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Citation for published version:

Laurie, G & Hunter, KG 2009, 'Mapping, Assessing and Improving Legal Preparedness for Pandemic Flu in the United Kingdom', *Medical Law International*, vol. 10, no. 2, pp. 101-138.
<https://doi.org/10.1177/096853320901000202>

Digital Object Identifier (DOI):

[10.1177/096853320901000202](https://doi.org/10.1177/096853320901000202)

Link:

[Link to publication record in Edinburgh Research Explorer](#)

Document Version:

Early version, also known as pre-print

Published In:

Medical Law International

Publisher Rights Statement:

© Laurie, G., & Hunter, K. G. (2009). Mapping, Assessing and Improving Legal Preparedness for Pandemic Flu in the United Kingdom. *Medical Law International*, 10(2), 101-138. 10.1177/096853320901000202

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MAPPING, ASSESSING AND IMPROVING LEGAL PREPAREDNESS FOR PANDEMIC FLU IN THE UNITED KINGDOM

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ABSTRACT

On 11 June 2009 the World Health Organisation declared the first flu pandemic for 41 years. This article assesses the legal framework within which responses are deployed in the face of such a pandemic or some other public health emergency in the United Kingdom. It begins with an account of the importance of legal preparedness as an essential feature of public health preparedness. It moves to an outline of the key legal provisions and parameters which provide the architecture for the existing framework in the UK, both domestically and internationally; thereafter, it identifies relevant factors that can be used to assess the efficacy of current legal preparedness, drawing on comparative experiences. Finally, it offers recommendations on how legal preparedness could be improved within the United Kingdom and in line with international obligations.

1. INTRODUCTION

On 11 June 2009 the World Health Organisation declared the first flu pandemic for 41 years. This announcement came only two months after the first cases of N1H1 flu were identified in Mexico, leaving authorities around the world with precious little time to prepare for pandemic.¹ While it would seem for now that this particular pandemic is relatively mild, its advent poses serious questions about global preparedness presently and in the future. This article is concerned with the importance of legal preparedness as an essential feature of public health preparedness more generally.

Law is merely a social tool, but it is a tool of considerable import. This is never truer than when society, its fabric, foundations and core values are under threat. Public health crises represent such a threat and at such times the role of law becomes crucial in maintaining the delicate balance between order and chaos, between public and private interests, and between promotion of the common good and protection of civil liberties.

Law can create not only powers to act, but also responsibilities to respond, obligations to communicate, authority to intervene, formality of hierarchies of response, clarity of lines of accountability, and mechanisms for resolution of conflicts when they arise. Public health emergencies require rapid, complex, multi-agency and multiple agent actions, as well as multi-layered-readiness at four stages in any public health emergency, being: (1) preparation, (2) response (3) protection and (4) recovery. Lack of clarity of law, or lack of clarity about legal rights and responsibilities, can seriously hinder or impede effective responses to public health emergencies.²

A recent Summit held in the United States on the National Action Agenda for Public Health Legal Preparedness pointed out that:

Summit participants concluded that, although there are barriers to co-ordination in the application of law-based measures during emergency responses, as well as gaps in both authority and implementation, these shortcomings are, or can be, addressed. To progress further in strengthening this element of public health legal preparedness, however, it will be paramount to add and engage multiple relevant sectors at all levels in planning, reviewing legal authorities and exercising those authorities necessary for co-ordinated responses to public

health emergencies. Finally, the development of familiarity and trust among sector partners must be a key part of the planning and implementation of co-ordinated, law-based responses to public health emergencies.³

As one commentator at the Summit put it:

...when it comes to pandemics, any community that fails to prepare – expecting that federal government can or will offer a lifeline – will be tragically wrong. Leadership must come from governors, mayors, county commissioners, pastors, school principals, corporate planners, the entire medical community, individuals and families.⁴

This suggests that there is a risk in over-centralisation of response mechanisms to public health emergencies. The threats are manifold, potentially affecting communication, co-ordination and contingency planning. It is against this backdrop that we consider the current legal approach in the United Kingdom. We should be clear that our concern is not the specific policies or politics of government departments or agencies charged with the task of responding to a public health emergency, nor any specific measures which have been instituted since the detection of H1N1 in Britain; rather we are concerned with the key legal provisions and parameters within which responses take place. Furthermore, while our focus is on England and Wales, we flag differences with Scotland and Northern Ireland where relevant. Finally, while we recognise that there has been much recent activity within government, including a planned review of legislation and consultations on emergency response and recovery, our concern is with how to map and assess the effectiveness of legal preparedness both now and in the future.

2. CURRENT FRAMEWORK ON LEGAL PREPAREDNESS

a. International dimension: WHO International Health Regulations 2005 (IHRs)

Although the declaration of H1N1 as the first flu pandemic since 1968 has hit the headlines hard and raised public awareness considerably, the outbreak of SARS in 2003 had already demonstrated how rapidly a new disease can spread in an interconnected world. It also signalled the ‘need for collective defences and for shared responsibility’ in defending against new global threats to public health.⁵ The experiences of the World Health Organisation (WHO) in monitoring and co-ordinating responses to SARS and other Avian flu outbreaks fed directly into the revision of the International Health Regulations (IHRs).⁶ Essentially unchanged since 1969,⁷ the 2005 version entered into force on 15 June 2007.⁸

The purpose and scope of the Regulations, which are binding on all States Parties, ‘are to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade’ (Article 2). The IHRs (2005) establish ‘an agreed framework of commitments and responsibilities for States and for WHO to invest in limiting the international spread of epidemics and other public health emergencies while minimizing disruption to travel, trade and economies’.⁹

The new Regulations provide a framework for surveillance and response to international emergencies. In particular, the regulations require States Parties to (i) develop, strengthen and maintain detection, assessment, notification and reporting capacity (Article 5 – Surveillance); (ii) notify the WHO of all events which may constitute a public health emergency of international concern within its territory (Article 6 – Notification); (iii) provide WHO with all relevant health information if the State Party has evidence of an unexpected or

unusual public health emergency of international concern, irrespective of its origin or source (Article 7 – Information Sharing).

The regulations also provide that the WHO may make recommendations of appropriate health measures to states parties. Under Article 18 these include requiring medical examinations; quarantine or other health measures for suspect persons; isolation and treatment where necessary of affected persons; refusing entry of suspect or affected persons; refusing entry of unaffected persons to affected areas; exit screening. Notwithstanding, Article 43(1) provides that:

These regulations shall not preclude States Parties from implementing health measures, in accordance with their national law and obligations under international law, in response to specific public health risks or public health emergencies of international concern, which: (a) achieve the same or greater level of health protection than WHO recommendations; or (b) are otherwise prohibited...provided such measures are otherwise consistent with these regulations.

Such measures shall not be more restrictive of international traffic and not more invasive or intrusive to persons than reasonably available alternatives that would achieve the appropriate level of health protection.

Article 1 of the regulations defines a ‘public health emergency of international concern’ as ‘an extraordinary event which is determined, as provided in these Regulations: (i) to constitute a public health risk to other States through the international spread of disease, and (ii) to potentially require a coordinated international response’. A ‘public health risk’ means ‘a likelihood of an event that may affect adversely the health of human populations, with an emphasis on one which may spread internationally or may present a serious and direct danger’.

The Director-General of the WHO will determine on the basis of information received whether an event constitutes a public health emergency of international concern (Article 12). In making the determination, the Director General will rely, in particular, on information from the State Party within whose territory an event is occurring which may constitute a public health emergency of international concern. Under Article 6 of the Regulations, a State Party is required to notify the WHO within 24 hours of assessment whether ‘events occurring within its territory... may constitute a public health emergency of international concern’. The assessment criteria are contained in a decision instrument in Annex 2 to the Regulations. States Parties must consider four criteria in assessing whether an event may constitute a health emergency of international concern: (1) Is the public health impact of the event serious? (eg. event caused by a pathogen with high potential to cause an epidemic); (2) Is the event unusual or serious? (3) Is there a significant risk of international spread? and (4) Is there a significant risk of international trade or travel restrictions?

It is here that the limitations of the international response mechanisms become apparent, for (a) the lack of capacity of a country to assess and report accurately on emerging risks, and (b) the lack of sanction mechanisms within the international framework to require compliance.¹⁰ And, while WHO can assist a country in its surveillance and response if requested (Article 44), the real problem of dealing with an aberrant state remains.¹¹ Compliance with, and enforcement of, international obligations among states is a notoriously difficult and lengthy affair, and recourse to attempts to enforce these international regulations are hardly a suitable mechanism in the highly time-sensitive circumstances of a public health emergency.¹²

The matter is further complicated by Article 57.3 of the IHRs 2005, which provides that ‘States Parties that are members of a regional economic integration organisation shall apply in their mutual relations the common rules in force in that regional organisation’; this

provision is without prejudice to the obligations of States Parties under the IHRs 2005. Since all members of the EU are also members of the WHO, this Article has obvious implications for EU countries. As Simon and Goodwin explain:

This means that all EU countries have to respect the IHR as single members of the WHO and not as part of the EU, as the EU is not a member itself (even if its role as a regional economic integration organization is recognized in IHR). However, exclusive competence for some relevant policy areas rests with the Community. For example, if the WHO were to recommend states refuse entry or departure for certain goods under the IHR, the EU would have to act collectively, at the initiation of the Commission, as EU single market legislation prevents MS from taking unilateral action (e.g. on bans on movements of poultry products following an avian influenza outbreak).¹³

These regional complexities aside, and while acknowledging that the WHO and the IHRs may play an important role in surveillance and reporting of pandemics, and in providing a framework for tackling the pandemic,¹⁴ effective action must begin and end at the state level.¹⁵

This having been said, there is additional international consensus on the importance and content of social and ethical principles which should guide state and international action in these matters. It is important to consider these before addressing the specific framework operating in the UK.

b. Ethical principles and their relevance

Several international documents¹⁶ point to the importance of ethical principles in framing, developing and implementing public health responses to disease emergencies. Central among these are the Siracusa Principles, which reflect the provisions of Article 3 of the IHRs and other international human rights instruments in that all measures must be with full respect for dignity, human rights and the fundamental freedom of persons.

