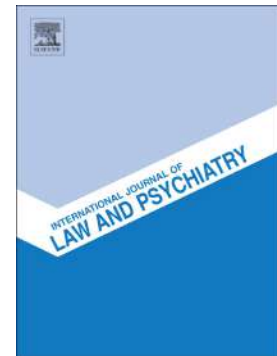


Journal Pre-proof

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PII: S0160-2527(20)30108-4

DOI: <https://doi.org/10.1016/j.ijlp.2020.101649>

Reference: IJLP 101649

To appear in: *International Journal of Law and Psychiatry*

Received date: 21 August 2020

Revised date: 10 November 2020

Accepted date: 10 November 2020

Please cite this article as: K. Liddell, A.R. Keene, A. Holland, et al., Isolating residents including wandering residents in care and group homes: Medical ethics and English law in the context of Covid-19, *International Journal of Law and Psychiatry* (2019), <https://doi.org/10.1016/j.ijlp.2020.101649>

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Isolating residents including wandering residents in care and group homes: Medical ethics and English law in the context of Covid-19

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ABSTRACT

This article investigates the lawfulness of isolating residents of care and group homes during the COVID-19 pandemic. Many residents are mobile, and their freedom to move is a central ethical tenet and human right. It is not however an absolute right and trade-offs between autonomy, liberty and health need to be made since COVID-19 is highly infectious and poses serious risks of critical illness and death. People living in care and group homes may be particularly vulnerable because recommended hygiene practices are difficult for them and many residents are elderly, and/or have co-morbidities. In some circumstances, the trade-offs can be made easily with the agreement of the resident and for short periods of time. However challenging cases arise, in particular for residents and occupants with dementia who 'wander', meaning they have a strong need to walk, sometimes due to agitation, as may also be the case for some people with developmental disability (e.g. autism), or as a consequence of mental illness.

This article addresses three central questions: (1) in what circumstances is it lawful to isolate residents of social care homes to prevent transmission of COVID-19, in particular where the resident has a strong compulsion to walk and will not, or cannot, remain still and isolated? (2) what types of strategies are lawful to curtail walking and achieve isolation and social distancing? (3) is law reform required to ensure any action to restrict freedoms is lawful and not excessive? These questions emerged during the first wave of the COVID-19 pandemic and are still relevant. Although focussed on COVID-19, the results are also relevant to other future outbreaks of infectious diseases in care and group homes. Likewise, while we concentrate on the law in England and Wales, the analysis and implications have international significance.

1. Introduction

COVID-19 is a serious problem for care homes, with some reports indicating more than 19,000 deaths in the sector in England and Wales,¹ accounting for more than half the country's coronavirus deaths so far.² Occupants in other group home settings have also been badly affected, for example people with intellectual disabilities living in residential care or supported living. Despite significant rates of mortality amongst their residents, it took several months for care homes to be prioritised for government support.³ In the meantime, staff in care and group homes across the country have managed the increased care and support needs of their residents, alongside increased workloads due to staff shortages, limited personal protective equipment,⁴ and much new policy guidance.⁵ At the time of writing, cases are now beginning to rise again in a second epidemic wave. Indeed, cases of COVID-19 are expected to continue for the foreseeable future. It is possible that the causative virus, SARS-CoV-2, will always circulate similar to influenza. Accordingly, it is important to reflect on best practice for isolating residents and avoiding COVID-19 infections in care homes, group homes and hostels (hereafter 'social care homes').

This article addresses three central questions: (1) in what circumstances is it lawful in England and Wales to isolate residents of social care homes to prevent transmission of COVID-19, in particular where the resident has a strong compulsion to walk? (2) what types of strategies are lawful to curtail mobility and achieve isolation and social distancing? and (3) is law reform required?

2. The challenges of social distancing in care homes

2.1 Mobility, 'wandering' and 'walking about'

Social care homes provide accommodation and support to elderly and frail residents, people with learning disabilities, and people with severe and enduring mental illness. Many people within these populations are vulnerable to the effects of COVID-19. They have pre-existing comorbidities associated with poor outcomes, and live in circumstances where it is difficult to practice good hygiene and social distancing. For example, staff may assist multiple residents with intimate tasks such as dressing and bathing, sometimes in more than one home,⁶ and buildings are often designed to bring people together for communal eating and activities. In normal circumstances, social interaction has many benefits, but in the pandemic, it increases transmission risks. A further challenge in these settings – and the focus of this paper – is the common occurrence of residents who 'wander' or walk extensively, for varied reasons.

This paper analyses the lawfulness of isolation for all residents, with a particular emphasis on the challenging cases that arise with residents with impaired cognition who walk extensively, and who find it difficult to appreciate the need for social distancing or whose need to walk is such that it is difficult for them to limit themselves to a restricted area. These individuals come into close proximity with other people, unless staff intervene. They include (among others) people suffering from dementia, some of whom may walk for extended periods during the day up and down corridors. They also include adults with autism and/or learning disabilities

who walk to offset anxiety and agitation perhaps due to changes in their routine during the pandemic, and people with enduring mental illnesses who walk for a diverse range of reasons.

Given the widespread and highly transmissible nature of SARS-CoV-2, isolation and restricted freedom of movement is an issue for any resident who is mobile. Questions of law and ethics will be relevant whenever a resident disagrees with distancing or hygiene recommendations. Particularly challenging issues arise with residents who walk extensively and experience a strong *need* to walk. There are different reasons for extensive walking. The individual may be trying to relieve boredom, pain, anxiety or restlessness, or they may feel, albeit possibly irrationally, that they are lost or need to find someone or something, or to get away. They may be confused and disorientated in time, place and person. Walking may be an ingrained habit, a normal routine, a way of staying independent or a source of pleasure. Sometimes the motion is driven simply by a strong and repeated feeling that they *need* to walk; which can be a side effect (akathisia) of some anti-psychotic medications.⁷ Depending on the reason for a resident's walking, isolation and confinement may be difficult to achieve.

'Wandering' is the vocabulary used in many medical journals to describe the walking behaviours associated with dementia or other cognitive impairment. For example, 'wandering' has been defined as:

*'seemingly aimless[,] or disoriented[,] ambulation throughout a facility ...often with observable patterns such as lapping, pacing, or random ambulation.'*⁸

However, there is no conclusive nor agreed definition, and recent literature tends to regard the term 'wandering' as unhelpfully imprecise, inaccurate and/or pejorative. The ordinary meaning of 'wandering' suggests the motion is simply casual meandering with minor significance. In reality, however, the wanderer may walk in a determined and persistent manner, with a purpose and/or the walking may be highly significant for the individual.

In this paper, echoing the Alzheimer's Society,¹⁰ we use the term 'walking about' to refer to a variety of behaviours including 'wandering', walking, including walking with purpose, and going out. As mentioned, there are times when all independent mobile residents will want to move about. Walking itself is not a problem – it is the circumstances in which the walking takes place, such as widespread COVID-19 and the need for infection control, which creates issues. The approach recommended in this article provides a broad and flexible framework for working through the issues. Residents who lack decision-making capacity or who refuse to isolate, and who walk extensively pose the greatest challenges.

