on liberty:

> *"…account must be taken of a whole range of factors such as the type, duration, effects and manner of implementation of the measure in question. The difference between deprivation and restriction of liberty is one of degree or intensity, and not one of nature or substance."* [80]

Importantly, this assessment may be made by reference to the context and circumstances in which the measures are imposed (*De Tommaso* at [82]). Thus, when considering whether a given set of measures constitute a deprivation of liberty, a holistic view must be taken of the situation in which those measures are imposed, and of their degree and intensity.

Applying this to the present situation, the lockdown measures have been imposed in order to prevent the spread of a global pandemic and to protect life in accordance with the State's positive obligations under Article 2 of the

Convention. Rather than confining people at home, the regulations prohibit individuals from leaving their homes without a reasonable excuse. A non-exhaustive list of examples is included in the regulations making it clear that activities such as exercise, shopping for essentials, and travelling to work – at least for some people – are reasonable excuses. The restrictions are to be reviewed at three week intervals and the regulations contain no temporal curfew or strict geographic limit on the distance one can travel from their home if they have a 'reasonable excuse'. It is, therefore, my preliminary view that the regulations as currently drafted would be considered a restriction of liberty rather than a deprivation and are likely compatible with the UK's obligations under the ECHR.

While the regulations as drafted may be Human Rights Act compliant, a discrete question also arises with respect to the manner in which the restrictions may come to be policed. For the most part the enforcement of the regulations by police so far appears to be relatively light-touch. It would seem that the authorities are doing their best properly and appropriately to impose unfamiliar regulations in a difficult and unprecedented situation. That said, there has been at least one case in which the nature, source and extent of the authorities' powers to enforce the lockdown have been badly misunderstood. Furthermore, there appear to be some reports of perhaps overzealous individual officers misconstruing the extent of the lockdown. These cases appear to be outliers – though perhaps amplified by social media. However, if such situations are not monitored and corrected, injustices may result. As we continue through the lockdown, vigilance is needed to ensure that the boundaries of what the authorities are empowered to do are not overstepped, and that powers that were granted for valid and worthy reasons are not used arbitrarily or improperly in the confusion of a national crisis.

Conclusion

The spread of coronavirus in the UK has created an emergency the likes of which have not been seen in this author's lifetime. Such circumstances pose difficult questions for a liberal, democratic society. From a human rights perspective the Government has positive obligations under Article 2 of the ECHR to put measures in place to protect the lives of those in the jurisdiction against any risks of which the State is aware or reasonably ought to be. Clearly such obligations are engaged by the current crisis. Furthermore, the scientific advice upon which the Government relies in designing its response to the COVID-19 crisis and seeking to fulfil these positive obligations, is that drastic and unprecedented measures of social distancing, quarantine and isolation are required to preserve the welfare of the public at large.

This response would appear to be in line with that of other democratic states and indeed less draconian than some. But the fact remains that in response to this emergency, the State's powers to impinge upon the lives of its citizens have increased significantly. Furthermore, certain safeguards and checks and balances that aim to preserve our fundamental rights and the rule of law have been diluted. Emergencies can be dangerous times for things such as these. In the words of the late Adrian Hardiman, a former Justice of the Irish Supreme Court:

"*The cry of emergency is an intoxicating one, producing an exhilarating freedom from the need to consider the rights of others and productive of the desire to repeat it again and again*" (*Dellway Investments and Others v NAMA and Others* [2011] 4 IR 1 at 289).

It is clearly incumbent on the population to support legitimate efforts to control the virus and to deal with the crisis it has created. However, it is also important that a sense of vigilance is maintained. The legitimate scrutiny of the Government's emergency actions and any encroachments into the lives of the population must continue throughout the crisis. Such scrutiny will ensure that those actions remain lawful and where they intrude on various rights, that they are limited to what is necessary and proportionate for dealing with the threat that we face. In our current circumstances, if we wish to protect the welfare of the public while resisting the intoxicating cry of emergency, we must seek to strike the difficult balance between compliance and vigilance.

This article also appears on the UK Human Rights Blog.

ORDER SEEKING POSSESSION OF A HOSPITAL BED DURING THE COVID-19 PANDEMIC

Rajkiran Barhey

University College London Hospitals NHS Foundation Trust v MB (Rev 1) [2020] EWHC 882 (QB)

The Claimant, the NHS Trust, sought possession from the Defendant, a patient called MB, of a bedroom on a ward of the hospital. The ward was intended for those requiring acute neuropsychiatry care for up to 14 days (sometimes up to 28 days).

The Claimant argued that the possession claim was urgent as the bed was needed for other patients due to the COVID-19 pandemic and because, in any event, MB was at increased risk of contracting COVID-19 and therefore staying on the ward was contrary to her interests. The Claimant argued that MB could be discharged to specially adapted accommodation with a care package provided by the local authority. MB's case was that she wished to be discharged but had concerns about the adequacy of the care package offered by the Claimant.

Background

MB was originally admitted to hospital on 18 February 2019 with a functional neurological disorder manifesting as limb weakness, tremors and speech disturbance. She also suffered from chronic fatigue, migraine, generalised pain, PTSD, disrupted attached, OCD, possible borderline personality disorder and Asperger's syndrome. She required help with personal care. During her stay in hospital, her behaviour had been exceptionally challenging and aggressive, limiting her progress.

Discussions regarding discharge of MB and a care package had been ongoing for over a year. However MB had declined the care packages offered to her, primarily on the basis that none of the packages included 24 hour care. A 24 hour package was eventually agreed followed by an assessment to determine ongoing need, but this was rejected by MB as she wanted a guarantee of 24 hour care for at least 1 year. At the time of the hearing, she also required some adaptations to be made to the accommodation into which she was to be discharged. MB argued that if her requirements were not met, she would be at risk of self-harm or suicide.

Some of the adaptations had been made, but they were not all deemed to be clinically necessary. Clinical evidence was also presented by the Trust as to MB's mental state, namely her risk of self-harm and suicide. The evidence suggested that MB had, in the past, threatened deliberate self-harm when her needs were not met and that there was no mental health reason to keep her in hospital.

Furthermore, the judge proceeded on the basis that MB had capacity.

Legal framework

The legal framework was set out by the judge at [37] to [39]. He noted that ordinarily the Trust would be entitled to seek an order for possession pursuant to CPR Part 55 but, due to the current general stay on possession claims effected by CPR 51Z PD this was not possible. However, as paragraph 3 of the PD notes, this stay does not affect claims for injunctions against trespassers (i.e. MB).