The *Siracusa Principles* require that state actions that limit human rights and freedoms must be:

- in accordance with the law;
- based on a legitimate objective;
- strictly necessary in a democratic society;
- the least restrictive and intrusive means available; and
- not arbitrary, unreasonable or discriminatory.¹⁷

At the UK domestic level, the Department of Health and the Cabinet Office have issued an Ethical Framework for Policy and Planning when responding to pandemic influenza. There is also a Committee on Ethical Aspects of Pandemic Influenza, which has pointed to the possibility of a legal colloquium “to address uncertainty within the health service about the legal framework that would exist in a pandemic, in relation to clinical decision-making”.¹⁸ In terms of ethical issues, the Framework identifies eight (8) principles to assist in decision-making, and which can serve as a check list to help ensure that the full range of ethical considerations have been taken into account. The Framework makes clear that there is no hierarchy of principles or values, nor are there necessarily any absolute right answers; the objective is, rather, to assist processes of decision-making and policy development.¹⁹ The principles are: respect, minimising harm, fairness, working together, reciprocity;

proportionality, flexibility, and the principle of good decision-making (which itself includes: openness, transparency, inclusiveness, accountability, reasonableness).

The guidance ‘is not designed to address individual clinical decision-making’, although ‘clinicians and members of the public who want to think about the ethical implications of their own behaviour during a pandemic are welcome to use it for that purpose’.²⁰ It is recommended that ‘[a]ppropriate records... be kept of decisions taken and the justification for them. This is important for accountability, but such records can also help people learn from experience in order to respond to further pandemic waves, or to a different pandemic in future.’²¹

The Nuffield Council on Bioethics has, in turn, pointed to the importance of precaution and proportionality when dealing with threats to public health.²² It has highlighted a European Commission Communication on the precautionary principle, which identifies five (5) elements for consideration: (a) scientific assessment of risk, acknowledging uncertainties and updated in light of new evidence; (b) fairness and consistency; (c) consideration of costs and benefits of actions; (d) transparency; (e) proportionality.²³ The Council prefers the term ‘precautionary approach’ and, in so doing, reflects the Department of Health Framework in suggesting that no one principle or consideration should have a trumping effect.

The value of these instruments lies in both their procedural and substantive contribution to decision-making processes. As we will see below, while there is a plethora of legal provision surrounding public health, this is not met in equal measure with consideration of how measures are to be implemented and monitored on the ground in order to maintain the fine balance that is at stake whenever a public health emergency grips us. Legal preparedness is not merely about knowing the rules and who is in charge; it is as much, if not more, about ensuring that difficult decisions are taken in keeping with the ethical, social, cultural²⁴ and moral values of our society which our laws are designed to embody and reflect. Ethical instruments such as those discussed above provide both a vocabulary as well as a tool-kit with which to tackle difficult decision-making and responses in a public health emergency. Their impact can go far beyond the rhetorical provided that – as we suggest below – they are mobilised effectively and with sufficient foresight when considering how legal provisions will be deployed when an emergency occurs.

c. National legal provisions and their scope

The Civil Contingencies Act 2004 repeals previous civil defence and emergency powers legislation²⁵ and replaces these with ‘modernised’ legislation which reflects the kinds of emergencies the UK now potentially faces (eg. terrorist threats, threats to the environment, and threats to public health such as pandemics). It is now the key piece of legislation that will govern legal authority to act in a ‘true’ emergency situation. It is crucial to note, however, that it is to be used as a mechanism to create emergency powers only as a last resort and only when existing legislation is insufficient to respond to the situation in an effective way.²⁶ Indeed, the consultation paper – Update of Emergency Response and Recovery (non-statutory guidance), which closed in April 2009,²⁷ attempts to make clear that: ‘There must be no expectation that the Government will agree to use emergency powers and planning and response arrangements should assume that they will not be used.’²⁸ For planning purposes, the Cabinet Office and Department of Health have said that ‘the presumption should be that the Government will rely on voluntary compliance with national advice and that it is unlikely to invoke emergency or compulsory powers unless they become necessary, in which case the least restrictive measures that are likely to achieve the objective will be applied first’.²⁹ We would hope that this will indeed be the case and our concern is not with the burgeoning planning and response arrangements *per se*, save to the extent that they deal with the law and

the legal parameters within which they are to be deployed. Those parameters necessarily include the Civil Contingencies Act 2004 and, given our key message here that it is essential to ensure legal preparedness for *all stages* of an emergency, it provides a focus for discussion.

As a further qualification, we note that there are many legislative routes through which responses to an emergency situation might be channelled; indeed, the Civil Contingencies Secretariat has initiated a ‘Better Fit with Other Legislation’ project as part of its CCA Enhancement Programme.³⁰ This might include, for example, Regulations on Control of Major Accidents, Radiation and other hazard-specific regimes. Our concern, however, is with pandemic flu and, specifically, with the respective rights and obligations involved as a matter of law. For this reason, and for reasons of space, we focus our discussion further on the interplay between the CCA and the *Health and Social Care Act 2008* – concerned with public health powers relating to infectious disease - not least for the potentially serious implications for civil liberties which might be involved.

Public health powers with regard to infectious disease in England and Wales have been found largely unchanged until very recently in the Public Health (Infectious Diseases) Act 1984 (together with the Public Health (Infectious Diseases) Regulations 1988).³¹ The Act provided for certain powers, including powers of detention and isolation, in relation to certain diseases specified in Schedule 1 to the Regulations. More specifically, this included powers for a local authority to seek orders from a Justice of the Peace requiring a person or group of persons to be medically examined, and for a person to be removed to or detained in hospital if there was reason to believe that they are or have been suffering from a ‘notifiable disease’ or, if not suffering from the disease, is carrying an organism capable of causing it. Other powers allowed a local authority proper officer (or equivalents) to request that a person not attend work, with a view to preventing the spread of infection; to require a child who has been exposed to infection not to attend school; and to place restrictions on children’s places of entertainment. The legislation created criminal offences where people exposed others to the risk of infection, and contained some powers to require the provision of information to help control the spread of disease. Most notably, however, there were no detention powers under the legislation in relation to ‘emerging diseases’ such as SARS and avian flu.³²

The Public Health Act has been subject to extensive review (see: www.dh.gov.uk) and Part 2 has now been superseded by Part 2A as detailed in the *Health and Social Care Act 2008* (passed on 21 July 2008). Furthermore, and at the time of writing, a consultation is running which proposes that much of the detail of the new legislation will be in the form of regulations;³³ three specific examples are laid out with respect to notifiable diseases (to include human influenza), protection measures for those subject to a Justice of the Peace Order (see further below), and regulations on local authority powers.

The robustness of such measures as to legal preparedness thus remains open to debate; a separate question is to ask how effective they or any new regulations might be in order to avoid recourse to the CCA.

Health and Social Care Act 2008

Section 129 of the *Health and Social Care Act 2008* inserts new sections 45A to 45T to the *Public Health (Control of Diseases) Act 1984*. Sections 45B and 45C confer powers on the Secretary of State to make provision by Regulations with respect to health protection measures for international travel and domestic affairs respectively. Provisions can be made both with respect to requiring action from professionals and authorities in the face of a public health threat and with respect to members of the public, their behaviour and their rights.

In terms of international travel, Regulations can relate to preventing danger to public health from vessels arriving or leaving any place in England and Wales to prevent the spread of infection or contamination. They can include provision for medical examination, and detention, isolation and quarantine of persons; provision of information from those persons, and the inspection, retention or destruction of things (ss.45B(1) and (2)).

As to domestic matters, Regulations can impose duties on registered medical practitioners and others to record and notify (suspected) cases of infection or contamination, as well as conferring functions on local authorities and others in relation to monitoring public health risks (s.45C(4)).

As to the effect on members of the English and Welsh public, Regulations can impose restrictions or requirements in relation to persons, things or premises in the event of or in response to a threat to public health (s.45C(3)(c)). In particular, this can include a requirement that a child be kept away from school, and a prohibition or restriction on the holding of an event or gathering (s.45C(4)). Regulations can also include provision for imposing 'a special restriction or requirement' as set out in Sections 45G(2)(e)-(k), 45H(2), and 45I(2). These include, among other things, that a person be disinfected or decontaminated; that a person wear protective clothing; that a person's health be monitored and the results reported; that a 'thing' be seized or retained, or be kept in isolation or quarantine; or that a premises be closed, decontaminated, or destroyed. Pursuant to section 45D(3), however, and unlike the powers in relation to international travel, domestic Regulations may not require that a person (i) submit to a medical examination; (ii) be removed to a hospital or other suitable establishment; (iii) be detained in a hospital or other suitable establishment, or (iv) be kept in isolation or quarantine. Such measures may be imposed only by an Order from a Justice of the Peace on application from a Local Authority. These Orders are known as Part 2A Orders and are enforceable by criminal prosecution (s.45O(1) and (2)).

Orders (like Regulations) can also extend to requirements that persons be disinfected or decontaminated, provide information on their health or other circumstances, be subject to monitoring and reporting, be subject to restrictions on where they go or with whom they have contact, and/or that they abstain from working or trading. In relation to things, an Order (like a Regulation) may provide that the thing be seized or retained, kept in isolation or quarantine, be disinfected or decontaminated, destroyed or disposed of (s.45H). Orders may also be made in relation to groups of persons, things or premises (s.45J). If a Justice of the Peace considers it 'necessary', Part 2A Orders may be made without notice (s.45M). Whether in the case of persons or things, the Justice may only make an Order if satisfied that (i) the person or thing is infected or contaminated; (ii) the infection or contamination presents or could present significant harm to human health; (iii) there is a risk of infection or contamination to (other) humans; and (iv) it is necessary to make the order to remove or reduce the risk (s.45G(3) and s.45H(1)). We comment on these parameters presently.

In a similar fashion to Orders, Regulations imposing a special restriction or requirement are only lawful in response to a serious and imminent threat to public health or if their imposition is expressed to be contingent on their being such a threat at the time when imposed. Health protection Regulations may create criminal offences but not such that are punishable with imprisonment or a fine exceeding £20,000 (s.45F(5)).