2.2 The benefits and detriments of walking about during the pandemic

There are strong reasons to help an individual stay mobile, especially if they walk regularly and extensively. Walking contributes to a person's fitness and general health, including preserving muscle mass and independence, and reduces tension. It can also be an important way in which an individual maintains interest in their life, a sense of self, and self-direction.¹¹ Even outside of the context of infectious disease, the benefits of

walking have to be weighed against the risks. These include the risk of falls, uninvited entry into other bedrooms, leaving the building, and getting lost. These are typically managed in a way that allows the person to carry on walking, including outdoors. Fall risks can be managed with hip pads, walking aids, and by removing trip hazards. Inappropriate pathways can be managed by staff observation, key cards, and wearable tracking devices.

The COVID-19 pandemic makes walking about additionally risky, and has accentuated tensions between risk and benefit, and what is acceptable restriction of mobility and what is not. COVID-19 is a potentially fatal condition resulting from infection with the virus SARS-CoV-2. Long COVID (also known as Post-COVID syndrome¹²) and ‘severe COVID’ (involving severe agitation and extremely severe breathlessness requiring opioids) have been described.¹³ The risk of transmission within the indoor environments of care homes are high. It is well-established that the SARS-CoV-2 virus transmits through contact and droplet transmission such as kissing, coughing, sneezing, loud vocalisation. Transmission risk is presently considered high if people are within 2 metres for 10-15 minutes.¹⁴ Airborne transmission (where infectious particles survive in air over long distances and time) and fomite transmission (where infectious particles contaminate surfaces and objects) are other suspected modes of transmission.¹⁵ Crucially, residents who walk about are exposed to, and expose others to, contact, droplet and fomite transmission. They can easily touch hard surfaces (walls, doors, bannisters) and come within two meters of other residents, staff, or the general public (often much closer) in corridors, common areas, public spaces, or when they mistakenly enter another resident’s private room. Cleaning measures will greatly reduce fomite transmission, depending on the frequency of the cleaning schedule.

2.3 Relevance of COVID-19 status

The risks posed from walking about during the COVID-19 pandemic differ depending on whether the person concerned is COVID-negative or COVID-positive. People who are COVID-negative and walk about put *themselves* at risk of acquiring a potentially fatal infection, and subsequently spreading the disease. Those who are COVID-positive primarily pose a risk to *other* residents and staff. Occasionally, a COVID-positive resident may also pose a risk to themselves, for example if they fail to realise the seriousness of their illness or are at increased risk of falling as a result of infection.

Distinguishing COVID-status is, however, difficult due to several sources of uncertainty. For all people, there is a period of latency and a significant number of false negatives with presently available diagnostic tests, possibly as high as 30%.¹⁶ There are additional difficulties for residents of social care homes.¹⁷ Until more practical tests are available (e.g. saliva tests), people with cognitive impairments are likely to have little patience for the uncomfortable nasopharyngeal procedure if they do not understand its purposes. Screening on the basis of symptoms is tricky because classic COVID-19 symptoms are much less prominent in elderly residents and it is unknown whether or not they are standard in people with specific genetic-linked learning disabilities. For example, elderly people rarely experience the fever and cough that are characteristic of COVID-

19 infections in younger people.¹⁸ Even in the absence of COVID-19 infection, elderly people commonly suffer from a cough, lack of smell and taste, fatigue, and have appetites and periods of confusion that wax and wane.¹⁹ Furthermore, people with dementia or severe learning disabilities may not have the vocabulary to report the symptoms they are experiencing.

2.4 The effects of isolation

When thinking about the effects of isolation, it is important to recognise that social care homes are not merely a place of care but also the residents' homes (even if not always adopted as such out of choice). Isolation from the world outside (including friends and family), and separation within a home can lead to boredom, loss of purpose, anxiety, low mood and subsequent decline. People with dementia and cognitive impairment are particularly vulnerable because they are no longer able to understand the situation and often cannot use IT or phones to contact others electronically. Sometimes walking – and associated interactions with other people and the environment – is one of the few activities that give a person's life purpose and enjoyment. Reportedly, isolation has been overused with major impact.²⁰ For example: “care home residents confined to their rooms and forbidden visits from loved ones are giving up on life and ‘fading away’”;²¹ “The virus won’t be the killer of these people, it’s the distress and fear of [isolation] that is doing it”;²² and “residents who were giggling, happy and active before the crisis now just lie in their beds or sit alone in their rooms with their doors closed...Many now barely respond when you speak to them...Some shout for their friends and family. Others have given up entirely and are fading away.”²³

2.5 ‘Soft’ and ‘hard’ strategies for isolation

Where a degree of isolation is required, different methods can be employed to curtail walking. A variety of low-intervention strategies, which we term ‘soft strategies,’ include: explaining the purpose of social distancing and seeking support of carers, family and friends to communicate this message; investigating and addressing unmet needs (pain, hunger/thirst, boredom; too much noise; medical attention for hyperactive delirium²⁴); offering distractions and enticements back to the person's own space (e.g. “let’s go have a cup of tea in your room”); increasing stimulation (e.g. purposeful activity, or TV) in their own room; increasing staff:resident ratio so it is possible for staff to accompany them on a walk; moving the resident to a room more distant from others or closer to a garden. Where people have learning disabilities, explanations can be simplified and repeated.²⁵

Soft strategies will not always be effective, and it may therefore be necessary to *consider* other techniques to restrict a resident's walking behaviour. We term these other techniques ‘hard strategies’ because they are more interventionist and raise more serious ethical concerns. They include: cohorting residents – also known as zoning residents – in groups of confirmed positive or confirmed negative residents; moving residents to different accommodation (e.g. with relatives, another care home, or a psychiatric hospital);

physical/mechanical restraint; and sedation. Physical restrictions that might be mooted include: door locks; ‘baffle’ handles; high bed rails; door alarms and tagged bracelets.²⁶ Types of sedation that might be considered, but not necessarily approved, include benzodiazepines, antipsychotics, or sedative antihistamines to settle a resident who is distressed by isolation or to reduce their movement.²⁷

These approaches are ethically problematic if they are overused, particularly with people with learning disabilities or cognitive impairment.²⁸ They also have practical drawbacks. Some physical restrictions can paradoxically increase the risks of falls and injury. They can make some walkers agitated, confused, angry and aggressive. These reactions are obviously upsetting for the individual and pose risks to staff and other residents in close proximity. They also affect valuable relationships of trust, and distress other residents. Physical restrictions can also be problematic even when the resident does not resist. As mentioned above, forced stillness can seriously reduce a person’s quality of life, particularly when walking or going out would otherwise provide stimulation or mental relaxation.

All hard strategies have potential harms and ethical concerns. For instance, finding the resident alternative temporary accommodation can cause a lot of anxiety, distress and confusion, decreased cognition and increased mortality in those with dementia, plus a high administrative burden for staff and families. Often there is no suitable accommodation, even with willing families, when the individual has dementia and/or needs high levels of care. Cohorting preserves a degree of space for walking about, but a resident’s walking is nevertheless restricted to a specific place for significant periods of time,²⁹ subject to surveillance and, should they try to breach the boundaries, physical re-direction.