It was noted that the effect of the injunction would be tantamount to final relief, such that it should not be granted if there was clearly no defence to the action. It was agreed that it would be wrong to grant the injunction if there was an arguable case that the Hospital's decision to cease to provide in-patient care had been taken in breach of its public law obligations.

At [51] the judge also noted: "*Patients have no right to occupy beds or rooms in hospitals except with the hospital's permission. A hospital is entitled as a matter of private law to withdraw that permission. In deciding whether to withdraw permission, the hospital is entitled and indeed obliged to balance the needs of the patient currently in occupation against the needs of others who it anticipates may require the bed or room in question. Unless its decision can be stigmatised as unlawful as a matter of public law, there is no basis for the court to deny the hospital's proprietary claim to restrain the patient from trespassing on its property. Where what is sought is an interim injunction which would effectively determine the claim, it is necessary for the court to be satisfied that*

there is clearly no public law defence to the claim; and the balance of convenience and other discretionary factors must also be considered."

Judgment

MB argued that the judge should adjourn and allow her to obtain her own expert evidence. This was refused for 3 reasons:

1. In judicial review proceedings challenging a decision by a hospital not to provide in-patient care to a patient on clinical grounds, it would not ordinarily be open to the Claimant to adduce expert evidence impugning the clinical basis of the decision. That would go beyond the limited circumstances in which expert evidence was permissible in JR proceedings. Although these were not JR proceedings, MB sought to raise collateral challenges to the Hospital's decision to remove her by way of public law defences and so it was appropriate to apply the same principles.

2. The clinicians' clear view was that MB did not require hospital care and could safely be discharged. Clinicians could not be compelled to provide treatment which they considered to be contrary to their clinical judgment and it would be wrong to entertain evidence with a view to requiring them to do so.

3. Thirdly, and practically, given the COVID-19 pandemic, it was highly unlikely that MB would be likely to obtain independent expert evidence in a reasonable timeframe. The practical effect of the adjournment would be to delay MB's discharge at the exact time her bed was needed, due to the pandemic, thus defeating the purpose of the application. The judge acknowledged that the expert evidence in front of him was not compliant with CPR Part 35 as the doctors were employed by the Trust, but his views represented those of an impressive MDT and were supported by two further clinical witnesses.

As to the risk to MB of discharge, the judge found that there was no dispute that MB's physical needs could be met satisfactorily by the care package proposed. He also found that MB frequently exhibits abusive and challenging behaviour to those providing care for her; that Camden Council had done a great deal to meet MB's concerns but that given her past behaviour it was unlikely they would ever be met; that MB used threats of self-harm and suicide to persuade others to meet her needs but there was no evidence of her actually resorting to self-harm; that the risk of self-harm or suicide to MB was low if discharged; that MB was likely to suffer extreme distress if discharged but it could be managed with the proposed care package.

The judge also considered MB's concerns regarding the care package in turn and concluded that each concern raised could not be met reasonably by Camden and that they had already gone to significant efforts to meet MB's concerns.

The judge then considered whether it was clear that MB had no public law defence to the claim. MB did not argue that the decision to require MB to leave was irrational in the *Wednesbury* sense.

As to Article 3 ECHR, MB's submissions were summarised as follows at [53]: "*if it can be established that, unless her concerns are addressed, discharge will precipitate suicide, self-harm or extreme distress rising to the level of severity necessary to qualify as inhuman or degrading treatment within the meaning of Article 3 ECHR, the Hospital is legally precluded from discharging her until those concerns are met, even if her concerns are, from an objective clinical point of view, unreasonable and unwarranted."*

The judge disagreed, finding that, given the unfortunate nature of MB's condition, where she suffered extreme distress frequently, this would effectively allow MB to veto any action with which she did not agree. Furthermore, where a hospital decides, rationally and in accordance with a lawful policy, to allocate finite resources to patient A over patient B, they are not precluded from doing so by Article 3.

The hospital had made a decision to discontinue in-patient care. This decision engaged the State's positive obligations under Article 3, which were to take all *reasonable* steps to avoid suffering. In the present case, reasonable steps had clearly been taken.

In any event, even if the question were simply whether discharge in current circumstances would lead to suffering rising to the level of severity required to engage Article 3 ECHR, the clinical evidence in the present case did not suggest that such suffering was likely to occur. MB's risk of self-harm or suicide was moderate to low and the provision of a 24 hour care package would be an appropriate safeguard.

As to Article 8, the interference with MB's private and family life was clearly justified in order to protect the rights of others. MB's arguments as to discrimination, based on Article 14 ECHR and the Equality Act, also failed.

The balance of convenience was clearly in the Hospital's favour. MB had access to care if her health deteriorated. If the order was not granted, the Hospital would lose access to a bed which may be needed, and staff would likely spend a lot of time caring for MB when such inpatient care was not necessary.

Chamberlain J granted an order requiring MB to leave the ward by 12pm the next day.

Simon Sinnatt from 1COR Brighton acted for the Claimant Trust in this case. He did not contribute to this article.

CORONAVIRUS, CARE HOMES AND BEST INTERESTS

Rajkiran Barhey

BP v Surrey CC [2020] EWCOP 17

This was an urgent application on behalf of BP, brought by his daughter and litigation friend, FP. BP is 83, suffers from Alzheimer's disease and is deaf but can communicate through a 'communication board.' FP brought an application seeking BP's discharge from his care home and that BP be returned home with an appropriate care package.

The application arose after BP's care home suspended all visits. FP argued that this was an infringement of BP's Article 5 and 8 ECHR rights. BP was assessed in July 2019 as lacking capacity to make decisions about his accommodation and care needs as a result of his cognitive impairment but nevertheless he understood most of the relevant information regarding these decisions.

Hayden J considered in detail the relevant ECHR obligations and BP's rights under the UN Convention on the Rights of People with Disabilities. He particularly made some rather notable comments regarding derogation from the ECHR which are considered in more detail on the EJIL: Talk Blog for those who are interested in this area.

Hayden J ultimately concluded that it was not realistic to discharge BP home to live with his daughter, FP. A plan was made to teach BP to use Skype and potentially instant messaging. Furthermore, the family could stand near BP's window and wave to him and use the communication board.

Scott Storey from 1COR Brighton appeared in this case. He did not contribute to this article.

CORONERS' INVESTIGATIONS, INQUESTS AND COVID-19

Richard Mumford and Caroline Cross

The coronial jurisdiction has been particularly affected by the COVID-19 pandemic. Death referrals to coroners are up significantly throughout the county, as much as fivefold in some jurisdictions. It therefore comes as no surprise that the Chief Coroner has rapidly brought out further guidance to assist coroners in this unprecedented situation.