Measures exist for Parliamentary scrutiny of Regulations, either by means of affirmative resolution or annulment by negative resolution, although prior Parliamentary approval is not necessary if the person making the instrument is of the opinion that, by reason of urgency, it is necessary to make the order without a draft having been laid and approved. This, however, is subject to annulment after 28 days, unless it is approved by each House of Parliament for England or the National Assembly for Wales (s.45R).

Whereas the old legislation raised a question as to its applicability to pandemic flu, section 45A of the 2008 Act makes it clear that a public health threat is defined broadly thus: ‘Any reference to infection or contamination is a reference to infection or contamination which presents or could present significant harm to human health.’ Such a widely-drafted definition will now undoubtedly cover pandemic flu and other potential pandemic threats.

The central question to ask about the 2008 reforms generally, and with specific reference to pandemic flu, is whether the public health legislation is now sufficiently effective to avoid resort to the Civil Contingencies Act 2004? The new provisions must be assessed both as to their scope – which is certainly far wider than under the previous legislation – but also as to their efficacy, and this involves both an element of *suitability* for responding to the threat at hand and, just as importantly, *alacrity*, that is, providing a framework which facilitates timely responses. An irony of the new provisions might be that, in attempting to build in protection mechanisms, the effectiveness of the law may suffer as a result. For example, procedural matters are complicated by the role of the Justice of the Peace and the distinction between Regulations and Orders. Moreover, the 2008 reforms are more concerned with responses once a threat has presented itself, and are less concerned with contingency planning to coordinate responses *prior* to any such threat. While there are provisions for monitoring and notifying outbreaks, there is far less consideration for joined-up working beyond the very local response. Our suspicion is that these reforms may be effective as a first line of defence but they do not and cannot preclude a detailed consideration of the potential role of the CCA Act 2004 which, as we will see, provides specifically for directed and collaborative preparedness and action. Indeed, an article on legal preparedness would be remiss were it not to consider all possibilities and associated legal contingencies.

It is interesting to note - in contrast to the historic position in England and Wales - that in Scotland, under the relevant legislation,³⁴ the powers outlined above are applicable to infectious diseases *generally*. This raises a number of questions, including the question of co-ordination: if the existing legislation in Scotland can manage the pandemic, then emergency powers under the CCA need not be invoked, potentially leading to disparate powers in different regions around the UK.³⁵ Indeed, this possibility may remain under the provisions of the Health and Social Care Act 2008, even if they are sufficient to avoid the need to invoke powers under the CCA. It is, therefore, to a consideration of these provisions that we now turn.

Civil Contingencies Act 2004³⁶

The 2004 Act is separated into two substantive parts: Part 1 – Local Arrangements for Civil Protection - establishes a statutory framework of roles and responsibilities for local responders; Part 2 – Emergency Powers - establishes a modern framework for the use of special legislative measures that might be necessary to deal with the effects of the most serious emergencies. Key to modernising the existing legislation is updating the definition of what constitutes an ‘emergency’.

The definition of emergency in the Act focuses on the consequences of emergencies. It defines an emergency as:

- an event or situation which threatens serious damage to human welfare;
- an event or situation which threatens serious damage to the environment; or
- war, or terrorism, which threatens serious damage to security.

The scope of ‘emergency’ is not, however, the same in both Parts of the Act. In Part 1, the event must threaten ‘serious damage to human welfare or the environment in *a place* in the

United Kingdom’ (Section 1): ‘This reflects the fact that Part 1 is designed to deal with preparations by local responders for localised emergencies’.³⁷ In Part 2, the event must threaten ‘serious damage to human welfare or the environment of *the UK or of a part or region*’ (Scotland, Wales or Northern Ireland): ‘This higher threshold reflects the fact that Part 2 is designed for use in very serious emergencies which affect a larger geographical area’.³⁸ In both Parts, events such as a terrorist attacks, disruption of fuel supplies, chemical contamination of land and an epidemic could satisfy the definition of ‘emergency’, should they reach the required level of seriousness.³⁹

Equally, in both Parts, an event or situation threatens damage to human welfare if it involves, causes or may cause:

- (α) Loss of human life,
- (β) Human illness or injury
- (χ) Homelessness,
- (δ) Damage to property,
- (ε) Disruption of supply of money, food, water, energy or fuel,
- (φ) Disruption of systems of communication,
- (γ) Disruption of facilities for transport, or
- (η) Disruption of services related to health.

But who defines an emergency? This is a central and crucially important question for both general and legal preparedness. Although the Queen will formally indicate that emergency powers are necessary, it still leaves open the question of who decides in the first place whether there is an emergency situation. The decision to use emergency powers under Part 2, or not, is a matter for UK central government and the relevant Lead Government Department (LGD), subject to collective agreement.⁴⁰ Curiously, the provisions in Part 1 of the Act are different from those in Part 2. Section 1(4)(a) of the Act (Part 1) enables a Minister of the Crown or, in relation to Scotland, the Scottish Ministers, to provide by Order that a particular event or situation is to be treated as falling within (or outside) the definition of emergency when that event or situation is limited geographically. There is no equivalent clause in Part 2 of the Act. It has been suggested that this is because it was ‘considered less vital than under part 1, given the lack of time for issuance and consideration in an unfolding emergency...’⁴¹ Part 2 provides only, in section 19(4), that the Secretary of State may amend the list of events or situations that may threaten damage to human welfare. Given what has been said above about the importance of international coordination, it is relevant to note that the decision as to whether there is a public health emergency of international concern is made by the Director-General of the WHO.⁴² The European Commission is also empowered to ‘recognize a pandemic’ and it can do so independently of the WHO.⁴³

Contingency Planning: the focus of Part 1

Part 1 of the Act establishes a statutory framework for civil protection preparedness at the local level. The Short Guide to the Act (produced by the Cabinet Office) states that ‘Local responders are the building blocks of resilience in the UK, and the Act will enhance existing arrangements by: (1) Establishing a clear set of roles and responsibilities for local responders; (2) Giving greater structure and consistency to local protection activity; (3) Establishing a sound basis for performance management at a local level.’

The Act divides local responders into 2 categories depending on the level of their involvement: **Category 1 responders** are at the ‘core’ of emergency response (eg. emergency services, local authorities), and are responsible for a wide range of duties, including assessing the risk of an emergency and ensuring that emergency plans are in place

(Section 2); providing advice and assistance to the Public (Section 4); sharing information with other local responders (Section 6), and co-operating with other responders and, in particular, cross-border collaboration (Section 15), in order to enhance co-ordination and efficiency. **Category 2 responders** (e.g. Health and Safety Executive, transport and utility companies) have lesser duties under the Act. These are primarily with respect to information sharing and co-operation.

When it comes to regulations for contingency planning, Section 2(3) and 2(4) empower a Minister (or Scottish Minister) to make Regulations about the extent and manner in which a duty to assess, plan and advise for an emergency is discharged. For example, the CCA 2004 (Contingency Planning) Regulations 2005⁴⁴ lay down general provisions on the nature and extent of duties of Category 1 responders, but these are not specific as to the kinds of emergency in relation to which risk and planning should be assessed. There is, nonetheless, the possibility for this mechanism to be used by Ministers to provide significant detail to responders on the nature and extent of their duties as well as to require groups of responders to collaborate in planning and preparedness decision-making.

Section 5 of the Act further permits a Minister of the Crown to require a Category 1 responder or responders to perform functions to prevent an emergency arising and/or reducing its effects. This means that a Minister can require action beyond mere planning for the eventuality of an emergency, which involves the discharge of normal functions by a Category 1 responder (i.e., it does not involve the imposition of additional functions).⁴⁵ Such an Order could, however, dictate the manner in which functions are discharged and/or require (or prevent) collaboration with other category 1 responders.

Power to make emergency regulations: the focus of Part 2

Part 2 is concerned with the creation of ‘emergency powers’ and allows centralised coordination of response when an emergency hits; it also requires appropriate action from those with responsibilities under Part 1.

Subsection 20(1) provides that Her Majesty may by Order in Council make regulations if satisfied that the conditions in Section 21 are met. Subsection 20 (2) provides that a Senior Minister of the Crown may make emergency regulations if satisfied that the conditions in Section 21 are met AND that it would not be possible without serious delay to arrange for an Order in Council. A Senior Minister of the Crown means: The Prime Minister, any of her Majesty’s Principal Secretaries of State, and the Commissioners of her Majesty’s Treasury.

Pursuant to subsection 20(5), regulations made under this section must be prefaced by a statement from the person making the regulations that he or she (i) Is satisfied that the conditions in section 21 are met, (ii) Is satisfied that the regulations contain only provision which is *appropriate* for the purpose of preventing, controlling or mitigating an aspect or effect of the emergency in respect of which the regulations are made; (iii) Is satisfied that the effect of the regulation is in due *proportion* to the aspect or effect of the emergency; (iv) Is satisfied that the regulations are *compatible* with the Convention rights (within the meaning of section 1 of the Human Rights Act 1998 (c.42).

Pursuant to Section 21 of the Act, three conditions must be met before emergency regulations can be made [the so-called ‘triple lock’ approach]:

- (1) An emergency has occurred, is occurring or is about to occur;
- (2) It is necessary to make provision for the purpose of preventing, controlling or mitigating and aspect or effect of the emergency;
- (3) The need for provision is urgent.

Section 22(2) of the Act provides that emergency regulations may make any provision which the person making the regulations is satisfied is appropriate for the purpose of, *inter alia*, (a) protecting human life, health or safety, and (b) treating human illness or injury. This category of provision concerns the protection of persons/property and/or prevention/mitigating effects of disruption.

Pursuant to Section 22(3) of the Act (Part 2), emergency regulations may provide for more draconian measures so long as these could be made by Act of Parliament or Royal Prerogative, including (among other things):

- The confiscation of property (with or without compensation);
- The destruction of property, animal life or plant life (with or without compensation);
- The prohibition or requirement of movement to or from a specific place;
- The prohibition of assemblies (of specific kinds, at specific places or at specific times);
- The prohibition of travel;
- Create an offence of failing to comply with the regulations.