2.6 Diversity of circumstances

Sections 2.2-2.5 demonstrate that there are many factors to consider when seeking to decide whether a mobile resident should be isolated in their room using soft or hard strategies, or allowed to walk about. The risks of a serious COVID-19 illness resulting from walking about vary considerably; for example, depending on the resident’s age, previous infection, or the level of virus currently circulating in the community. The benefits of walking about for an individual’s well-being are also highly variable. For some, walking about relieves boredom so alternative stimulation could take its place. In contrast others need to walk to relieve pain or anxiety. Responses to isolation (essentially forced introversion) also differ. For example, some residents become extremely agitated or emotionally locked-in if confined to a room with limited movement or social contact; others are content to ‘wait it out’. Furthermore, we noted that the availability and impact of isolation techniques differ across social care homes. Some, for example, have facilities for segregating residents with different risk levels; others do not. Some have staffing levels that can provide alternative stimulation or 1:1 support whilst walking; but not all.

3. Central Ethical Concepts

Being faced with such a wide variety of circumstances, blanket rules directing how and when residents of social care homes should be isolated are clearly inappropriate. A principle-based approach, coupled with case-by-case application of the principles for individual residents, will be far more sensitive and specific. Ethical reflection steers one towards such principles, which can then be applied in any country, and also identifies the ideas underpinning the English legal framework analysed in Section 4.

The ethics of managing COVID-19 in care homes raises a challenging blend of concepts from clinical ethics, disability ethics, public health ethics, organisational ethics and human rights. Space does not allow a full discussion - after all, an uncontroversial ethical system has eluded humankind for thousands of years - but several principles are clearly relevant and reflect fundamental human rights.

1. **Respect personal autonomy** – in simple terms, autonomy is about a person's ability to act on his or her own values, interests and desires, to live a life of their own choosing. Typically, autonomy is highly valued—and therefore should be respected—because personal autonomy provides each person with their *own* life path, which lets them balance pros and cons in their own way, and gives them and their life identity and meaning. If an action affects a person with the capacity to make their own choices, it is common to permit the action with the individual's informed consent. For example, if a COVID-negative resident wants to prioritise quality of life over quantity, they might choose to keep walking about. There may be other ways to justify the action, for example if the resident was COVID-positive then even without their consent the action might be justified to protect the welfare of others. The ultimate decision depends on a careful assessment of all the other principles.
2. **Support personal autonomy** – Residents of social care homes have different capabilities for living autonomously. Impaired capacity to process information can make it more difficult to exercise personal autonomy but does not erase its importance. Therefore it is vital that people with impaired decision making are supported to make their own choices so far as they can.
3. **Protect welfare** – the ethical idea of welfare is that one should act so as to protect and take care of other people. When the action affects a person positively for their own good, the language of 'best interests' is often used to capture this general concern. If the person has the capacity to act with autonomy, giving priority to a decision in their best interests is considered paternalist. For those who are unable to make their own autonomous decisions, it is appropriate when making choices for them to make decisions in their best interests, taking into account their past and present wishes and feelings. A person's best interests includes not only their medical interests (e.g. the benefits of protecting them from infection) but also their overall wellbeing (e.g. the benefits of having contact with other people). Where the action is guided by other people's interests and affects an individual negatively, the language of 'the public interest' or 'third party interests' is often used. Public health quarantine laws, which allow officials to keep people isolated against their will to limit the spread of COVID-19, are an example of rules to protect welfare, in particular third party residents and staff, and the wider public.
4. **Respect privacy** – the importance of privacy is partly linked to personal autonomy (and the importance of *choosing* how, when and why we interact with other people) and partly flows from

the value of having a zone of separateness from other people including the State so that a distinct identity and inner world can be formed. The ECHR upholds the respect for privacy and family life in Article 8. However, this right is not absolute. For example, a state-managed care home can restrict visiting by friends and family where protection of public health requires.

5. **Respect human dignity** – the idea of ‘human dignity’ is that each person should be valued, protected and respected for their own sake, not because of what they do. In Europe, and some other societies, the absolute right not to be subjected to inhumane or degrading treatment is a manifestation of the principle of human dignity. Overuse of psychoactive drugs to keep residents still and compliant is considered a failure to respect human dignity, and inhuman and degrading treatment.
6. **Uphold equality** – this is the idea that one should respect the interests, rights, and freedoms of each person equally. This does not mean all people should be treated identically, because their circumstances will differ. ‘Consistent treatment’ is a related idea: it requires that like cases are treated alike. Equality legislation and anti-discrimination principles protect certain characteristics, and prevent them from being used inappropriately to draw distinctions between people. For example, a person with a disability should not be denied services *because* they have a disability, but may be denied services because they are unable to benefit (provided that this does not amount to unjustified indirect discrimination). Article 14 of the ECHR also provides some protection.
7. **Protect liberty** – simply stated, liberty is freedom. Freedom from constraints is referred to as negative liberty, to distinguish it from positive liberty which requires a person to be given *support* to act freely. For instance, the State may have to provide nursing care and reasonable adjustments to support the liberty of elderly and disabled people. In Europe, Article 5 of the ECHR protects the right to liberty and security. Working without being confined to a particular place is an important liberty in social care homes. However, Article 5 is not an absolute right, nor is the duty to make reasonable adjustments to support people with disabilities under the Equality Act 2010.
8. **Protect fundamental rights** – theories of human rights seek to set out the rights to which individuals can lay special claim to protect them from abuses or exploitation. Because the rights of one person impose duties and responsibilities on another, usually only fundamental human rights get special protection. These are the rights necessary for an ethical and peaceful society. For example, the right to life, freedom from torture, respect for property, and rule of law. Constitutional rights, and the ECHR, are examples of *enforceable* fundamental rights. The right to healthcare is not expressly protected by the ECHR, but it is considered a fundamental human right by many and public authorities must take steps to protect a person’s health to a certain extent in order to protect their right to life, and private and family life.³⁰ Many other international treaties exist, not all of which are enforceable to the same extent; for example the United Nations Convention on the Rights of Persons with Disabilities.³¹
9. **Act justifiably and proportionately** – the principle of proportionality (also known as the principle of justification or the principle of reasonableness) is the idea that actions that affect others negatively should be backed by a legitimate reason, necessary, and proportional to the goal.

The overarching point is that it is wrong to interfere with other people without justification. This stems from respect for personal autonomy and other personal rights and interests.

10. **Ensure that major decisions and actions are transparent, accountable and open to independent review:** the principle of transparency makes decisions and actions visible so that it is possible to verify whether they are justifiable and proportionate. Accountability ensures that mistakes are rectified. Independent review creates the opportunity to check the process of reasoning and important facts. In a care home setting, policies affecting residents should be openly available. A government policy can be challenged in judicial review if it is irrational, unlawful or failed to sufficiently consult those that it affects. The government and care homes can be sued if they negligently harm a resident directly or indirectly. Care plans are reviewed by more than one person, and serious restrictions of liberty are independently reviewed.
11. **Fair allocation of resources** – Healthcare resources, (such as budgets for treatments, trained personnel, clinic appointments, machinery and devices, diagnostic tests, protective equipment) are scarce resources. Demand from those in poor health or for preventative care will always exceed supply. The available resources should therefore be distributed fairly. Fair allocation does not necessarily mean an equal amount for each person – individuals' needs and expected outcomes are relevant differences. During the pandemic, staffing levels and PPE have been inadequate. This raises the question whether health resources have been fairly allocated across acute and social care domains.