On 26 March 2020 the Chief Coroner published Guidance Note 34 for Coroners on COVID-19 ("GN34") which can be found here. He also brought out Guidance Note 35 (Hearings during the Pandemic) on 27 March and

Guidance Note 36 (Summary of the Coronavirus Act 2020) on 30 March 2020. The Guidance Notes address many of the issues relating to the impact of COVID-19 on the coronial service. We set out below some answers to questions those involved with the coronial system may currently have in mind, taken from the Guidance Notes and other sources ("Guidance Note" has been abbreviated to "GN" - GN34 [No.]" refers to paragraph numbers in the Guidance Note).

1) Are Coroners' Courts conducting hearings at the moment?

GN34 [10] provides that *"no physical hearing should take place unless it is urgent and essential business and that it is safe for those involved for the hearing to take place. A particular concern is to ensure social distancing in court and in the court building."*

It is also noted that *"All hearings that can possibly take place remotely (via whatever means) should do so, and other hearings should continue only if suitable arrangements can be made to ensure distancing although the Chief Coroner accepts that in many jurisdictions this may be difficult. Hearings which must continue should be those considered essential business"*

2) Can Coroners' inquests and/or PIRHs be conducted remotely?

The Coroners (Inquests) Rules 2013 rule 11(3) provides:

> *"An inquest hearing and any pre-inquest hearing must be held in public unless paragraph (4) or (5) applies."*

Rule 11(4) provides an exception for hearings being in public where interests of national security are engaged. Rule 11(5) provides an exception for pre-inquest review hearings being in public where the interests of justice or of national security are engaged. There has been no declaration to date that holding PIRHs privately would be in the interests of justice.

GN34 [10] sets out practical steps to be considered and includes the following observations:

> *"All hearings that can possibly take place remotely (via whatever means) should do so, and other hearings should continue only if suitable arrangements can be made to ensure distancing although the Chief Coroner accepts that in many jurisdictions this may be difficult. Hearings which must continue should be those considered essential business.*
>
> *Coroners are reminded that such hearings must in law take place in public and therefore coroners should conduct telephone hearings from a court, not their homes or their office. In the light of the statement of the Prime Minster on March 23, 2020 as to gatherings and travel only where absolutely necessary, hearings taking place in public may mean they take place where only a member of the immediate family is present and with a representative of the press being able to be present."*
>
> *Given the need for coroners to travel to hold telephone hearings from a court (note it does not have to be a coroners court, given that the court may be shut), coroners are considered to be conducting "essential business".*

Some pre-inquest review hearings can be done on paper. Coroners are sending out agendas and asking for responses and submissions.

In response to what must have been a myriad of questions on virtual hearings, GN35 [2]-[6] stated:

> *"2. Various questions have been asked about 'virtual hearings'…*
>
> *4. In the civil jurisdiction it is possible for certain hearings to take place in private or without the need for a judge to be physically present. This has been the case for some time and utilises the flexibility already provided for in the CPR. It is not the result of the emergency legislation. It does not apply to the coroner jurisdiction.*

5. Why must the hearing happen with the coroner physically present? Simply put absent a coroner, it is not a court. Although all parties who need to be present may do so by phone or any other link, the Chief Coroner's guidance is that, as the law currently stands, a coroner should be present at the hearing.

6. Can the coroner be present by Skype or phone? As the legislative provisions currently stand, the answer is no."

3) Are post-mortems still taking place?

GN34 [24]-[29] discusses post-mortem examination practice in general and the current pressures on the system, concluding that *"The availability or lack of availability of post-mortem examination facilities and pathologists will be a factor for coroners to consider in deciding whether to order an examination (or a particular type of examination) in each case. Coroners may need to consider partial or external examinations by pathologists as well as non-invasive examinations, or no examination at all. Cases of particular complexity and sensitivity may need to be prioritised."* However, given the emergency situation, it may be that post mortem examinations are not possible, either because of infection risk grounds or capacity problems ([23](v)). In such a scenario, coroners are invited to consider other relevant medical and other evidence that may enable a conclusion to be reached – see [23](vii-viii).

4) Does suspicion of COVID-19 as a cause of death mean that the death must be reported to a Coroner?

Not necessarily. GN34 [18] provides:

"COVID-19 is an acceptable direct or underlying cause of death for the purposes of completing the Medical Certificate of Cause of Death (MCCD);

COVID-19 as cause of death (or contributory cause) is not a reason on its own to refer a death to a coroner under the CJA 2009;

That COVID-19 is now a notifiable disease under the Health Protection (Notification) Regulations 2010 does not mean referral to a coroner is required by virtue of its notifiable status (the notification is to Public Health England), and there will often be no reason for deaths caused by this disease to be referred to a coroner"

GN34 [19]-[20] continues:

"19 To restate: COVID-19 is a naturally occurring disease and therefore is capable of being a natural cause of death. There may of course be additional factors around the death which mean a report of death to the coroner is necessary – for example where the cause is not clear, or where there are other relevant factors. This is set out in the Notification of Death Regulations 2019. There may also be cases where an otherwise natural causes death could be considered unnatural.

20. The aim of the system should be that every death from COVID-19 which does not in law require referral to the coroner should be dealt with via the MCCD process. On this matter the Chief Coroner and the National Medical Examiner are in full agreement."

5) How long will hearings be adjourned for?

The Guidance (which refers to Chief Coroner COVID-19 Note #3, circulated on 19 March 2020 but partially overtaken by events) states at [10] that it is likely that the coroner will hold some inquests (non-contentious Rule 23 hearings) over the coming months.

Any jury inquests that are due to start between 31 March and Friday 28 August of any significant length should be adjourned. Cases that are scheduled for 1 September onwards should generally remain in the list. [COVID-19 note #3, page 2]

No new jury trials should take place [according to the HMCTS, which overtakes the COVID-19 note #3, page 2]

Likewise any long or complex inquests not involving a jury, which require a large number of witnesses to attend in person, should be reviewed and may need to be adjourned. [COVID-19 note #3, page 2].

COVID-19 note #3 says that ongoing inquests, including jury inquests, should not automatically be abandoned, and less complex inquests and PIRHs listed to start between now and 31 March should generally proceed. It is unclear whether this has been overtaken by GN34, but in any event it is presumed that this would only be the case if:

- All relevant witnesses are able to attend remotely;
- All relevant witness are available (which they may not be, if they are medical staff, key workers or are suffering from COVID).
- The PIRH cannot be done on paper (see above)

It is advisable to check with the coroners' court as to whether the inquest is proceeding or not.