Section 22(1) also provides that regulations may 'enable the Defence Council to authorise the deployment of Her Majesty's armed forces'. Section 23 provides that emergency regulations *may not*:

- prohibit any activity in connection with a strike or other industrial action;
- instigate any form of military conscription;
- alter any aspect of criminal procedures;
- create any new offence other than breach of the regulations themselves.

Overarchingly, emergency regulations must be compatible with the Human Rights Act and EU law and are open to challenge in the courts. As to geographical scope, however, emergency powers may be used on a regional and/or devolved administration basis. Accordingly, any special temporary legislation will apply only in the part of the UK affected by the emergency, leaving those elsewhere unaffected.

Emergency regulations lapse 30 days after the date they were made unless the regulations themselves provide for lapse at an earlier date. This does not preclude new regulations being made (s.26). Emergency regulations must be presented to Parliament for its approval as soon as practicable after being made. Parliament may amend the regulations and must approve them within seven days. If Parliamentary approval is not forthcoming, the regulations cease to have effect. The maker of emergency regulations would be subject to an obligation to protect and restore the ability of Parliament to scrutinise emergency regulations, and the ability of the Courts to entertain challenges (ss. 27 & 28).

Emergency powers are a reserved matter. Part 2 ensures, however, that the devolved administrations will be consulted, if emergency powers are to be used in their territory, wherever possible. It allows emergency powers to be used in Scotland, Wales or Northern Ireland alone for the first time, though the use of emergency powers remains with Westminster. Concordats setting out in more detail how these arrangements will work in practice have been agreed with the Welsh Assembly Government and with Scottish Ministers, while that with the Northern Ireland Administration remains to be finalised at the time of writing. As part of the consultation on Emergency Response and Recovery, referred to above, and for purposes of legal preparedness, it was suggested that if a responder

organisation considers it necessary to request the use of emergency powers it ‘will need to seek advice from its legal advisers to confirm that there is a genuine gap in legal powers which prevents the necessary action being taken’. The organisation will need to provide answers to questions such as:

- What action needs to be taken and why?
- When does this action need to be taken?
- Why can’t this be achieved under existing powers?
- What temporary new powers are requested?
- What are the implications of not being granted the powers?
- Which organisations have been consulted, and what are their views?

As noted above, the presumption is against the use of emergency powers. The guidance states that “Even if it is agreed that a temporary change to the law is necessary, other options, including an emergency Bill to Parliament, must be considered first”. In all cases, the final decision rests with central government. Responder organisations requesting the use of emergency powers must bear in mind that ‘requests that seem relatively straightforward to those on the ground, may raise a wide range of complex issues that need to be considered at the centre (e.g. liability and compensation issues or compatibility with Human Rights or European Law) and it may take some time before it is possible to issue a response’.⁴⁶ Notwithstanding that a precautionary approach is advocated and expected, the above provisions raise numerous questions about legal preparedness and how it should be assessed.

3. ASSESSMENT OF LEGAL PREPAREDNESS

The legal position in the United Kingdom for responding to pandemic flu or some other serious public health emergency is most appropriately described as piecemeal and patchy. The Civil Contingencies Act 2004 (CCA) is a measure of last resort when it comes to the creation of ‘emergency powers’, leaving existing legislation to govern responses across an incredibly wide range of areas and actors. The ability of this legislation to empower actors to respond adequately is questionable. The CCA itself lays down a broad framework for preparedness, but it is far from clear how, or indeed when, this would operate when we move from the stage of preparation to action, and whether the complex lines of communication and coordination that are essential to an effective response to a public health emergency are in place. Nor is it clear whether relevant actors are sufficiently apprised of the measures and the legal parameters within which they will be expected to act when an emergency comes.

When the *Civil Contingencies Act 2004* (CCA) was passed, there was an intention to review it within three years, and a ‘light touch’ review was initially planned. Since the passing of the Act, however, a series of ‘disruptive challenges’ (eg. floods, Bluetongue disease, foot and mouth, the Buncefield fire) and the subsequent inquiries (particularly the Pitt and Newton reviews) provided evidence that certain aspects of the CCA required a more thorough review and, thus, the Civil Contingencies Act Enhancement Programme (CCAEP) was initiated in December 2008.⁴⁷ The Programme, which focuses primarily on Part 1 of the Act, is organised in four phases, Phase 3 of which is concerned with ‘Enhancing the CCA’ and contemplates the need for legislative changes; this has been scheduled for roll-out over 2009/2010 but with the advent of H1N1 we consider that this discussion is all the more pressing.

One key intention of the CCAEP is to produce products that make it easier for responders to interpret the CCA in a practical and effective way, and ensure they are fulfilling

their statutory duties.⁴⁸ We submit that legal preparedness, as we discuss below, must be an integral part of such a process.

What follows is a framework to assess the UK's legal preparedness and it is offered against the background of actions as at 31 March 2009 with updates where these have been possible. It draws on experiences and discussion that have taken place elsewhere. We provide a vital checklist of questions to ask of the UK legislative situation, pointing to particular examples from the above account where attention might be focused. The framework for assessment considers the four key stages in a response to a public health threat like pandemic flu:

- (a) Preparation (Pre-event)
- (b) Response (During event)
- (c) Protection (During event)
- (d) Recovery (Post-event).

a. Preparation

The objective in this stage is to maximise effective preparedness of all relevant actors and potentially affected persons and communities.

It is particularly telling and worrying that the chronology of H1N1 from its emergence to its categorisation as a pandemic was so rapid.⁴⁹ This is the best possible illustration of the importance of sufficient levels of *prior* knowledge of the laws which might be invoked in a public health emergency as well as understanding and training with respect to expected responses and responsibilities. We have outlined the core pieces of legislation as these relate to (public health) emergency situations, but it must be noted in addition that relevant laws with relevant provisions might be found in any number of disparate pieces of legislation. This legislation may be found in realms as diverse as local government law, administrative law, transport law, employment law, education law, data protection law, mental capacity law, and, of course, public health law. Core questions are:

i. Are all public health officials and other actors with responsibilities fully apprised of the relevant legal provisions, their duties and the limits of their roles?

The range of actors and of their information needs are considerable, covering national, regional and local public health officials, emergency response personnel & law enforcement personnel, fire & other security services, public transport officials, elected officials, civil servants (especially those with responsibilities for database management and access), lawyers, employers, care workers, data protection officers, heads of universities and schools, and all of those responsible for training the above actors. There are almost as many fields of law in play as there are possible categories of actors.

The kinds of (legal) information to which these actors need access is equally extensive, including, information about relevant public health provisions, their application to their sphere of competence, checklists of respective rights and responsibilities, access to legal advice and existing opinions on lawful courses of action, access to ethical decision-making protocols (see above), knowledge about potential access to judicial authorities or equivalent personnel for prompt resolution of conflicts (see below).

The National Framework for responding to an influenza pandemic, produced by the Cabinet Office, includes a chapter on the roles and responsibilities of a variety of international, European, national and regional actors during a pandemic.⁵⁰ Chapter 11

provides a chart of key decisions/actions that are likely to be required at the national and local level at various stages of a pandemic. For each decision/action, lead and support responsibilities are set out by organisation. Other chapters outline planning and response during the different phases of a pandemic, as developed by the WHO.⁵¹ It is telling that in none of these provisions is there discussion of legal preparedness, legal training needs, or provisions to assess the role of law and lawyers in the preparation phase. It is to be hoped that the current crisis and current activities as part of the CCAEP remedy this, but the original timescale for delivery on this programme was to the end of 2011 and the need is now to be asking to right questions about legal preparedness.

ii. **What is the level of informational joined-up-ness between sectors, jurisdictions, disciplines and professionals? That is, are lines of communication and balance of responsibilities clear within the complex web of potential actors?**

While much of the discussion on preparedness and response to pandemic flu talks about the need for new laws, the legal framework in the UK imposes obligation of preparation on certain actors under Part 1 of the CCA, but also anticipates that existing legal provisions will continue to apply during an emergency, and that Part 2 powers will only be measures of last resort, as we have seen.

This requires, therefore, that all those with duties in the preparation phase, and those who will be expected to act during an emergency, must be apprised both of the CCA and potential on-going responsibilities under other laws. They must be sufficiently familiar with their nature, scope and application, and of the circumstances in which existing provisions might be overridden.

As an example, consider that the economic and social impact of school closures could be one of the most significant factors in determining an effective response to pandemic flu and, indeed, in influencing the ability of health services to cope with a crisis.⁵² Yet, the legal authority for school closures is not a matter routinely considered in public health measures, and school masters are not routinely included in contingency planning. They are not, for example included in the CCA as ‘responders’. Are these actors sufficiently aware of the rights and responsibilities in the event of pandemic flu outbreak? Which piece or pieces of legislation govern?

iii. **Do existing laws impede preparedness, either through unnecessary provisions or lack of clarity or inflexibility?**

This question implies, in turn, a series of other questions. For example, when are existing laws no longer to be applied? To illustrate the lack of clarity in law or potential for confusion over authority to act, consider s.21(5) CCA which is concerned with determining when it is ‘necessary’ to make emergency provisions. This can occur, if: (a) the existing legislation cannot be relied upon without the risk of serious delay, (b) it is not possible without the risk of serious delay to ascertain whether the existing legislation can be relied upon, or (c) the existing legislation might be insufficiently effective.

Note the highly speculative nature of these provisions, and in particular the potentially subjective assessment that existing legislation ‘...*might* be insufficiently effective’. This has the potential to be open to draconian discretion despite the fact that the provision is, in fact, attempting to define a high threshold for intervention as ‘necessary’. It also raises the potential for dispute as to the applicability of the CCA and the legitimacy of it being invoked to supersede existing provisions.

Another question is when will a state of emergency be declared, and by whom? We are concerned that there is no clear statement in law of when and how an emergency will be declared, and by whom, under the Civil Contingencies Act 2004. While ultimate authority rests with the Monarch, the law seems to permit a range of actors to intervene, including, for example, the Prime Minister, Principal Secretaries of State or Commissioners of HM Treasury.