Considered separately, each of these principles is widely accepted as an important ethical value; regardless whether one ascribes to utilitarianism, rights-based reasoning, duty-based reasoning (e.g. Kantianism), virtue ethics, libertarianism, communitarianism, Catholicism, Judaism etc. Differences emerge when considering the principles with greater granularity, or when the principles appear to require trade-offs. For example, people differ in their interpretation of autonomy, whether and what kinds of outcomes justify exceptions to each of the principles, and the resources that should be made available.

The challenge for ethical frameworks that seek to guide practice is to provide a system for resolving detailed questions (e.g. is it acceptable to take away a resident's walking frame to confine them; is an exception to independent review warranted in the urgent circumstances of the pandemic; how much weight should be given to the resident's past versus present wishes?), and tensions between the principles (when should the health of others take precedence over the resident's well-being; should the resident's strong desire for liberty and quality of current life be prioritised over living another year or two possibly under pandemic-like conditions?). A key difference between legal and ethical frameworks is that the law is enforceable. In any given case, the legal framework must have a system for deciding contentious details. We turn to this in the next section, and explain how the English legal system deals with the challenges of social care home residents walking about during the pandemic.

4. English law

4.1 The legal framework

Hundreds of Spanish care homes are facing criminal and civil investigations for allegedly substandard COVID-19 care,³² which demonstrates the importance of UK care homes being properly aware of their legal obligations. Less obviously, but perhaps more importantly, the law sets out a helpful framework for the exercise of professional judgement. To date there has been very little scrutiny of the legal issues for care home residents who walk about,³³ although some practical advice has been developed³⁴ and the government has published general legal advice for care homes supporting people with impaired decision-making during the pandemic.³⁵

In many circumstances, rather than dictating particular outcomes, the law sets out principles that reflect and attempt to balance a wide variety of interests relevant to the individual, other residents, the healthcare system, and the public. In this way, the law is somewhat like an enforceable framework of ethical principles, and fortunately there are many similarities with the core ethical principles described above. For example, as this section explains, the law emphasises that: residents should be treated in a non-discriminatory manner (see above principle 6 ‘uphold equality’) and hence supported to make their own decisions when they have decision-making capacity (see principle 1 ‘respect personal autonomy’ and principle 2 (support personal autonomy)); additional safeguards should apply for more substantial restrictions of liberty (see principle 7 ‘protect liberty’, principle 8 ‘protect fundamental rights’) including independent and judicial review (see principle 10 ‘ensure major decisions ... are open to independent review’); restrictions should be no more than necessary, and must be proportionate to the risk of harm (see principle 9 ‘act justifiably and proportionately’); that (where the resident lacks capacity) decisions should be in the resident’s best interests (see principle 3 ‘protect welfare’), determined through consultation with people who know them and taking into account the person’s previously or presently expressed wishes and values (see principles 1 and 2 ‘respect and support personal autonomy’).

Ideally, social care homes would not restrict a resident’s movement without their prior consent (assuming they have decision-making capacity) and cooperation. Consent is a proper source of legal justification for restricting individuals’ freedoms and rights, and coheres with ethical principles because generally it is one of the most practical ways to respect personal autonomy, protect welfare, respect privacy, respect human dignity, protect liberty, protect fundamental rights, act proportionately and so on. However it is not always possible to obtain or necessary.³⁶ In the absence of valid consent, the legal system offers other arrangements and justifications for restricting freedoms. These can seem complex. However, our research has distilled the key legal factors, which we have organised with reference to the ethical framework above. The remainder of the article explains this ethico-legal structure.

In summary, from a legal perspective, in England, the final decision on whether or not to restrict walking about to achieve isolation, the decision-maker, the means of restricting walking, and the legal justification differ depending on:

(i) whether the social care home resident has decision-making capacity and is consenting or not (see Section 4.2);

- (ii) an assessment whether, for a resident lacking decision-making capacity, prevention of walking is in their best interests (see Section 4.3);
- (iii) whether the restrictions amount to what the law terms ‘a deprivation of liberty’ (see Section 4.4);
- (iv) whether the purpose of isolation is to protect third parties rather than the resident’s best interests (see Section 4.5); and
- (v) whether the strategy to restrict walking respects human dignity (see Section 4.6).

The main sources of law governing whether a restriction on a person’s freedom to walk about is lawful include the general law, the Mental Capacity Act 2005 (‘MCA’), the Human Rights Act 1998 (which implements the ECHR) and the Coronavirus Act 2020. Two further sources of law include the Mental Health Act 1983 (‘MHA’) and the courts’ inherent jurisdiction to protect vulnerable people.

4.2 Autonomy

4.2.1 Isolating a social care home resident *with capacity to consent*

If an adult social care home resident has decision-making capacity, they must be treated like other adults. This applies regardless of whether their decision is considered rational by another person. General principles of law on battery, assault, and trespass require a person’s consent (or other legal justification)³⁷ before other people may touch or interfere with their body. Confinement also requires a person’s consent (or other legal justification). Paternalistic efforts to help, even though well-meaning, are not permitted if they interfere with, or confine, the resident’s body. This follows the long-established ethical principle (see above ethical principle 1) that an adult’s personal autonomy should be respected.³⁸ It also reflects human rights protected by the ECHR; namely Article 8 (the right to respect for private and family life) and Article 5 (the right to liberty).

This substantially restricts the circumstances when a social care home resident with decision-making capacity who refuses to isolate and continues walking around the home putting themselves at risk of a COVID-19 infection can be isolated lawfully. Soft strategies (which don’t involve force or confinement) are permitted.

In contrast, hard strategies, including physical restraints, sedation and cohorting are generally not lawful without the resident’s consent.³⁹ If the resident with capacity is COVID-positive, putting others at risk, an act to prevent a person causing harm to another may be justified by the common law defence of necessity, but this will not cover situations where restrictions are imposed repeatedly or on an on-going basis. It excuses occasional incidents only.

There are four exceptions to the prohibition on hard strategies when residents have capacity. Firstly, the MHA allows a person affected by a mental disorder, including one with capacity, to be involuntarily detained, assessed, and treated in hospitals and specially designated mental health facilities, providing all

necessary criteria are met.⁴⁰ Section 63 of the MHA also allows some treatment of the mental disorder and its symptoms without the person's consent for their own protection and the protection of third parties.⁴¹

Compulsory medical treatment powers under the MHA must be used sparingly. But their most limiting feature for the settings at the centre of this article is that very few social care homes are designated as mental health establishments, meaning the MHA provisions can be used to isolate a resident of a social care home only if the resident is moved to a psychiatric in-patient facility.⁴² Such a transfer would need to meet the legal threshold for this to occur and is unlikely to be a solution for large numbers of people given the limited resource available.

Contract law presents a second possible exception. A contract between a social care home and a privately-paying resident may specify relevant terms, for example that the resident must follow all policies and procedures (such as a policy on cohorting or isolation during the pandemic). However, contractual provisions are very unlikely to allow a breach of contract to be managed with force. More likely, the contract will allow one party to terminate the care arrangement but only after a notice period. Contractual exceptions are thus unlikely to enable swift action to avoid transmission of COVID-19 and could, if enacted, leave the resident homeless.