6) Will juries be required to sit for inquests involving COVID-19?

Not as a matter of course.

The Coroners and Justice Act 2009 ("CJA 2009") section 7 provides that a jury inquest is triggered where the senior coroner has reason to suspect (amongst other things) "*that the death was caused by a notifiable accident, poisoning or disease."*

On 6/3/2020 COVID-19 was designated a notifiable disease under the Health Protection (Notification) Regulations 2010 and would therefore in principle have triggered jury inquests in cases where the death was reported to the Coroner.

However, section 30 of the Coronavirus Act 2020 (which came into force on 25 March 2020) provides:

> *"30 Suspension of requirement to hold inquest with jury: England and Wales*
>
> *(1) For the purposes of section 7(2)(c) of the Coroners and Justice Act 2009 (requirement for inquest to be held with jury if senior coroner has reason to suspect death was caused by notifiable disease etc), COVID-19 is not a notifiable disease.*
>
> *(2) This section applies to an inquest that is opened while this section is in force (regardless of the date of the death)."*

See also the Explanatory Notes to the 2020 at p13 [67]-[70] and p42 [315]-[318] which can be found here.

It is important to note that the Coronavirus Act 2020 is not retrospective (GN36, page 3). Therefore, where the person died before 25 March 2020 and their inquest was opened before that date, there will need to be a jury, but not if the inquest was opened on 25 March or thereafter.

There may, however, be circumstances that do trigger the requirement for an inquest to be held with a jury, such as where the death occurs in custody and the deceased, whilst suffering from COVID-19, dies an unnatural death.

7) What happens to outstanding Prevention of Future Death reports?

GN34 [10] invites coroners to recognise the primary clinical commitments of medical professionals. As far as responses to existing PFD reports are concerned, it is suggested that *"Coroners may wish to proactively review outstanding PFD responses and write to some recipients, as they see appropriate, inviting an extension. However, there should be no blanket policy of extension for all PFD reports – many recipient organisations, individuals or businesses have nothing to do with the COVID-19 response and are continuing to work in as normal a way as possible."*

8) Can additional coroners be appointed to deal with any increased number of cases?

GN34 [11]-[15] sets out options for the appointment of additional assistant coroners, including re-appointment of retired assistants as well as new appointments (which may not be subject to open competition). GN34 [14] promises an update to senior coroners and local authorities in relation to *"a number of avenues"* being pursued "*to widen the pool of assistant coroners".*

9) How is COVID-19 likely to be recorded in the cause of death?

GN34 [19] states that *"COVID-19 is a naturally occurring disease and therefore is capable of being a natural cause of death."* Therefore, where an inquest is held and the cause of death is found to be COVID-19, box 4 on the record of inquest is likely to read *"natural causes"* (see the Record of an Inquest form attached to the Chief Coroner's Guidance Note No. 17).

10) What happens to non-COVID-19 deaths?

At present, deaths that are referred to the coroner are going through the usual processes, which can include investigation and inquests. However, coroners and coroners' officers are under severe pressures due to COVID-19 related deaths, their own illness or self-isolation, or their own care commitments. As such there are likely to be long delays, breaching the Chief Coroner's 12 month target for completing an inquest. This is recognised by the Chief Coroner [10].

11) What happens if there is a death in prison or otherwise in state detention?

Under s.1 CJA 2009 coroners are required to open an inquest into deaths in prison or otherwise in state detention, even if it is a natural death. Following *R (Tainton) v HM Senior Coroner for* Preston *and West Lancashire* [2016] EWHC 1396 (Admin) there is no need for a jury when the death is from natural causes. It will be necessary for the coroner to open an investigation but delay the inquest until the pandemic has passed ([38]-[41] and [23](ix)).

The Chief Coroner continues to keep these issues under constant review in a significantly altered –and rapidly changing – legal landscape. It would therefore be helpful to keep a close eye on the Chief Coroner's Guidance, Advice and Lawsheets website (https://www.judiciary.uk/related-offices-and-bodies/office-chief-coroner/guidance-law-sheets/coroners-guidance/) for further updates.

A Tribute to Sir John Laws

Matthew Flinn

As we in the legal profession struggle and strive to keep pace with all the legal developments and practical guidance being issued in response to Covid-19, it is vital not to lose sight of the tragic human cost it is exacting across the world. Families from all walks of life, from all parts of our community and all across the country are grieving the loss of loved ones. Recently, that includes the family of Sir John Laws.

Born on 10 May 1945 to parents who were both doctors, Sir John Grant McKenzie Laws studied at Exeter College, Oxford, before pursuing a career at the bar. After being appointed as a judge of the High Court in 1992, he served on the Court of Appeal between 1999 and his retirement from the bench in 2016.

Sir John was, quite simply, a jurist of uncommon ability, who left an indelible mark on the common law. He is rightly known for his contribution to the development and elucidation of the principles of constitutional and administrative law, through his judgments in now-famous cases such as *Thoburn v Sunderland City Council* [2002] EWHC 195 (Admin). He also had an enviable ability to capture profound insights with both economy and flare. Contributing to the Cambridge Law Journal in 2012, he wrote:

"Without democracy, law is the puppet of tyrants while, without law, democracy is mob rule."

Another of his celebrated judgments, this time in a medical context, is *R v Cambridge Health Authority, ex parte B (A Minor)* (1995) 25 BMLR 5. In that case, patient "B" was a ten-year-old girl who had suffered a relapse of acute myeloid leukaemia. A further 2-stage course of treatment had been proposed, but the chances of success at each stage were less than 20%, and it was considered to be "high risk" and "experimental" by the clinicians involved in her care. The cost of the treatment would be £15,000 for the first stage of chemotherapy, and if that was successful, a further £60,000 for a bone marrow transplant. The Health Authority refused to fund the treatment, without which the young patient had 6 - 8 weeks left to live.

When B's father brought judicial review proceedings to challenge the Health Authority's decision, Laws J found in his favour. He identified various errors in the Health Authority's decision, but most memorably, he held that *"where the question is whether the life of a 10 year old child might be saved by however slim a chance, the responsible authority... must do more than toll the bell of tight resources... it must explain the priorities that have led it to decline to fund the treatment".*

This stemmed from an analysis in which B's right to life, as protected under Article 2 of the European Convention on Human Rights, assumed central importance. Laws J held that where that right was to be interfered with in such a profound way, there had to be a clear justification on substantial public interest grounds:

"…certain rights, broadly those occupying a central place in the ECHR and obviously including the right to life, are not to be perceived merely as moral or political aspirations nor as enjoying a legal status only upon the international plane of this country's Convention obligations. They are to be vindicated as sharing with other principles the substance of the English common law."