Walker and Broderick have said that the Statement required in section 20(5) of the Act (discussed above) from the person making emergency regulations,

...is the closest approach in Part II of the 2004 Act to the formal declaration or proclamation of emergency under s 1 of the Emergency Powers Act 1920. It also represents a departure from a more formal, two-stage process proposed under the original draft Bill of June 2003, wherein the process started under cl 18 with a Royal Proclamation by which Her Majesty could by proclamation declare herself satisfied that (a) an emergency has occurred, is occurring or is about to occur, and (b) it is necessary to make emergency regulations.⁵³

While some have suggested that a formal Proclamation is unnecessary and anachronistic,⁵⁴ the symbolic nature of the action should not be underestimated, and moreover, from a legal standpoint, it represents a clear change of circumstance from which legal, civil and political consequences might flow, including parliamentary and judicial review, closer attention to issues of civil liberties protection, and a potential threshold for considering future claims for compensation. We address all of these presently.

iv. Are we aware of gaps in existing legal provision and are we clear on how these gaps will be filled (in particular how the CCA will be deployed)?

Perhaps the most serious gap is any legal provision or robust contingency planning for a 'Worst Case Scenario'. We note below that there is mention that the expectation is that the military will not be involved, but effective legal preparedness requires *full* legal preparedness and it is not acceptable to obfuscate the legal position with respect to circumstances where legal protection and the Rule of Law will be most important.⁵⁵ Nor should we rest on our laurels if the current pandemic proves to be 'mild'; it is to be noted that the categorisation of "pandemic" is a measure of geographical spread on a global level, not an indication of the seriousness of the threat to human life.⁵⁶

v. Are we naive in our premises, for example, that voluntariness will prevail? If so, are we clear enough on what will happen next?

Following on from the above, we must ask whether the assumption that voluntary conduct will prevail is tenable, and in legal terms, we must ask what will be the legal consequences if it is not. The Virginia Social Distancing Law Project offers the following cogent statement:

There are severe limits on the ability to compel the actions of the general public, in particular with issues regarding sufficient law enforcement. As a result, efforts to maximize the level of voluntary compliance will be critical...This will need to focus on minimizing panic – although to some extent, fear could also help to keep people from interacting. Compliance may be improved by balancing the response: if the situation cannot be managed by a lot of restriction for a short time, then it may be more likely to be successful if smaller restrictions are implemented but for a longer time. It will be important to communicate with the public, but care is required to not over assure people of their safety. Finally, a concern is that the actual

ability of individuals to comply for longer periods is extremely small – even for affluent individuals prolonged movement restrictions may be difficult.⁵⁷

vi. Do we have adequate mechanisms to test legal preparedness and to benchmark best practices?

In 2007, the Cabinet Office, the Department of Health and the Health Protection Agency conducted Exercise Winter Willow⁵⁸ with over 5,000 people from UK organisations representing government, industry and the voluntary sector in order to test plans, procedures and preparedness for an influenza pandemic. In particular, the exercise tested the planning presumptions in the UK National Framework for Responding to an Influenza Pandemic, and issues raised during the exercise were to be used to inform revisions to the Framework. Although a number of areas for further work were highlighted, such as travel advice, science advice and advice on school closures, there is no mention of legal advice or training in relevant legal provisions, and questions of legal preparedness were not raised. Examples of tools to test legal preparedness from the United States include the Virginia Social Distancing Law Project,⁵⁹ the Turning Point Model State Public Health Act,⁶⁰ and the Emergency Preparedness, Response and Recover Checklist.⁶¹ Many of these have, however, been criticised as unconstitutional and an affront to civil liberties.⁶² We address such matters for the United Kingdom below.

vii. Do we have adequate mechanisms to test the competencies of relevant actors with respect to legal preparedness?

The competency of any actor with responsibility in a public health emergency is crucial to both an effective and lawful response. Actors should be competent not only in their knowledge of laws, but also in their decision-making skills and their ability to assess and respond to circumstances within an agreed value framework. In this regard, the Department of Health Ethics Framework (see above) could prove to be of central utility in achieving preparedness. It is important to note, too, that it highlights that as many actors as possible should be involved, and should, therefore, achieve sufficient levels of competency and preparedness. Important legal and value parameters include:

- Duties to respond
- Powers to act
- Procedures to follow
- Knowledge of limits of legal powers and duties
- Appreciation of lines of authority and communication
- Recognition of the implications of (non)-action and (non)-response (especially concerning civil liberties)
- Understanding of when to seek (legal) advice (and from whom).

Central to all of this is the question of how to test and measure competencies. The example of schools is once again pertinent. School closures came up in the Winter Willow exercise and raised ‘many issues about the practical and operational aspects of potential school closures, including the triggers for reopening, redeployment of staff and guidance on how to continue to handle educational assessments and examinations.’⁶³

In the Joint response from the Association of Directors of Adults Services (ADASS) and the Association of Directors of Children’s Services (ADCS) to the Department of Health

consultation on *A National Framework for Responding to an Influenza Epidemic*, it is pointed out that:

The final version will need to spell out, particularly for schools, under what authority and in place of which current legislation, local or central government, or indeed a combination of both, could decide a school, a group of schools, or other providers, should close. Under current legislation, the authority to close a school rests with the governing body or executive of the school concerned, whether it is a Community, Foundation, Aided, Controlled, Trust, Academy or public school. The guidance does not at present indicate which central or local government measures would be put in place legally to supersede schools' and others' accountabilities and governance under current law. The guidance should also need to spell out for local authorities where their accountabilities in this situation end, given they would be stepping in, under whatever policy or emergency regulations, to territory currently covered by other parties' direct management and service delivery responsibilities.⁶⁴

Guidance for Schools was produced by the Department for Education and Skills in 2006. Regarding school closures, the guidance simply said:

Advice or obligation?

1.22 If the Government decides that closing schools and childcare settings for child welfare reasons is advisable, we expect to issue advice to schools and childcare providers, and do not expect to use emergency powers under the Civil Contingency Act 2004 (see Annex A) to oblige services to close. We believe that all concerned will share the desire to safeguard children's health, and will want to comply with advice based on children's welfare.⁶⁵

The National Framework states that 'The Government would take decisions on whether or not to advise closures on the basis of an assessment of emerging characteristics and impact as the pandemic develops'.⁶⁶ It is also recognised that, even if there is no advice to schools to close, 'some may decide to do so because of staff shortages or local health and safety reasons'.⁶⁷

As far as we know, this position remains vague in law, calling into serious question the competency of actors within schools to play an effective role in preparing for, and ultimately responding to, a pandemic flu epidemic or other public health emergency.⁶⁸

b. Response

The objective in this stage is to provide efficient and effective containment of the threat and to minimise impact at *both* community and personal level.

At no point in the four-stage process under consideration are matters more time-critical than during the event/response phase. Circumstances may change radically on an hourly basis, and the informational needs of all actors increase exponentially during this time.⁶⁹ While, of course, surveillance of the developing emergency is crucial, so too is surveillance of legal developments both as a measure of on-going preparedness and, now in a period of pressure and crisis, as a continuous measure to ensure as far as possible that laws and persons are properly respected and that problems with legal solutions are suitably resolved.

i. What are provisions for effective communication and coordination of legal materials and information about legal responsibilities?

It is trite to confirm that relevant legal materials should be at hand for those who need them, including case and context-specific legal opinions, checklists, draft executive and court orders, and guidance on legal justifications for escalating interventions and the circumstances in which these might, or would not, apply. All categories of actors must be apprised of the relevant materials, from initial responders through coordinators and Ministers and, crucially, to the courts themselves which will act as ultimate arbiters and must be fully trained in the legal provisions and with ready access to the necessary instruments to oversee an effective response.⁷⁰

ii. What provisions exist for decision-making when information is ‘less than complete’?

The National Framework for Responding to an Influenza Pandemic does not address legal preparedness issues directly. The section which deals with the Legal Framework merely outlines the international and legal landscapes. There is no mention of legal information in the *Communication and Public Engagement* section of the Framework,⁷¹ except to say that the aims and objectives of the government’s communication and public engagement strategy is, among other things, to ‘uphold the rule of law and democratic process’.⁷²

Importantly, issues of potential legal liability arising from decisions that result in recoverable harm may remain. This may be all the more likely if decisions are taken with incomplete information. Officers of the government can require information about (non) response to be disclosed and/or explained (CCA, s.9), and proceedings can be brought with respect to failures under the Act which can result in ‘any relief’, ‘any remedy’ or ‘any order’ the relevant court thinks appropriate (CCA, ss10-11).

Walker and Broderick have noted that ‘all the responders duties are potentially susceptible to judicial review proceedings’;⁷³ and also, potentially, to actions in tort.⁷⁴ Considering potential liability, it is imperative that responders understand not only their legal obligations, but also the potential legal liabilities.

iii. What is the role of social distancing and who has authority to require or restrict it?

A number of options for mitigating the impact of a pandemic in the UK are outlined in the National Framework.⁷⁵ The UK’s mitigation strategy includes ‘medical or pharmaceutical countermeasures, combined with public health and personal infection control initiatives, and the possible application of measures to reduce social mixing’.⁷⁶ Measures to reduce social mixing include border restrictions; isolation, voluntary quarantine and social distancing; internal travel restrictions; restrictions on public gatherings; and school closures.

It is not entirely clear whether and when social distancing should be enforced, for example, as a disease prevention measure - or discouraged, for example, if distancing will actually have a serious adverse social and economic impact.⁷⁷ In Argentina, for example, which is among the hardest hit nations in terms of deaths from the current pandemic crisis, it has been suggested that as much as 0.5% of the GDP could be lost between July and September 2009 as a result of wide-spread closures of schools and other public venues.⁷⁸

Furthermore, given the serious liberty implications of such measures, implemented either way, there is a need for extremely clear lines of authority and action for such measures, which can include isolation, quarantine, closure of public places, schools, and cancellation of public events, or conversely, could require certain professionals such as health care staff or

teachers to attend their places of employment. Clear, prior-agreed and approved ‘decision trees’ are necessary for any emergency, including adequate training and communication.

iv. What is the role of the Military?