Thirdly, and of most relevance, there are occasions when hard strategies could be lawfully justified in order to protect *other* people or the public interest. To prevent the spread of infectious diseases, these sorts of powers are set out in public health legislation. The Coronavirus Act 2020 provides new powers for Public Health Officers to direct and detain potentially infectious persons. Section 4.5.2 explains these powers, including their limitations, for instance that they do not permit a resident to be forcibly restrained or sedated in their bedroom. A fourth exception relates to the courts' inherent jurisdiction to protect vulnerable people. This is also explained below.

4.2.2 Mental capacity determinations

The MCA and its associated case law and Code of Practice govern the circumstances under which a person is considered to have decision-making capacity.⁴³ The starting assumption is that a person has capacity. However, they may lack capacity for a particular decision if, after being offered all appropriate and practical support for decision-making (reflecting ethical principle 2), they are functionally incapable of understanding, retaining, using, and weighing the relevant information, or communicating their decision. If incapable, it must also be established that this is caused by an impairment or disturbance in the functioning of the mind or brain. Capacity is time and decision specific, and often dynamic, so may need to be regularly assessed. For instance, a resident suffering from a urinary tract infection (which can increase confusion) may have the capacity to decide small matters such as what to wear and when they want to sleep, but lack the capacity to decide whether they will isolate as requested by care home staff to reduce the transmission of COVID-19. However, when the urinary tract infection resolves, they may regain the capacity to make decisions about isolation.

4.3 Welfare of the individual: Best interests

4.3.1 Isolating a care home resident *without capacity to consent*

For residents lacking decision-making capacity for isolation and walking about, the MCA predominantly governs the steps that staff are permitted to take. The MCA is geared towards protecting the *best interests* of adults lacking capacity since they cannot weigh up the possible consequences for their interests and make their own autonomous choices. In this way, the law protects their welfare. The law also sets out additional safeguards for acts which interfere more substantially with a resident's liberty. For instance, a distinction is drawn between *restricting* a person's liberty and *depriving* a person of their liberty. Additional procedures and criteria must be met for the latter. By and large, soft strategies for preventing walking during the pandemic fall in the category of liberty *restrictions*. This is also true of the hard strategy of moving a resident to alternative accommodation because the liberty restrictions for the move are short-lived. Actions that are 'restrictions' and do not amount to 'deprivations' are lawful under the MCA provided they are in the person's best interests, and their best interests have been assessed in accordance with the MCA and its Code of Practice; they must also be necessary and proportionate to the risk of harm that the person would suffer otherwise. On the other hand, hard strategies involving physical restraint and pharmacological sedation are likely to count as *deprivations* of liberty. For these actions, a social care home must have additional safeguards in place (as well as undertake a careful best interests assessment. The special additional safeguards for 'deprivations' are discussed below in Section 4.4.2, but first we explain the best interests analysis that applies more widely.

4.3.2 Strategies permitted on best interests grounds

The MCA makes it clear that acts can only be done if they are reasonably believed to be in the individual's best interest.⁴⁴ In fact, the principle is slightly more nuanced in section 5 of the legislation, a point which explains why best interests assessments are not carried for all acts done to individuals lacking capacity. Section 5 of the MCA states that actions that would *ordinarily require consent* from a person *with capacity* can be done to a person lacking capacity if they are in their best interest.⁴⁵ This follows the ethical reasoning that where consent would be a way to authorise care and treatment of a person capable of making their own decisions, acting in the best interests of a person lacking capacity is a reasonable proxy. This is not the same as the more sweeping statement in section 1. Section 5 is more refined because it leaves open the possibility that actions can also be justified by reasons other than the best interests of the person; in the same way that actions done to a person with capacity can be justified by reasons other than consent. For example, actions done to a person might be justified because they have so few implications (ie that they would not require the consent of a person with capacity), or based on public health powers.

Soft strategies for curtailing walking about involve low degrees of intervention. Most are so innocuous or so obviously in a resident's best interests that a formal assessment is unnecessary. For instance, a best interests evaluation is unnecessary prior to *explaining* repeatedly the purpose of social distancing, addressing unmet needs, increasing stimulation in the resident's bedroom, and increasing staff:resident ratios. It is also obviously in a resident's best interests to address unmet needs which might be driving their desire to walk about

(e.g. pain, boredom). A swift, informal best interests assessment will usually be sufficient with other soft strategies such as offering distractions and enticements back to the person's own space. A more formal best interests assessment might be required for soft strategies such as moving the resident to a different bedroom in the same care home, where these could create a degree of anxiety or confusion.

A best interests assessment should also be carried out before *asking* a resident lacking capacity to isolate in their bedroom for long periods of time. Such actions may seem entirely benevolent and, in the case of a compliant resident, it may appear harmless. However, as described above,⁴⁶ isolation, loneliness and stillness can have serious consequences. A degree of social interaction may be one of life's few pleasures for social care home residents, and in law compliance with isolation and confinement is irrelevant if the person concerned lacks the capacity to make decisions about these matters.⁴⁷

Unfortunately soft strategies will not always protect a resident's best interests effectively. For example, moving someone to a more appropriate bedroom may be impossible depending on the size and layout of the building. Offering distractions, enticements, and more stimulation requires staff time and skill which may not be available, and ultimately may not be effective. Some residents will continue to try to walk, particularly those with dementia (old and young) who do not understand the purpose of social distancing or those with autism who become highly anxious when their routines change. It will therefore be necessary to consider harder strategies, such as cohorting, moving a patient to another care home, physical/mechanical restraint or sedation.

It is always advisable to evaluate best interests carefully prior to implementing hard strategies; all of them have potential harms and ethical concerns. For instance, finding the resident alternative temporary accommodation can cause a lot of anxiety, distress and confusion, decreased cognition and increased mortality in those with dementia, plus a high administrative burden for staff and families. Often there is no suitable accommodation, even with willing families, when the individual has dementia and/or needs high levels of care. Cohorting preserves a degree of space for walking and may be common practice in care homes, but a resident's walking is nevertheless restricted to a specific place for significant periods of time,⁴⁸ subject to surveillance and, should they try to breach the boundaries, physical re-direction.

Physical and pharmaceutical restrictions must be considered carefully; some will be entirely unsuitable. For example, high bed rails can be dangerous. A resident with cognitive impairment might try to climb over (and fall), or wriggle under bed rails (and asphyxiate).⁴⁹ In rare situations, residents may benefit from anti-psychotic medication (such as in cases of significant aggression).⁵⁰ However, using these medications to reduce movement would generally be dangerous, rendering the resident at greater risk of falls. Such drugs are also associated with increased cerebrovascular events and mortality. Furthermore, there is only limited evidence that in acceptable doses they reduce a resident's wish, or ability, to move freely.⁵¹ (As well as best interests issues, physical and pharmaceutical restrictions also raise issues for deprivation of liberty and degrading treatment. See Sections 4.4 and 4.6).

4.3.3 Best interests determinations

When evaluating a resident's best interests, the decision-maker should consider all relevant circumstances,⁵² and in particular:

- whether it is likely that the person could regain capacity and if so whether the decision can wait
- ensuring participation if reasonably practicable
- the person's past and present wishes and feelings, and beliefs and values that would be likely to influence their decision
- the views of the person's family members and those interested in the person's welfare, if it is practicable and appropriate to do so.