This was of course before the Human Rights Act 1998, and so was in some respects ahead of its time. Indeed, his decision was overturned the very same day by the Court of Appeal. However, his bold judgment, in which he eloquently articulated a clear and principled basis for a decision that was clearly motivated by a strong sense of compassion, showed that at least in a human sense, even when he was wrong, he was right.

We are grateful for his immense contribution. He will be missed, but long celebrated, long cited and studied, and long remembered.

Note from the Editor: The Twitter account @CrimeGirl has been tweeting a list remembering solicitors, barristers and other professionals from the justice system who have lost their lives to COVID-19.

APPLICATION FOR ADJOURNMENT DUE TO COVID-19

Rajkiran Barhey

Re One Blackfriars Ltd (In Liquidation) [2020] EWHC 845 (Ch)

At a pre-trial review on 1 April 2020, the joint liquidators of One Blackfriars Ltd applied to adjourn a 5-week trial which was due to start on 8 June 2020. The Applicants argued that the adjournment was necessary due to the restrictions caused by the coronavirus pandemic.

The trial was due to involve 4 live witnesses and 13 expert witnesses. At the outset, it was noted that the earliest that the trial could be rescheduled for was early 2021. Furthermore, the Respondents did not agree that the adjournment was necessary.

The submissions

The submissions were best summarised by the judge at [11] to [12]. The Applicant submitted that:

"a. To proceed with the trial would be inconsistent with the Prime Minister's instruction to stay at home except for very limited purposes, issued on 23 March 2020, and more commonly referred to as the 'Lockdown'.

b. The trial, he submitted, cannot proceed without exposing participants and others working behind the scenes to an unacceptable risk to their health and safety.

c. The technological challenge posed by a five-week trial was too great. Such technology, as exists, he said, was untested.

d. There is a real risk of unfairness or potential unfairness in conducting a remote trial of this claim."

In response, the Respondent argued that:

"a. Far from being inconsistent with Government instructions, to proceed with the trial would be fully in accordance with both the primary legislation enacted in response to the COVID crisis and specific guidance given to the civil courts, both of which make clear that the appropriate response is to proceed with as many hearings as possible using video and remote technology.

b. A properly arranged remote trial could proceed without endangering the safety of the individual participants or the public.

c. The technology to conduct a fully remote trial is already available and has been successfully deployed already in some cases.

d. Whilst a remote trial will present challenges to all involved, it would not lead to unfairness.

e. The application was in any event premature because the parties have not yet had an opportunity to explore all of the remote technology options for a trial which, after all, is not scheduled to take place for another ten weeks."

Judgment

As to the Applicants' first argument, that to proceed with the trial would be inconsistent with government advice regarding the lockdown, the judge did not agree with the Applicants. He agreed with the Respondents that the tenor of the Coronavirus Act and the Coronavirus Regulations were that: "*the legislature is sending a very clear message that it expects the courts to continue to function so far as they able to do safely by means of the increased use of technology to facilitate remote trials."* [23].

He also referred to the message from the Lord Chief Justice to the judges of the Civil and Family Courts, the Remote Hearing Protocol, the further message from the Lord Chief Justice regarding court arrangements, Practice Direction 51Y and a decision of Teare J in *National Bank of Kazakhstan and Others v Bank of New York Mellon and Others* dated 19 March 2020. He concluded at [37] that:

"If a remote trial is ordered pursuant to Remote Hearings Protocol, then it seems to me that the Coronavirus Regulations permit, for example, a witness to travel to a solicitors' office or to any place equipped with a high-quality video link to give evidence, or for counsel to do the same thing to make submissions. The Coronavirus Regulations would also, in my judgment, permit an employee of a remote trial service provider to travel to any location (including a witness' home) to assist with the set-up and oversight of the operation of a remote trial technology."

As to the issue of safety, the judge noted that the pandemic was a fast-moving situation and much may change between the date of the judgment and that of trial, such that an adjournment was not yet justified. As to the risk that a remote hearing might pose to those participating who could be classed as vulnerable or had caring responsibilities, the judge noted that no evidence had been presented of any particular difficulties which participants might face and the parties had not yet ascertained whether those difficulties could be mitigated. In so far as difficulties existed, the judge expected the parties to co-operate to try and resolve these and propose solutions. Finally the judge noted that some aspects of preparation could be safely completed in the run-up to the trial which would need to be completed regardless of whether the trial was adjourned e.g. exchange of expert memoranda and agreeing the trial bundle.

As to the technological challenge, the judge noted that two trials had taken place since 16 March 2020. He concluded at [50] to [51] that:

"I am not satisfied, however, that the technological challenges which no doubt will be presented are so great as to make it appropriate to adjourn now. In my judgment, co-operation and planning is essential if a remote trial in this case is going to be possible, and that is why I have ordered the parties to co-operate in seeking potential remote trial platforms and document handling systems. In light of the comments by Birss J cited above I would expect any proposed system to subject to robust testing from as many of the locations from which participants are likely to be giving evidence (or making submissions) not only to ensure adequate video and audio quality but to ensure that documents can be displayed quickly. In particular, careful attention must be paid to the Internet bandwidth available at the locations from which witnesses intend to give evidence…my current view is that it may well be preferable for witnesses to travel to a few locations as close as possible to their home, such as solicitors' offices or other premises, with dedicated servers and IT staff on hand, rather than to dial in from home without any assistance. That also will alleviate the anxiety that many people suffer from, including judges, when it comes to the moment of being dialled into proceedings and to being interrupted in the course of the proceedings by unexpected household events."

As to fairness, the judge found that the challenges of a remote hearing would affect both sides equally, as they were equally well-resourced sophisticated parties.

Finally, as to the overriding objective, the judge noted that the litigation had been hanging over the Respondents' heads since 2011, and it would also not be in the Applicants' interests to delay matters.

Furthermore at paragraphs [56] to [57] he noted, "*I also take account of the fact that virtually every step in this administration was recorded, or appears to have been recorded, in a contemporaneous document…. There are no allegations of dishonesty or fraud. So whilst it is undoubtedly the case that both sides must have the opportunity to put contemporaneous documents to the factual and expert witnesses, it is not, it seems to me, a case in which it can be said that it is essential to have the witness, the cross-examiner and the judge and the other participants in the same physical space."*

Comment

This judgment, whilst not in the medical context, provides some guidance as to how the courts are approaching applications to adjourn trials. The clear message is that, where possible, trials ought to proceed. However, in some cases this may not be appropriate. For example, if there are large factual disputes between the parties or allegations of dishonesty or fraud, it may not be suitable.