The issue of military support in local crisis response also came up in the Winter Willow exercise. But as the report notes, ‘existing guidance on the UK Resilience website sets out the principles for the use of defence assets in a crisis and makes it clear that contingency planning should not assume the involvement of the military.’⁷⁹ We have already highlighted this as a gap in (legal) preparedness during the response phase, and this applies even more strongly as regards the next section on protection of civil liberties. Although it is understandable to avoid raising expectations of military involvement, the matter of adequate policing of vital services, such as food and fuel distribution, cannot be ignored.⁸⁰ These might represent some of the most immediate of emergencies, necessitating adequate, lawful and sustained responses from many more actors than those identified in the CCA. A role for the military or other peace-keeping mobilisations in the Recovery phase is discussed below.

c. Protection

A further objective in the event phase is the imperative to permit interferences with civil rights and liberties only as necessary and proportionate and in keeping with ethical and human rights measures.

Legal preparedness in this respect is about ensuring that all measures taken that impact on civil liberties and human rights are necessary and proportionate to the social objective sought. In particular, protection of individual rights and liberties should be directed most particularly to (1) Scenario planning, involving escalations and limits of interventions, (2) Worst case scenarios and the role of military, and (3) Role of judiciary as policing lawfulness of responses.

The *Civil Contingencies Act 2004* cannot amend the *Human Rights Act 1998* (c.42), and any emergency regulations promulgated under the Act are treated as subordinate legislation for the purposes of the 1998 Act.⁸¹ Pursuant to Section 22 of the 2004 Act (Part 2), emergency regulations may provide for:

- The confiscation of property (with or without compensation);
- The destruction of property, animal life or plant life (with or without compensation);
- The prohibition or requirement of movement to or from a specific place;
- The prohibition of assemblies (of specific kinds, at specific places or at specific times);
- The prohibition of travel.

Most obviously, these provisions could raise the following human rights/civil liberties issues:

- privacy; (Article 8 of the European Convention on Human Rights)
- property; (First Protocol to the Convention);
- mobility/liberty; (Article 5 of the Convention); and

- freedom of association; (Article 11 of the Convention).

There are a number of points to note about the nature and operation of human rights laws as they relate to public health emergencies. It is trite that while human rights are *fundamental* rights, it is rarely the case that such rights are *absolute*. That is, while human rights instruments identify protections that are considered to be of core value to our society, these do not deserve protection at any cost, and exceptions are possible.⁸² The starting point is, however, that fundamental rights should be protected and the *onus* is on those who would interfere with such rights to *justify* any interference.

For each of the human rights specified above – privacy, property, liberty and association – interferences are possible, and in three of these cases the protection of the health of others is directly specified as a justification of interference. Thus, Article 5 (protection of liberty) allows for detention of persons ‘for the prevention of the spreading of infectious diseases’, while Articles 8 and 11 (privacy and association respectively) permit interferences ‘...for the protection of health...or the rights and freedoms of others’. Property is protected save when interference can be justified in the amorphous ‘public interest’ (First Protocol).

By the same token, interference with some rights is more readily justified than in other cases. For example, Article 5 only permits exceptions from a restricted and limited list, while Articles 8 and 11 permit a range of exceptions which are subject to the watchwords of *necessity* and *proportionality*. In such cases, interferences with human rights are only justifiable when they are in accordance with the law, necessary to address a pressing social need, and employ proportionate means towards specified ends. This can only be judged on a case-by-case basis, but permits a degree of latitude in determining what is necessary and proportionate, albeit interferences should be minimal to achieve the social objectives.⁸³ The practical consequence of Article 5 is, however, that a potentially higher level of protection is accorded, in that it is more difficult to depart from its provisions. This gives effect to a form of hierarchy of rights, such that the ease with which interferences can be justified ranges from most difficult (Article 5) through moderate (Articles 8 and 11) to more easily justified (Article 1; Protocol 1 on property).

To the extent that interferences must be ‘in accordance with the law’, the role of the judiciary is crucial in reviewing interferences, considering appeals and policing the parameters of human rights protection. Thus, central to the protection phase of legal preparedness is the need for the courts to be maintained, or at least that judicial oversight is possible.

There is a lack of clarity in the possible meanings of the threshold terms used in law, such as ‘necessary’, ‘proportionate’ and ‘public interest’. Notwithstanding, there is a wealth of case law and literature which has attempted to flesh-out meaning over time.⁸⁴ There is much on which to draw to anticipate *ahead of time* what might and – equally importantly might *not* – meet these thresholds in scenario planning and response on the ground.

There is also a lack of clarity in existing provisions about the circumstances in which there will be an escalation of interventions and, most worryingly, what will happen in a ‘Worst Case Scenario’. From the perspective of human rights and civil liberties, however, we would point to the *intervention ladder* developed by the Nuffield Council on Bioethics which offers a way of thinking about possible government action and appreciating the associated consequences for civil liberties. This ranges across options from ‘doing nothing’ and monitoring a situation, through measures oriented towards ‘enabling choice’, ‘guiding choice’, ‘restricting choice’ and, ultimately to ‘eliminating choice’.⁸⁵ As the intervention becomes more intrusive so the need for justification becomes more compelling.

Additionally, we recommend that a *Civil Liberties Impact Assessment* should accompany all contingency plans with particularly close attention paid the points at which

escalation of action will take place. Such an impact assessment might be modelled, for example, on existing privacy impact assessments which have operated in many countries world-wide for many years and are now strongly advised by the UK's Information Commissioner's Office.⁸⁶

d. Recovery

The objectives in the post-event phase are to redress social balance (as far as possible and desirable) and to address any injustices done during the public health emergency.

i. Compensation for loss

It is important to assess ahead of time, where possible, the legal provisions for compensation for undue interference with civil liberties and property which will apply in the recovery phase. The CCA is open-ended, if not deliberately vague, about the question of whether compensation might be paid for the confiscation or destruction of property. As a possible temper, however, the First Protocol of the ECHR provides that denial of compensation should only occur in 'exceptional circumstances'. At best, the government has pointed to its track record of paying compensation in civil contingency circumstances, but has offered no legal guarantees.⁸⁷

ii. Workers' compensation

The position of workers' rights and entitlement to sick pay must also be considered. The issue receives scant consideration in the National Framework (Nov 2007) which simply states under *Sickness and other benefits* that for 'sickness absence policy including statutory sick pay', there will be 'Business as usual for as long and as far as possible. Advice may be issued as pandemic develops'.⁸⁸ The Scottish Framework (2007) states that 'Guidance regarding Statutory Sick Pay (SSP) will be issued by HMRC at the time of pandemic. Most employers will be paying Occupational Sick Pay OSP that must be at least as generous as SSP. Rules for controlling payments are for employers to determine'.⁸⁹

iii. The role of the Military

Recovery Guidance on the UK Resilience website explains that:

During a Recovery/consequence management operation the provision of Armed Forces' support will require the approval of a Defence Minister following the receipt of a formal request by a government department...The framework for MOD involvement in the consequence management of civil contingencies in the UK is therefore one of civil primacy, civil capability and civil capacity. Case-by-case assistance to the civil authorities is possible through the Standing Home Commitments Group of Military Tasks but resilience and recovery planners must understand that planned Defence contributions at home are very much by exception, in particular where it is unreasonable or unrealistic to expect the civil authorities to develop their own capabilities.⁹⁰

The website makes it clear that the legal basis for instructing Armed Forces personnel to provide support to the civil authorities can only be one of the following: s.2 of the Emergency Powers Act 1964, Part 2 of the Civil Contingencies Act 2004 (for which, see above), and common law authority for a Defence Minister to direct the Forces to provide

specialist support to the police. However, ‘Military units and personnel remain under the MOD chain of command at all times and are not subordinated to the command of civil authorities.’

iv. Assess effectiveness of legal preparedness and responses and learn lessons

While it is obvious to suggest that lessons should be learned in the aftermath of a public health emergency, and most particularly the current H1N1 pandemic, there is a need for more research on how to measure the effectiveness of responses, and more particularly, how to measure legal preparedness and the lawfulness of responses that took place. Lessons can already be learned from other public health emergencies, both here and in other countries, and it is useful in this regard to note in the case of SARS that public responses were very different in different countries: ‘While Canadians generally complied voluntary [sic] with quarantine requests, public health officials in other countries, such as China, Hong Kong, and Singapore had to use more coercive measures’.⁹¹ The same is proving to be true with H1N1.⁹² Closer to home, the recent Anthrax outbreak in Scotland may also reveal valuable lessons,⁹³ as may lessons from the foot-and-mouth outbreaks; thus, the Department for Environment, Food and Rural Affairs might usefully assist the Department of Health in ‘lessons learned’.⁹⁴ By the same token, containment should never lead to complacency.

4. IMPROVING LEGAL PREPAREDNESS

Drawing on all of the above, we suggest that there are 10 key areas where the United Kingdom could pay close attention to improving legal preparedness for the outbreak of pandemic flu or other public health emergencies.

1. Assessing and meeting the (legal) training needs of all relevant actors, and not merely responders identified in legislation;
2. Drafting legal instruments to govern practices in emergencies and testing legal validity beforehand;
3. Establishing a central repository of legal instruments and measures;
4. Identify more clearly tolerances for escalation of efforts and carrying out civil liberties impact assessments on all stages of contingency planning;
5. Assessing and providing support for courts and associated personnel as crucial mechanism for dispute resolution and protection of civil liberties during outbreaks;
6. Articulating and exploring the legal situation in the event of full escalation, and in particular, considering worst case scenario planning and the arrangements for policing such scenarios;
7. Establishing and clarifying legal authority for deployment of military, limits and controls, if contemplated;
8. Learning (legal) lessons from other public health emergencies, for example, SARS in Canada & Asia, Anthrax in Scotland, or even emergencies in other government departments such as the experiences of the Department for Environment, Food and Rural Affairs with foot-and-mouth.

9. Clarifying and assessing balance of powers and competencies across jurisdictions;
10. Conducting further research on evaluating legal preparedness, for example, how best to protect civil liberties as threats increase and/or plans fail.

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¹ Up to date information about swine flu may be found at:

<http://www.nature.com/news/specials/swineflu/index.html> (last visited 13 July 2009).

² See: M A Larkin and A K McGowan, ‘Strengthening Public Health through Knowledge of the Law and Legal Strategic Thinking’, (2008) 36:3 *Journal of Law, Medicine and Ethics* (Special Supplement) 4-5, and associated papers. For a European perspective see: R. Martin, ‘The role of law in pandemic influenza preparedness in Europe’, (2009) 123 *Public Health* 247-254.