A key question is *which* strategy is in a resident's best interest. It is important to emphasise that soft strategies should always be used in preference to harder strategies for first-line management of social distancing.⁵³ Partly this is because soft strategies involve fewer risks to a resident's safety and well-being. Legally then, the best interests calculus will favour the soft strategy, if it works. Legally, this approach is also imperative to accord with Article 8 of the ECHR, and the Human Rights Act 1998. Article 8 protects a resident's right to a private life, and an interference to protect the resident (or another person) can only be justified where it is necessary and proportionate for one of the aims prescribed in Article 8(2) such as to protect health.

There is also an important question *prior* to deciding which strategy to use – namely whether isolation or cohorting is indeed in their best interests. The value of isolation and cohorting during the COVID-19 pandemic is mixed. It certainly reduces the risk of viral exposure, but it does not eliminate it. Residents could still be exposed to the virus by staff members. It is also important to recall that viral exposure is not a bad outcome *per se*. Not all exposures lead to infection, and not all infections are serious or cause death. So, although COVID-19 is a potentially serious infection and has particularly serious outcomes in social care homes, and despite walking about increasing the risk of transmission, should not assume that walking should be prevented via hard approaches if softer measures are unsuccessful.

It is also important to avoid concluding that isolation in a *bedroom* to reduce the risk of COVID-19 infection is in the resident's best interests. Confinement in a bedroom for extended periods of time carries a variety of risks as described in Section 2.4; for example boredom, isolation, loss of purpose, anxiety, cognitive decline. There is also some evidence that physical exercise outside a bedroom could reduce the risk or impact of respiratory infection (such as influenza, pneumonia or COVID-19).⁵⁴ When the pros and cons for confinement to a bedroom are debatable, cohorting will often be in the best interests of a COVID-negative walker, provided the area where the cohort is confined is large enough and set up appropriately, so that a good quality of life is maintained.

Whether cohorting or bedroom isolation is in the best interests of a COVID-*positive* walker requires finer balancing because they are already infected. Restricting their movements will not reduce their risk of infection (they already have the virus), but rather prevent them from passing it on. When analysing the best interests of a COVID-positive walker, it is relevant that the law takes a wide⁵⁵ approach to the concept of ‘best interests’. Relevant circumstances include more than the resident’s medical interests, meaning that it is possible that cohorting or bedroom isolation is in the COVID-positive walker’s best interests even though it has no positive effect upon their own health. For instance, being kept separate from COVID-negative residents might prevent a COVID-positive walker from being angrily challenged by other residents, and support the walker’s friendships with staff and other residents.⁵⁶ Occasionally, the courts have also considered *third* party interests, beyond self-focussed interests, provided that concern for the third party’s interests has some bearing on the individual’s overall own interest. For example, a resident’s own interests might be advanced by respecting the duties or inclinations of a reasonable or responsible citizen, or by being a generous or altruistic person. Knowledge of the resident’s past personality and their values, or the fact that many people with capacity take such factors into account, mean such factors can be included in the weighing up of interests.⁵⁷

It is important to recognise that a walker’s interest in altruistically or responsibly preventing transmission to third parties is just one factor in a best interests analysis. It is unlikely to outweigh significant harms. People with capacity do not routinely put themselves in the way of significant harm for the sake of their interest in altruism, and being *expected* to do so undermines the very concept of giving beyond the call of duty. Accordingly, it would be false to assert that, based on altruism, responsible citizenry, or normal decency, it is in a resident’s best interests to isolate for a long time while they face the negative consequences of loneliness, stillness, and a poor quality of life. Similarly, it would be wrong to assert that some of the harder strategies to isolate a COVID-*positive* walker such as physical restraint, sedation, or moving the resident to alternative accommodation are in a walker’s *best interests* due to the benefits they bring to others. Cohorting and wearable surveillance devices might be justified by altruism. But as explained, harder strategies carry major risks well beyond the loneliness, and low-grade anxiety and depression that people with capacity experience when they isolate. Very few, if any, individuals with capacity would agree to be locked in a room or medically sedated for prolonged periods due to the weight they attach to being a responsible, altruistic person. Giving so much weight to virtue and generosity could have wider repercussions for the management of their finances, genetic information, and tissue samples amongst other issues. It could be seen as a justification for actions without consideration as to alternatives or to whether or not they were proportionate to the risk of harm. Thus, assumptions of altruism could become a problematic ‘back door’ for doing things *to* persons lacking capacity rather than *for* them. By and large, the best interests test should remain a self-focussed assessment, with public interest reasoning (eg public health, criminal justice, national security, safety of other people) transparently noted and used appropriately. This is discussed further in Section 4.5.

4.4 Liberty

4.4.1 Strategies involving a deprivation of liberty

Hard strategies for isolation involve more extensive restrictions on an individual's liberty than soft strategies. They will more commonly amount to a 'deprivation of liberty' and are thus more tightly regulated. The additional safeguards provide important protection for residents without capacity but add a significant regulatory burden for social care homes, hence there is a lot riding on the legal definition of 'a deprivation of liberty'.

The European Court of Human Rights has defined deprivation of liberty as confinement, without valid consent, in a restricted space for a non-negligible amount of time.⁵⁸ Several factors are relevant. If a person has decision-making capacity, their consent to the lack of freedom means that it is not a deprivation. Other factors include the degree of supervision and control exercised over the person's movements, the extent of isolation and social contact, and whether it is possible to leave the restricted space.⁵⁹ The ECtHR also made the point that 'commonly' occurring restrictions on movement are not deprivations of liberty (eg being crammed in a crowded train).⁶⁰

UK courts have further elaborated the definition of 'deprivation of liberty' for persons lacking capacity, i.e. those who are within scope of the MCA. The Supreme Court in *P v Cheshire West and Chester Council and P & Q v Surrey County Council*⁶¹ said the definition consists of two questions, frequently referred to as the 'acid test'. The first question is whether the person is subject to 'continuous supervision and control?' Lady Hale noted that 24-hour round-the-clock supervision and control would of course meet this threshold but is not necessary. 'Continuous supervision and control' can also arise in a setting where significant decisions are routinely subject to the discretion of the authority responsible for a person's care. Other factors include the extent of monitoring, and length of confinement. The second question is whether people exercising supervision and control would allow the person to leave?⁶² Phrasing the question as whether the resident "would be allowed to leave" means additional safeguards may still be required when a compliant person is confined. This is important because many persons lacking capacity have compliant, vulnerable personalities, putting them at risk of extended periods of confinement in their bedrooms, potentially to their own detriment, with limited safeguards.

To assist hospitals and social care homes in the COVID-19 pandemic, the Department of Health and Social Care (DHSC) published emergency guidance on 9 April 2020, with updates on 29 May, 15 June and 15 October 2020.⁶³ Amongst other issues, the guidance offered pointers for determining whether a social care home resident is deprived of their liberty. The DHSC guidance takes the view that if a social care home resident or hospital patient is free to leave the setting/supervision permanently (albeit not in the instant moment), then they are not deprived of their liberty. This view must be considered carefully and cautiously in a social care home setting. In contrast to a hospital setting (where patients are generally allowed to leave), the right to leave a social care home setting is more illusory. The right to leave may be theoretically possible – for example, a resident could seek to move care homes, or stop paying their fees – but in practice the resident may have no near-term ability to leave permanently. Where would they go? How long would it take them to put a move in

place? Would they need help, and who would help them? Would staff and family genuinely allow them to leave when all the steps were in place?