In medical cases of any kind, there are likely to be other relevant considerations which do not apply in other cases. For example, witnesses who are medical professionals may not be able to make themselves available to give evidence. The judgment also highlights the importance of obtaining solid evidence of a participant's caring responsibilities or vulnerabilities and efforts taken to mitigate these before relying on this as a reason for adjournment.

A further, more recent decision, which may be of interest to readers is *Heineken Supply Chain BV v Anheuser-Busch Inbev SA (Rev 1)* [2020] EWHC 892 (Pat), considers an application to extend by two weeks the deadline for

reply evidence and to push back the trial start date to outside the trial window. Daniel Alexander QC, sitting as a Chancery Judge, refused the application.

At paragraph 28, the judge noted: *"In considering this issue, it is, however, necessary to bear in mind, particularly in current circumstances, that while lawyers are preparing expert evidence, some of their often much less well-remunerated compatriots may be putting themselves and their families at risk in saving lives, working long hours in inhospitable conditions. The guidance to which I have referred strongly suggests that, where it can be safely done and without risks to the integrity of the legal process, the wheels of justice should keep turning at their pre-crisis rate. It is not unreasonable to expect that lawyers concerned in keeping cases on track may need on occasion to push a little harder to enable that to be achieved. I also bear in mind that the nature of the proposed expert evidence is such that what may be lost in polish as a result of having fewer hours devoted to it by lawyers may be gained in raw authenticity, as well as the fact that a more limited time encourages confining the evidence to that which is truly essential."*

PRACTICE DIRECTION UPDATES, PROTOCOLS AND OTHER HELPFUL GUIDANCE

Rajkiran Barhey

In this section, we have aimed to set out, or provide links to, they key guidance documents, protocols and practice direction updates of which readers will want to be aware. We have focused on areas which we deem of most relevance to our readers. We have summarised some documents, simply copy and pasted others where necessary, and for others simply provided links if they are covered elsewhere in the publication.

The aim is to collate everything in one place in the hope that it may be helpful, although we appreciate it is somewhat unwieldy! If you consider it would be helpful to include any other documents, please do get in touch, our contact details are on the first page.

The main judiciary.uk page concerning COVID-19 is here.

The main judiciary page containing civil guidance is here.

Tribunals guidance is here.

The main HMCTS page is here. The main COVID-19 page is here.

HMCTS

HMCTS weekly operational summary on courts and tribunals during coronavirus (COVID-19) outbreak – as at 20 July 2020

- *Updated: The Lord Chancellor has announced locations for 10 'Nightingale Courts' which have been rapidly set up to tackle the impact of coronavirus on the justice system.*
- *As Government social distancing guidance is updated, we will continually assess how these measures are applied in our buildings and will only implement change to our measures when it is safe to do so. Anyone using our court and tribunal buildings should see no difference to existing safety, security or social distancing measures – any changes will be communicated and published in advance.*
- *Updated: The work of courts and tribunals was consolidated into fewer buildings at the beginning of the coronavirus outbreak, maintaining the safety of all in our buildings. From 17 July 2020, we are no longer publishing the tracker list as most of our courts and tribunals buildings are now open in line with public health advice. Find the current status and contact details of courts and tribunals using our court and tribunal finder service.*

- *The Kinly Cloud Video Platform (CVP) is being rolled out to Crown and magistrates' courts across England and Wales to support video enabled hearings. We are extending the availability of our new video platform to civil and family courts, to enable more remote cases to be heard safely and securely. For more info on joining telephone and video hearings please see our guide. We've also published information for legal practitioners who are involved in video enabled criminal hearings. If you require technical support for a telephone or video hearing can call 0330 8089405.*

- *Our Courts and Tribunals Service Centres will be available from 8am to 5pm Monday to Thursday and 8am to 4pm on Fridays until further notice. Courts and Tribunals Service Centre - advice on contacting HMCTS during coronavirus (PDF, 218KB, 5 pages).*

- *Welsh Language services available during the coronavirus outbreak. Welsh language services update (PDF, 131KB, 1 page).*

Civil court listing priorities: w/c Monday 20 July 2020

Introduction

1. *Listing is a judicial function.*
2. *All applications/hearings/trials should be considered in advance by a judge in order for the judge to decide*
1. *whether it should be listed for hearing and to give all necessary directions.*
2. *The decision as to whether or not the application/hearing/trial should take place at all, and if so, whether it should be partly or fully remote (in view of the continuing Covid-19 crisis), or whether there should be a physical hearing in court, are all matters for the judge.*
3. *When making such decisions, judges will consider carefully whether suitable practical arrangements can be made to ensure the application/hearing/trial can take place safely. This will involve consideration of a variety of factors including the type of case, the venue (i.e. whether there are suitable court buildings and court rooms available where proper social distancing can take place), the length of any trial, and (if relevant) the number of witness, the available witness handling facilities and available technology.*
4. *It will therefore often be appropriate specifically to list cases for triage to consider:*
    (a) whether in principle the application/hearing/trial should be listed; and
    (b) whether in practice all arrangements can be made to enable it to take place safely.

Priority 1 – work that must be done

- *Injunctions…*

- *Any applications in cases listed for trial in the next three months*

- *Any applications where there is a substantial hearing listed in the next month.*

- *All Multi Track hearings (including trials) which the judge considers to be i) urgent and ii) suitable for hearing (either remotely or in a physical hearing).*

- *Appeals in all these cases*

Other Work Which Should Be Done

All other applications/hearings/trials which (subject to staff support and listing capacity) the judge considers i) should be heard and ii) suitable for hearing (either remotely or in a physical hearing).

HMCTS telephone and video hearings during coronavirus outbreak - *Information about how HMCTS will use telephone and video technology during the coronavirus (COVID-19) outbreak.*

Remote Hearings Protocol – dated 26 March 2020 (supersedes the version issued on 20 March 2020)

The Royal Courts of Justice Operational Update – 20 July 2020

Coronavirus – Information for Queen's Bench Division Court Users:

1. Bulletin 1 – appears to be largely superseded.
2. Bulletin 2 – information regarding hearings, documents, e-bundles.
3. Bulletin 3 – concerns PD updates.
4. Bulletin 4 – concerns Court Funds Office.
5. Concerns interim applications.
6. Bulletin 5 – concerns foreign courts only
7. Bulletin 6 – concerns possession claims against trespassers.
8. Bulletin 7 – concerns taking control of goods and certification of enforcement agents.
9. **Bulletin 8 – proceedings before Queen's Bench Masters from 15 June 2020. Likely to be of use to many readers.**
10. Bulletin 9 – concerns extensions of stays on enforcement proceedings.