³ Special Supplement, The National Action Agenda for Public Health Legal Preparedness, (2008) 36:1 *Journal of Law, Medicine and Ethics* at 62.

⁴ *Ibid* at 11.

⁵ WHO, ‘International Health Regulations Enter into Force’, WHO News Release at: <http://www.who.int/mediacentre/news/release/2007/pr31/en/> (last visited 19 March 2009).

⁶ It has been noted that ‘Although the IHR (2005) build in part upon the text of ... IHR (1969), they are primarily based on the recent experiences of WHO Member States in national surveillance systems, epidemic intelligence, verification, risk assessment, outbreak alert, and coordination of international response, all of which are part of WHO’s ongoing work on global health security’. See: G Rodier, M Hardiman, B Plotkin and B Ganter, ‘Implementing the International Health Regulations (2005) in Europe’, (2006) 11:12 *Eurosurveillance*, citing WHO, Fifty-fourth World Health Assembly, Resolution WHA54.14: Global health security: epidemic alert and response (2001). Available at: <http://www.eurosurveillance.org/> (last visited 19 March 2009).

⁷ In 1951 the WHO members adopted the International Sanitary Regulations (ISR). These were renamed the International Health Regulations (IHR) in 1969. Since then the IHRs have been slightly modified, first in 1973 (primarily for cholera) and then in 1981 (to exclude small pox). See: L Gostin, ‘International Infectious Disease Law: Revision of the World Health Organization’s International Health Regulations’, (2004) 291:21 *JAMA* 2623-2627 at 2624.

⁸ WHO News Release, note 5 above.

⁹ *Ibid*. The ‘UK international preparedness strategy’ (2008), developed by the Cabinet Office in conjunction with the Department of Health and other Government Departments, ‘sets out a framework through which international pandemic influenza activities should be taken forward over the next five years’, and is available at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089527 (last visited 22 April 2009).

¹⁰ K Wilson, B von Tigerstrom and C McDougall, ‘Protecting global health security through the International Health Regulations: requirements and challenges’ (2008) 179:1 *Canadian Medical Association Journal* 44-48 (available at www.cmaj.ca (last visited 19 March 2009); and L Gostin, ‘International Infectious Disease Law’, note 7 above.

¹¹ Calain has commented that ‘How and if Member States of WHO will abide by the IHR (2005)... will depend on a delicate balance between perception of threats from specific health events (public health effects *per se*, or political or economic consequences), incentives set up by interested parties

and any consideration of national sovereignty’. P Calain, ‘Exploring the international arena of global public health surveillance’, (2007) 22:2-12 *Health Policy and Planning* at 5.

¹² See R Dopplick, Inside Justice, 27 April 09, available at : http://www.insidejustice.com/law/index.php/intl/2009/04/27/swine_flu_who_pheic (last visited 12 July 2009).

¹³ S M Simon and F Goodwin, EPHA Briefing on the International Health Regulations (4/12/2006) at 3. Available at: http://www.eph.org/IMG/pdf/IHR_Briefing_sm_FGreviewed20070411final.pdf (last visited 19 March 2009).

¹⁴ In April 2009, the WHO issued revised global guidance on pandemic preparedness to Member States ‘which reflects new scientific findings and which to a greater extent is based on experiences from pandemic planning in Member States. The new publication contains more detailed guidance on community-level disease control and response and it includes guidance on pandemic planning in the whole society’. The new guidance is available at: <http://www.who.int/csr/disease/influenza/PIPGuidance09.pdf> . General information about Pandemic Preparedness in Europe may be found at: http://www.euro.who.int/influenza/20080618_19 (last visited 13 July 2009).

¹⁵ See WHO, Guidance for National Authorities, available here : http://www.who.int/csr/disease/swineflu/guidance/national_authorities/en/index.html

¹⁶ L Gostin and B Berkman, WHO draft paper for Working Group Two Project on Addressing Ethical Issues in Pandemic Influenza Planning: ‘Ethics of Public Health Measures in Response to Pandemic Influenza’ (2006), available at: http://www.who.int/eth/ethics/PI_Ethics_draft_paper_WG2_6_Oct_06.pdf (last visited 19 March 2009); WHO, Ethical Considerations in Developing a Public Health Response to Pandemic Influenza, (2007).

¹⁷ The Siracusa Principles are available at: <http://www.article23.org.hk/english/research/ICCPR.doc> (last visited 19 March 2009).

¹⁸ http://www.dh.gov.uk/en/PublicHealth/Flu/PandemicFlu/DH_065163.

¹⁹ Department of Health and Cabinet Office, *Responding to Pandemic Influenza – The Ethical Framework for Policy and Planning*, November 2007.

²⁰ *Ibid* at 1

²¹ *Ibid* at 6.

²² Nuffield Council on Bioethics, *Public Health: Ethical Issues* (2007).

²³ European Commission, Communication from the Commission on the Precautionary Principle, COM (2000)1, available at: http://ec.europa.eu/environment/docum/20001_en.htm (last visited 19 March 2009).

²⁴ See: R Martin, ‘Implementing Public Health Policy and Practice within a legal Framework: Constraints of Culture, Faith and Belief’, (2008) 9:4 *Medical Law International* 311-330.

²⁵ See: Cabinet Office, *Civil Contingencies Act: A Short Guide (Revised) (CCA Short Guide)*, at 1. Available at: <http://www.ukresilience.gov.uk/media/ukresilience/assets/15mayshortguide.pdf> (last visited 19 March 2009).

²⁶ The UK Resilience website states that emergency legislation under the Civil Contingencies Act is: ‘...a last resort in the most serious of emergencies where existing legislation is insufficient to respond in the most effective way. If the situation or event is so serious as to warrant consideration of use of the powers then the deciding factor will be whether existing powers, that could be used to deal with it, are insufficient or ineffective. If they are sufficient then emergency powers cannot be used, no matter how serious the emergency’. See: <http://www.ukresilience.gov.uk/response/emergencypowers.aspx> (last visited 19 March 2009).

²⁷ The outcome of the consultation had not been published at the time of writing.

²⁸ Civil Contingencies Secretariat, *Update of Emergency Response and Recovery: Non-statutory guidance to complement Emergency Preparedness, Consultation Paper* (25 March 2009), para. 13.16. Available at: http://www.cabinetoffice.gov.uk/media/132086/err_consultation.pdf (last visited 19 April 2009).

²⁹ Cabinet Office and Department of Health, *Pandemic Flu - A National Framework for Responding to an Influenza Pandemic (National Framework)* (November 2007) at 13, available at:

<http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH080734> (last visited 19 March 2009).

³⁰ Civil Contingencies Secretariat, *Civil Contingencies Act Enhancement Programme (CCAEP), Programme Initiation Document* (24 October 2008), paras. 37-41, available at: http://www.cabinetoffice.gov.uk/media/131900/ccaep_pid.pdf (last visited 19 April 2009).

³¹ There were 6 ‘notifiable diseases’ in the Public Health (Control of Diseases) Act 1984: cholera, plague, relapsing fever, smallpox, typhus and food poisoning. The Public Health (Infectious Diseases) Regulations 1988 added 25 diseases, including meningitis, anthrax, leprosy, malaria, scarlet fever and TB, but influenza was not included. The 2008 Act adopts an “all hazards” approach and the consultation proposals suggest the inclusion of ‘human influenza virus’ and a more flexible approach to amend the list in the future.

³² See: R. Martin, ‘The Exercise of Public Health Powers in Cases of Infectious Disease: Human Rights Implications’, (2006) 14:1 *Medical Law Review* 132-143 at 136.

³³ Department of Health, *Health Protection Regulations: A Consultation* (8 July 2009).

³⁴ Relevant legislation in Scotland is now the *Public Health etc. (Scotland) Act 2008* which was passed on 12 June 2008. This restates and amends the existing law on public health, and in particular, it makes all types of Influenza virus ‘notifiable organisms’ under the new provisions. The previous legislation was the *Public Health (Scotland) Acts* of 1897 (c.38) and 1945, and *Health Services and Public Health Act 1968* (c.46).

³⁵ For a regular update on the Scottish position, see Health Protection Scotland: <http://www.hps.scot.nhs.uk/resp/swineinfluenza.aspx>

³⁶ An overview of the Civil Contingencies Act 2004 is provided in the *CCA Short Guide*, note 25 above, and the *Explanatory Notes* to the Act itself, available at: http://www.opsi.gov.uk/acts/acts2004/en/ukpgaen_20040036_en_1 (last visited 19 March 2009).

³⁷ *CCA Short Guide*, note 25 above at 2.

³⁸ *Ibid.*

³⁹ *Explanatory Notes to the CCA 2004*, note 36 above at 3.

⁴⁰ See: www.ukresilience.gov.uk/response/emergencypowers.aspx (last visited 19 March 2009).

⁴¹ C Walker and J Broderick, *The Civil Contingencies Act 2004: Risk, Resilience and the Law in the United Kingdom* (Oxford: Oxford University Press, 2006) at 75.

⁴² International Health Regulations (2005), Article 49(6). The Director General of the WHO declared the current pandemic on 11 June 2009, see note 1 above.

⁴³ Decision No 2119/98/EC of the European Parliament and of the Council of 24 September 1998 setting up a network for the epidemiological surveillance and control of communicable diseases in the Community, available at:

http://eur-lex.europa.eu/pri/en/oj/dat/1998/l_268/l_26819981003en00010006.pdf (last visited 19 March 2009). For a recent pronouncement on the influenza pandemic from the EU Health Commissioner, see: http://ec.europa.eu/health/ph_threats/com/Influenza/novelflu_en.htm

⁴⁴ SI 2005/2042 and its Scottish equivalent SSI 2005/494.

⁴⁵ *Explanatory Notes to the CCA 2004*, note 36 above at 4.

⁴⁶ CCS, Update of Emergency Response and Recovery, note 28 above, paras. 13.13-13.16.

⁴⁷ Cabinet Office, CCAEP Briefing Pack, available at:

http://www.cabinetoffice.gov.uk/media/131897/ccaep_briefing_pack.pdf (last visited 13 July 2009).