DHSC guidance about ‘deprivation of liberty’ during the pandemic also advised care homes that they could rely on the exception to the ‘acid test’ set out by the Court of Appeal in *R (on the application of Ferreira) v HM Senior Coroner for Inner London South*.⁶⁴ The *Ferreira* exception provides that a situation of continuous supervision and control does not count as a ‘deprivation of liberty’ as defined by *Cheshire West* if the State is providing life-saving medical treatment in the person’s best interests *and* the liberty restriction, albeit substantial and continuous, is materially the same as what would occur when treating a patient with a sound mind.⁶⁵ The court’s reasoning was that such situations should be understood as part of standard good-faith medicine, rather than an exercise of State confinement.⁶⁶ In the court’s view, only the latter required additional safeguards and procedures. Adopting this approach meant that doctors, such as those in *Ferreira*, would not face additional procedural rigmarole (beyond a best interests assessment) to give a person with a mental impairment standard medical treatments. In the court’s view, to do so would divert clinical resources, time and attention, jeopardising the outcome for all intensive care patients.

The facts of the *Ferreira* case help illustrate the scope of the exception, and its limited relevance to residents who walk about. The person lacking capacity, Maria, was an adult woman with Down’s Syndrome. She was admitted to an intensive care unit with pneumonia and heart problems. Without informed consent, she was sedated and intubated for mechanical ventilation, but died following a cardiac arrest. The hospital had sedated and treated Maria based on a best interests assessment, and had not sought any authorisation under the MCA for depriving her of her liberty. Standard medical practice for a person with Maria’s cardio-respiratory symptoms was to intubate and provide mechanical ventilation. It was also standard for ICU patients to be pharmacologically sedated to avoid the discomfort of the breathing tube and to immobilise the muscles of their body. Immobilisation prevents patients pulling out their breathing tube and coughing involuntarily. Sedation means the patient is continuously confined to their hospital bed and supervised by medical staff. The deceased woman’s sister brought legal proceedings, appealing a coroner’s decision that there would be no jury involved in his investigation of Maria’s death. The sister argued that Maria was deprived of her liberty at the time of her death, and that the coroner was obliged under the Coroners and Justice Act 2009 (CJA 2009) to hold an inquest with a jury if a person dies in “state detention”.

A variety of other parties argued that the court should uphold the coroner’s decision, fearing that a decision in favour of Maria’s sister could mean a lot more administration for intensive care units across the country. The Court of Appeal agreed, creating an exception to the definition of ‘deprivation of liberty’ for persons lacking decision making capacity.⁶⁷ The exception included two provisos, meaning it does not (currently) exempt sedation or physical restriction *for any medical purpose*.

Lady Justice Arden (as she then was) stated that the exception applied when continuous control and supervision was for life-saving purposes and was *standard practice for people of sound mind*.⁶⁸ Outside of these

situations, where a deprivation of liberty affects a person with a long-term mental impairment, additional safeguards remain necessary. So, in fact, *Ferreira* has negligible relevance to residents who walk about. *Ferreira* does not apply in situations where sedatives and other restraints stop the resident from walking. Although the objective may be to avoid viral transmission (a medical purpose), it is not normal to administer sedatives, lock doors, attach tracking wearables, or impose bed restraints on persons of sound mind to prevent viral spread. If a care home reasonably believes this would be in the patient's best interests, it would constitute a deprivation of liberty for which additional safeguards must be observed. These safeguards are described below in Section 4.4.2. The *Ferreira* exception also does not apply in situations where a care home, in the resident's best interest, gives them sedatives so that they accept a standard oxygen mask (as distinct from mechanical ventilation). Such extensive control is not standard medical practice for a basic oxygen mask and must therefore be subject to additional safeguards. It would also be a stretch too far to argue that cohorting of COVID-negative residents fits under the *Ferreira* exception.⁶⁹ Although the goal is to prevent an infection with no known cure (so in a weak sense it prevents deterioration of a life threatening condition), and although people of sound mind are also required to cohort in households, and although the acid test may mean social care homes' resources are diverted by procedure, cohorting in social care homes would probably be distinguished from the facts in *Ferreira*. *Ferreira* involved the intensive care setting where treatment is generally time-pressured and short, supervised by doctors, and where there is a strong culture of discharging confined patients as soon as possible. The trust the court placed in the general ICU setting probably would not, and should not, extend to social care homes cohorting residents in the pandemic.

Pandemic-related examples in social care homes where the *Ferreira* exception *could* be relevant include situations where palliative sedation is given to a COVID-positive resident in their final days and hours to ease their anxiety and pain. Beyond this, very few situations exist. It is rare for a resident to be intubated in a care home for mechanical ventilation. In this situation, the confinement would need to be in the resident's best interest, but additional procedural safeguards would not be necessary so long as no other restraints were employed.

4.4.2 Safeguards in the event of deprivation of liberty (eg DoLS)

When a strategy amounts to a 'deprivation of liberty', the social care home must meet special legal safeguards and have evidence that isolation is in the resident's best interests. Article 5 of the ECHR states that it is unlawful for a public authority to deprive a person of their liberty *except* where the deprivation is for a reason stipulated as legitimate by the ECHR, no more than necessary, proportionate to the legitimate purpose, and subject to legally-sufficient procedural safeguards.⁷⁰

The ECHR lists six grounds for lawful deprivation of an individual's liberty; two have relevance to this article.⁷¹ One reason is where a deprivation of liberty is necessary and proportionate to prevent the spread of infectious disease. Another reason is that the individual is 'of unsound mind'. To ensure the safeguards are observed, ECHR Article 5(4) further states that a person deprived of their liberty by detention shall be entitled

to have their detention scrutinised speedily by a court. In response, English law has developed protocols, including options for judicial review, that must be followed when a resident is deprived of their liberty. These rules reflect the ethical principle (see above ethical principle 9) that major decisions and actions must be transparent, accountable and open to independent review. Several systems are relevant where a social care home thinks that a resident should be isolated during the COVID-19 pandemic. But there is still a need for law reform.⁷² The most well-known system is the Deprivation of Liberty Safeguard procedure for hospital and care home residents, commonly referred to via the acronym ‘DoLS’, set out in Schedule A1 of the MCA.⁷³

For a DoLS authorisation, a care home or hospital makes an application to the ‘supervisory authority’ which is usually the relevant local authority (in England). The supervisory authority then assesses the application, and authorises the deprivation of liberty when relevant criteria are met. For standard authorisations, a number of reports are required from a variety of parties to check, in particular, that the proposed deprivation of liberty is in the person’s best interests, proportionate to legitimate objectives and no more than necessary. The application must cover: the purpose of the restrictions, how they are to be used, by whom and when; the steps that the care home has taken to help the relevant person understand the effects of the authorisation and their rights; a mechanism for keeping the measures under regular review; clear records when the authorisation will expire triggering a review date to assess whether a further application will need to be made.⁷⁴ Drawing up a specific plan together with scrutiny by the supervisory authority are two safeguards implemented by the DoLS procedure. Another key safeguard is the appointment of a ‘relevant person’s representative’, usually a family member or friend, to support the person during the authorisation process and the life of the authorisation. Other safeguards include access to Independent Mental Capacity Advocates in some circumstances, and the right to challenge authorisations in the CoP.⁷⁵

The DoLS procedure can authorise detention only in a resident’s best interests; not for public health reasons. Accordingly, it is most relevant to situations where a COVID-negative resident is isolated in order to avoid them becoming infected. As discussed above (in Section 4.3.3), the best interests of a suspected COVID-positive resident will often be more finely balanced. Sometimes isolation will be in their best interests – for example, where they comply with minimal objection for the full two weeks while they could be shedding virus, and the harms (or potential harms) of isolation are outweighed by the intangible benefits of preserving friendships, and acting altruistically and as a responsible citizen. But there will also be occasions when isolation of a suspected COVID-positive resident is clearly not in their best interests. For example, where a resident objects to locked doors or physical restraints and becomes agitated, anxious or angry, or where the resident is sedated.