Coroners' Courts

Guidance Note 34 – Chief Coroner's Guidance for coroners on Covid-19 – 26 March 2020

Guidance Note 35 – Hearings during the pandemic – 27 March 2020

Guidance Note 36 – Summary of the Coronavirus Act 2020 – Provisions Relevant to Coroners

Guidance Note 37 – COVID-19 deaths and possible exposure in the workplace - Amended

Guidance Note 38 – Remote participation

Guidance Note 39 – Recovery from the COVID-19 pandemic

Chief Coroner COVID-19 Note #3

Revised Notification of Deaths Regulations 2019 guidance

"*This guidance to medical practitioners on notifying deaths to the coroner is an amended version of previous guidance to reflect the temporary changes made by the Coronavirus Act 2020."*

Practice Directions

Practice Direction 51ZA – Extension of time-limits and clarification of practice direction 51Y - Coronavirus – 1 April 2020

This PD is effective from 2 April 2020 and ceases to have effect on 30 October 2020.

Paragraph 2 of the PD amends Rule 3.8, replacing the reference to 28 days to 56 days. The amended Rule 3.8 will therefore read:

(4) In the circumstances referred to in paragraph (3) and unless the court orders otherwise, the time for doing the act in question may be extended by prior written agreement of the parties for up to a maximum of 56 days, provided always that any such extension does not put at risk any hearing date. [emphasis added].

Paragraph 3 confirms that, for an extension longer than 56 days, parties must make an application which will be considered initially on paper and then, where relevant, reconsidered at a hearing.

Paragraph 4 provides that: "*In so far as compatible with the proper administration of justice, the court will take into account the impact of the COVID-19 pandemic when considering applications for the extension of time for compliance with directions, the adjournment of hearings, and applications for relief from sanctions."*

Comment

The Practice Direction will be welcomed by most practitioners, however undoubtedly many will feel that it does not go far enough. Prior to the issuance of PD 51ZA, an open letter, produced by Gordon Exall of the Civil Litigation Blog, called on the Rules Committee to permit parties to agree open-ended extensions of time, not least to avoid the courts from being clogged up with applications for extensions of time and/or relief from sanctions for months, or even years, to come. Readers may also be interested to know that the new PD follows allegedly the 'first COVID-19 direction' in which Master Davison granted permission to parties in a high value brain injury case to agree extensions of up to 56 days by consent without further order. It is not possible to know how the situation will develop further and whether any further changes will be made. One can only wait and see.

In practical terms, when considering paragraph 4 of PD 51ZA, parties ought to be ready to explain why COVID-19 has led to the application in question. For example, if it has not been possible to obtain witness statements from treating clinicians, a judge may want more information than simply stating the fact of the pandemic. This is particularly so where the connection to COVID-19 is not obvious e.g. if the treating clinician is a psychiatrist or a maxillofacial surgeon. It may be the case that there has been a significant knock on effect in the hospital leading to unavailability, or clinicians have been redeployed, or they have self-isolated. Parties ought to be ready to provide a context specific explanation of how COVID-19 has impacted on the case, and should not assume that judges will wave through extensions. They may, or they may not – we do not yet know - but it is better to be safe than sorry and collect as much information as possible.

Practice Direction 51Y – Video or Audio Hearings during Coronavirus Pandemic - dated 24 March 2020

This Practice Direction came into force on the day after it was approved and remains in force until the Coronavirus Act ceases to have effect.

The second paragraph of PD 51Y provides that, where the court directs that a hearing is to take place using video or audio technology, and it is not practicable for the hearing to be broadcasted in a court building, the court may direct that the hearing must take place in private where it is necessary to do so to secure the proper administration of justice.

The third paragraph states that if a media representative is able to access proceedings remotely while they are taking place, they will be public proceedings. In this situation, it will not be necessary to make an order under paragraph 2 and such an order may not be made.

Paragraph 4 provides that a hearing held in private under paragraph 2 must be recorded, where that is practicable, in a manner directed by the court. Where authorised under s.32 of the Crime and Courts Act 2013 or s.85A of the Courts Act 2003 (as inserted by the Coronavirus Act 2020), the court may direct the hearing to be video recorded, otherwise the hearing must be audio recorded. On the application [read 'request'] of any person, any recording so made is to be accessed in a court building, with the consent of the court.

Section 32 of the Crime and Courts Act 2013 enables the making, and use, of films and other recordings of proceedings, lifting (in part) the pre-existing absolute prohibition on photographs and recordings in court. The new Coronavirus Act 2020 inserted Section 85A of the Courts Act 2003. This provides that if the court directs that proceedings are to be conducted wholly as either audio or video proceedings, the court may direct that the proceedings are to be broadcast for the purposes of enabling the public to see and hear the proceedings or may direct that the proceedings be recorded for the purposes of keeping a record.

Comment

The judiciary.gov website confirms that this PD sits alongside the rules in Part 39, which permits hearings to be held in private in very limited circumstances. Therefore, a court may direct that a hearing is held in private either on the bases in CPR 39.2, or on the basis set out in the new Practice Direction.

Furthermore, the reference to 'application' in Paragraph 4 is to be read as 'request' and parties are not required to make a formal application under Part 23. This is clarified in Practice Direction 51ZA (above).

The purpose of this Practice Direction is to balance the need to ensure hearings can continue to go ahead, despite being in private, and also ensuring open justice. Early reports from journalists have reported reasonable success in accessing hearings remotely, albeit with some teething problems.

The speed at which the courts have managed to adapt to video/audio hearings has surprised many practitioners and commentators alike, and begs the question of whether the current situation will become the norm, once restrictions are lifted. It remains to be seen. Whilst many would welcome greater use of video/audio technology, particularly for case management and procedural hearings, it is essential to remember the potential challenges this may pose to open justice and legal journalism.

Guidance from professional bodies, associations, etc.

The Personal Injuries Bar Association (PIBA) is collating COVID-19 guidance here.

The Association of Personal Injury Lawyers (APIL) and the Forum of Insurance Lawyers (FOIL) have agreed a set of best practices which they recommend members adopt.

The APIL Coronavirus page is here.

The Inns of Court College of Advocacy has published its *Principles of Remote Advocacy* here.