⁴⁸ J. Heaton, ‘Review, Respond, Recover’, (April 03, 2009) 19 *Public Service Review : Home Affairs*, available at :

http://www.publicservice.co.uk/article.asp?publication=Home%20Affairs&id=384&content_name=Civil%20contingencies&article=11666 (last visited 16 April 2009). For further information on the Civil Contingencies Act Enhancement Programme (CCAEP) see:

<http://www.cabinetoffice.gov.uk/ukresilience/preparedness/ccact.aspx> (last visited 16 April 2009).

⁴⁹ A chronology of the pandemic may be found in D Butler, ‘Flu pandemic underway’, *Nature*, Published online 11 June 2009, doi:10.1038/news.2009.564, available at :

<http://www.nature.com/news/2009/090611/full/news.2009.564.html> (last visited 13 July 2009).

⁵⁰ *National Framework*, note 29 above at 41-59.

⁵¹ For example, Chapter 3, Table 2, at 28-40 - UK planning presumptions during the different WHO phases. At the time of writing, the WHO phase of pandemic alert is 6.

⁵² See: Md Z Sadique, E J Adams and W J Edmunds, 'Estimating the costs of school closure for mitigating an influenza pandemic' (2008) 8:135 *BMC Public Health*, available at: <http://www.biomedcentral.com/1471-2458/8/135> (last visited 19 March 2009); but compare N Ferguson, 'Strategies for mitigating an influenza pandemic', (2006) 442 *Nature* 448-452.

⁵³ Walker and Broderick, note 41 above at 157.

⁵⁴ Walker and Broderick, *ibid*, citing House of Commons Library, Civil Contingencies Bill (Research Paper 04/07, House of Commons, London).

⁵⁵ 'It is accepted that during an emergency, unforeseen failures of the resilience plan or events in excess of planning assumption, will generate requests for Military aid. Planners should bear in mind that Defence's priority will be focused on delivering Defence outputs. Any requests will be scrutinised in terms of Military capability and capacity available and whether the actual request is a good use of Military assets - a positive response is not guaranteed. For instance, should Defence contribute to the delivery of security and public order or should they be utilised for municipal tasks; this will be a decision for ministers.' See:

http://www.ukresilience.gov.uk/response/recovery_guidance/generic_issues/military_aid.aspx

⁵⁶ See http://www.who.int/csr/disease/avian_influenza/phase/en/ (last visited 13 July 2009).

⁵⁷ The final report is available at:

http://www.vdh.virginia.gov/EPR/pdf/SDLP%20LCM%20Final%20Report%2010_31_07.pdf, at 22-23 (last visited 19 March 2009)

⁵⁸ The Winter Willow Report is available at:

http://www.ukresilience.gov.uk/news/winter_willow_lessons.aspx (last visited 19 March 2009) A similar exercise was held in Scotland. The report may be found at:

<http://www.scotland.gov.uk/Publications/2007/08/winter-willow> (last visited 19 March 2009).

⁵⁹ *Ibid*.

⁶⁰ Commissioned originally by the CDC. See:

<http://www.publichealthlaw.net/ModelLaws/MSPHA.php> (last visited 19 March 2009).

⁶¹ American Health Lawyers' Association:

http://www.healthlawyers.org/Content/NavigationMenu/Public_Interest_and_Affairs/Public_Information_Series/pi_EmergencyPreparedness.pdf

⁶² G J Annas, 'Bioterrorism, Public Health and Civil Liberties', (2002) 346:17 *New England Journal of Medicine* 1337-1341.

⁶³ *Winter Willow Report*, note 58 above at 16.

⁶⁴ Available at:

http://adcs.org.uk/Downloads/Consultation%20responses/0705_ADASS_ADACS_consultation_response_to_DH_framework_for_responding_to_Influenza_epidemic.pdf (last visited 19 March 2009).

⁶⁵ DFES, *Planning for an influenza pandemic: Guidance for schools and children's services* (2006) section 1.22, available at <http://www.teachernet.gov.uk/doc/9942/FullGuidance.pdf> (last visited 19 March 2009).

⁶⁶ *National Framework*, note 29 above at 81-82.

⁶⁷ *Ibid* at 82. Updated information for schools may be found at:

<http://www.teachernet.gov.uk/educationoverview/fluandemic/>

⁶⁸ In England, the decision to close a school is normally delegated by the Chair of the school's governing body to the head teacher. In a public health emergency, the head teacher would need to be clear whether that decision had been delegated to them. In addition, Local authorities (LAs) have a power to direct community, community special, or voluntary controlled schools as to the use of its premises; in theory, this power could be used to direct a head teacher to close a school if the LA had reasonable grounds (See: DfES Guidance, note 65 above, sections 2.24 and 2.6). A check list, to be used in conjunction with the DfES Guidance, states that while the "principle decision" that schools should close is taken by the Ministerial Committee in Civil Contingency, the final decision as to when schools close is taken by the school or childcare provider. Checklist available at:

<http://www.teachernet.gov.uk/docbank/index.cfm?id=10714> (last visited 19 April 2009). The

Department for Children, Schools and Families has also recently issued guidance on remote learning

during a pandemic, available at: <http://www.teachernet.gov.uk/emergencies/planning/flupandemic/#1> (last visited 19 April 2009). In Scotland, legal powers to close schools rests with local authorities; however, managers (normally at local authority level) could also decide whether a school should close for other reasons (i.e., lack of staff). See: Scottish Government, *Planning for a Human Flu Pandemic – Summary Guidance for Schools in Scotland* (2006) available at:

<http://www.scotland.gov.uk/Resource/Doc/135140/0033446.pdf> (last visited 19 March 2009).

⁶⁹ See: Special Supplement, note 3 above at 42.

⁷⁰ The Ministry of Justice recently conducted a consultation on ‘Planning Guidance for agencies and others involved in the Justice System’. The consultation document and questionnaire are available at: <http://www.justice.gov.uk/publications/consultation-pandemic-flu.htm> (last visited 14 July 2009).

The report of the consultation was not available at the time of writing.

⁷¹ *National Framework*, note 29 above at 115 ff.

⁷² *Ibid* at 116.

⁷³ Walker and Broderick, note 41 above at 122.

⁷⁴ *Ibid* at 205ff.

⁷⁵ *National Framework*, note 29 above at 73ff.

⁷⁶ *Ibid* at 73.

⁷⁷ See: Sadique et al, note 52 above, and Gostin and Berkman, note 16 above at 18.

⁷⁸ ‘Swine flu in Argentina: Pigheaded policies’, *The Economist*, 9 July 2009, p.49, also available at: http://www.economist.com/world/americas/displaystory.cfm?story_id=13998616. See also: V Smink, Swine flu infects Argentine economy, BBC News World, 10 July 2009, available at: <http://news.bbc.co.uk/1/hi/world/americas/8141996.stm> (last visited 13 July 2009).

⁷⁹ *Winter Willow Report*, note 58 above at 11.

⁸⁰ H Peck, *Resilience in the Food Chain: A Study of Business Continuity Management in the Food and Drink Industry* (2006), available here:

http://randd.defra.gov.uk/Document.aspx?Document=FT0352_4705_FRP.doc (last visited 19 March 2009)

⁸¹ The *Human Rights Act 1998* gives domestic effect to the rights contained in the *European Convention on Human Rights* (1950).

⁸² Note, however, that Article 15 of the European Convention on Human rights allows a State party to derogate from its obligations under the Convention in a time of war or a public emergency that threatens the life of the nation (except Articles 2, 3, 4(1) and 7), meaning that those provisions discussed here could be derogated from.

⁸³ See: Martin, ‘The Exercise of Public Health Powers’, note 32 above.

⁸⁴ For an excellent review of both the literature and jurisprudence see: J Rivers, ‘Proportionality and Variable Intensity of Review’, (2006) 65(1) *Cambridge Law Journal* 174-207.

⁸⁵ Nuffield Report, note 22 above at paras 3.37-3.38 and Box 3.2.

⁸⁶ Information Commissioner’s Office, *Privacy Impact Assessment Handbook* (2007), available at: http://www.ico.gov.uk/Home/for_organisations/topic_specific_guides/pia_handbook.aspx (last visited 19 March 2009)

⁸⁷ House of Commons Debates, Standing Committee F, col 230, 5 February 2004 (Fiona MacTaggart), available at:

<http://www.publications.parliament.uk/pa/cm200304/cmstand/f/st040205/pm/40205s07.htm> (last visited 19 March 2009).

⁸⁸ *National Framework*, note 29 above at 37.

⁸⁹ HMRC issued new SSP rates and guidance to be used from 1 April 2009. The guidance states that ‘In the event of a Pandemic alert being declared by the Government you will be informed of any changes to be made to the operation of the Statutory Sick Pay scheme during the period of the alert via HMRC’s web pages and the Employer Helpline and more general information would be provided via DWP’s and the Department of Health’s web pages, Television and Radio. Any changes announced would only be for the duration of the alert and information on when normal operation of the scheme should recommence would be provided through the same channels.’ The Guidance is available at: http://www.hmrc.gov.uk/employers/employee_sick.htm (last visited 13 July 2009).

⁹⁰ UK Resilience Website, Recovery Guidance – Military Aid: http://www.cabinetoffice.gov.uk/ukresilience/response/recovery_guidance/generic_issues/military_aid.aspx (last visited 22 April 2009).

⁹¹ Gostin and Berkman, note 16 above at 24 referencing WHO, Draft Protocol for Rapid Response and Containment.

⁹² Indeed, lessons can already be learned from the current pandemic. See: Keynote speech at meeting on influenza A(H1N1): lessons learned and preparedness Cancun, Quintana Roo, Mexico, 2 July 2009: ‘Influenza A(H1N1): lessons learned and preparedness’ given by Dr Margaret Chan, Director-General of the World Health Organization, available at : http://www.who.int/dg/speeches/2009/influenza_h1n1_lessons_20090702/en/index.html (last visited 13 July 2009).

⁹³ See report available here: http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/13_12_07_anthrax.pdf (last visited 19 March 2009).

⁹⁴ We are grateful to the anonymous referee for offering this example.