The latest Bar Council updates are here.

BSB updates are posted here. The equivalent SRA page is here.

The Law Society is providing information here.

1COR Information For Clients

COVID-19 Outbreak – Information for Clients

The following information provides outline guidance on Chambers' current position with respect to COVID-19. If you have a question that is not covered below please do not hesitate to contact our clerks using the contact information below.

Chambers' absolute priority remains the safeguarding of the health and wellbeing of clients, staff, Members and the wider community. We can achieve these objectives at the same time as maintaining services to clients because all our telephone and IT systems are cloud-based. Thus, our phones and all our IT systems operate exactly as they would in Chambers even though staff and Members are working from home - unless physical attendance at Chambers is absolutely necessary.

To assist us in minimising social interaction, please send us papers in digital form rather than hardcopy (as far as possible) and arrange for conferences to happen virtually (by phone or video-conference) rather than in-person.

1COR is working with the judiciary to ensure hearings will continue to take place. All Members and clerks have access to Microsoft Teams and other conferencing platforms to enable meetings, hearings and training sessions go ahead as planned.

If you wish to contact us for any reason please do so via our clerks using the following contact details.If you wish to contact us for any reason please do so via our clerks using the following contact details.

To instruct us, confirm tele-conference details, rearrange current appointments or discuss anything, please contact our clerks on 020 7797 7500 or via london@1cor.com.

Our clerks are contactable as usual **for emergency assistance** outside normal business hours on: 07885 745450.

For marketing matters (such as events) please contact our Marketing Manager Olivia Kaplan. Keep up to date with our podcast Law Pod UK, Quarterly Medical Law Review (QMLR) and UK Human Rights Blog.

If you have any concerns at all about our service which cannot be addressed by our clerks, please do not hesitate to email our Chambers Director via andrew.meyler@1cor.com.

NEWS & EVENTS

Further news and events information can be found on our website. On 24th September Richard Booth QC joins a panel of 7 clinical negligence silks for an afternoon clinical negligence conference to raise funds for The Lee Spark Necrotising Fasciitis Foundation.

Law Pod UK - Podcast

There are a number of episodes concerning the COVID-19 pandemic which can be found here.

UK Human Rights Blog

There are a number of interesting pieces relating to COVID-19 on the UK Human Rights Blog.

Letters to the Editor

Feel free to contact the team at medlaw@1cor.com with comments or queries.

Previous issues can be found on our website under News & Events > Newsletter.

You can also follow us on Twitter @1corQMLR for updates.

EDITORIAL TEAM

Rajkiran Barhey (Call: 2017) – Editor-in-Chief

Rajkiran accepts instructions in all areas of Chambers' work and is developing a broad practice, particularly in clinical negligence, personal injury, inquests and public law and human rights. Kiran joined Chambers as a tenant in September 2018 following successful completion of a 12-month pupillage. She is currently instructed by the Grenfell Tower Inquiry and has recently undertaken a secondment at a leading clinical negligence law firm.

Jeremy Hyam QC (Call: 1995, QC: 2016) – Editorial Team

Jeremy is a specialist in clinical negligence, administrative and public law, inquests, public inquiries, and professional regulatory work. He has particular experience in all aspects of health law and has appeared in a number of leading cases in the field at all levels including in the Supreme Court and Privy Council.

Shaheen Rahman QC (Call 1996, QC: 2017) – Editorial Team

Shaheen Rahman QC specialises in public law, clinical negligence and professional discipline. Recognised by the legal directories as a leading practitioner in multiple areas, she is instructed in complex and high value clinical negligence matters including catastrophic brain injury cases, has particular expertise in judicial review challenges to healthcare funding decisions, appears at inquests involving detained or otherwise vulnerable patients and acts for healthcare professionals in regulatory and MHPS proceedings.

Suzanne Lambert (Call: 2002) – Editorial Team

Suzanne has a broad practice, with a particular focus on healthcare/medical law. She has experience mainly in clinical negligence and inquests, but also in disciplinary law and judicial review. Suzanne is instructed by claimants and defendants in a wide variety of cases involving serious and catastrophic injuries e.g. cerebral palsy, spinal injuries, loss of fertility, and delayed diagnosis of cancer. She has experience with complex legal issues such as contributory negligence, apportionment between defendants, and consent.

Matthew Flinn (Call: 2010) – Editorial Team

Matt's practice spans all areas of Chambers' work, including clinical negligence, personal injury, public law and human rights. He is developing particular expertise in inquests, and clinical and dental negligence claims, acting for both claimants and defendants. He undertakes a wide range of advisory and court work. He also has experience in information law and has advised in private litigation stemming from the Data Protection Act 1998.

Dominic Ruck Keene (Call: 2012) – Editorial Team

Dominic has considerable experience of acting in clinical negligence claims for both claimants and defendants: drafting pleadings, advising on merits, quantum and settlement; successfully representing parties at RTMs and at mediation; as well as appearing in case management hearings, application hearings, and at trial in both the county and High Courts. As a result of his background in the Army, Dominic has a particular interest and expertise in all nature of cases involving service personnel and National Security. He is on the Attorney General's C Panel.

CONTRIBUTORS

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Richard Mumford's healthcare work is focused on claims relating to medical accidents of all descriptions (including product liability claims arising from medical devices) but also encompasses regulatory proceedings and contractual claims relating to the provision of healthcare and related services.

In addition, Richard regularly deals with personal injury claims ranging from serious road traffic injury and industrial injuries to physical and sexual abuse. Richard also advises and represents clients in relation to costs arising from litigation.

Caroline Cross (Call: 2006) – Contributor

Caroline Cross has a diverse civil and public law practice with particular interests in inquests, human rights, clinical negligence, mental health and personal injury. She represents both claimants and defendants.

She is Assistant Coroner for Southwark.

Gideon Barth (Call: 2015) – Contributor

Gideon has a busy practice spanning all areas of Chambers' work including clinical negligence and personal injury, public and human rights law, inquests and public inquiries, and tax.

Before coming to the Bar, Gideon obtained a First Class degree from Cambridge University where he read History, before achieving a distinction on the GDL.

Darragh Coffey (Call: 2018) – Contributor

Darragh Coffey accepts instructions in all areas of Chambers' work and is working to develop a broad practice. He appears in courts and tribunals on behalf of both Claimants and Defendants in a range of civil hearings.

Before to coming to the Bar, Darragh spent four years at the University of Cambridge where he is pursuing a Ph.D. in the area of human rights law. Prior to that, he served for six years as an Army Officer in the Irish Defence Forces.