Where the DoLS procedure is relevant, care homes should check whether the resident already has a DoLS authorisation. If so, the care home should also check whether the authorisation covers the restrictions proposed to prevent viral transmission. A resident with dementia or a person with learning disabilities, already known to walk about or go out if given their liberty, will most likely have a DoLS authorisation that allows staff to limit walking at some times of the day. The question then is whether the proposed strategy to prevent walking

about would require an application to review and amend the terms of the DoLS. In *Munjaz*,⁷⁶ the European Court of Human Rights held that a restriction on residual liberty could amount to a deprivation, but it applied a (surprisingly) high threshold for reaching such conclusion. Arguably, it might be said that cohorting involves minimal additional deprivation for a resident who is already confined to their bedroom at some times of the day and prevented from walking in some areas of the care home (e.g. other residents' rooms, kitchens, some corridors) or outside. After all, cohorting allows social interaction with other people and some space for walking. But cohorting could involve a deprivation of residual liberty if the resident could previously walk for longer durations and over a bigger area. There is almost certainly a requirement to review and amend the terms of a pre-existing DoLS if a resident is sedated or confined in solitude in their bedroom for extended periods of time without visits from family, communal meals, or association with other residents.⁷⁷ It is very unlikely that a resident with the strength and inclination to walk about before the pandemic will have been, or should have been, subject to such heightened restrictions in their best interests. At law, the resident's compliance with pandemic-style lockdown is irrelevant. For these reasons, in our view, it was an overstatement for DHSC pandemic guidance to say that in "many cases,"⁷⁸ restrictions to treat or to prevent infection will not constitute a further deprivation of liberty triggering a need to review and amend the DoLS.

If the current DoLS does not cover the restrictions proposed during the COVID-19 pandemic, then a new authorisation must be made. The only change to the DoLS legal framework is that remote assessments are permitted. DHSC guidance also confirmed that urgent applications (while seeking standard authorisation) permit immediate deprivation of liberty up to a maximum of 7 days (which can be extended for a further 7 days). The extended urgent authorisation covers a 14-day isolation period – which falls short of the lengthy isolation periods imposed on a COVID-negative residents. A standard authorisation is necessary for a longer-term isolation. In view of the backlog of DoLS applications, care homes have little option but to apply (documenting carefully the dates of their applications), and then proceed as if the DoLS application will eventually be approved.⁷⁹

It is surprising that the frequency of applications for DoLS authorisations seems to have declined noticeably during the first wave of the pandemic.⁸⁰ Given the extensive use of radical 24/7 style isolation strategies to prevent SARS-CoV-2 transmission in care homes, group homes, and private homes, one would have expected applications for DoLS, and potentially to the CoP, to have increased.⁸¹

4.5 Welfare of Other People: Third party and Public Interests

4.5.1 Isolating a care home resident under public health laws

On their face, the Coronavirus Act 2020 and other public health laws look relevant to situations where COVID-positive residents put other people at risk, regardless whether the resident has capacity. However, in this section, we explain that public health legislation is drafted in such a way that the powers are of limited

assistance in the case of residents lacking capacity. Whether they should be reformed and extended depends on whether one is willing to allow hard strategies to be used on persons lacking capacity in order to protect third parties, with DoLS-like safeguards to prevent misuse.

4.5.2 Coronavirus Act 2020 and other public health laws

DHSC guidance recommends that staff of social care homes contact Public Health Officers ('PHOs') where they need to isolate a COVID-positive resident to protect people other than the person themselves and it is not possible to manage the resident lawfully under the MCA or MHA.⁸²

Interaction between care home staff and PHOs is sensible during the pandemic. PHOs can provide significant advice to help identify residents' COVID status, and have relevant prior experience managing infectious diseases in social care homes such as seasonal influenza, diarrhoeal illnesses, and tuberculosis. That said, the utility of public health laws for difficult cases in social care homes is actually more limited than first appears.

Regulation 6 of the Health Protection (Coronavirus, Restrictions) Regulations 2020, now revoked, imposed restrictions on movement outside a place of residence, but did not give PHOs (or other people) powers to confine a person to a particular bedroom or internal space.⁸³

Powers under the Coronavirus Act 2020 are more extensive but still relatively limited for social care homes during the COVID-19 pandemic. Compared with seasonal influenza, diarrhoea, and tuberculosis outbreaks, COVID-19 poses new challenges. Firstly, large numbers of social care homes have been simultaneously facing COVID-19 outbreaks. Accordingly tried-and-tested public health strategies where homes are temporarily closed and residents transferred are less feasible. Secondly, COVID-19 infection can be transmitted by people who are asymptomatic, and for a few days before symptoms emerge, increasing the need for preventative isolation.⁸⁴ Thirdly, it is difficult for staff at social care homes and PHOs to assess a care home resident's COVID-19 status. At times during the pandemic, when there was significant community circulation and limited diagnostic testing, all people in care homes were treated as potential carriers.⁸⁵ Even with diagnostic testing now more available, it is often difficult to obtain a good (and therefore accurate) swab from elderly residents or from a person with learning disabilities with significant cognitive impairment. Both these populations may not understand the nature of the procedure and may find the gag response very uncomfortable.⁸⁶ And as noted in Section 2.3, diagnosis based on phenotypic symptoms of COVID-19 infection is difficult because classic symptoms are much less prominent in elderly residents and not well understood in people with specific genetic-linked learning disabilities. A fourth challenge is that hard isolation strategies are more likely to be needed for COVID-19 than other infectious outbreaks, due to its long incubation period, relative ease of transmission indoors, the potential seriousness of the disease, and uncertainties about a person's disease status. For related reasons, a fifth issue is that bedroom isolation is more likely to be needed, whereas

PHOs have previously treated care homes as a household and, as a matter of practice, have not tended to use their powers of isolation *within* private households.

Schedule 21 of the Coronavirus Act 2020, specifically paragraph 14⁸⁷ for England,⁸⁸ provides that the PHO may decide that isolation is required to protect other people if they have reasonable grounds to suspect a person is potentially infectious. They can also direct, instruct and remove the potentially infectious person, even where this results in a deprivation of liberty. This can last an initial 14-days; thereafter, isolation by a PHO must be reassessed every 24 hours.⁸⁹ In these respects, the powers are broad. However in other ways the powers are limited.⁹⁰ It is legally doubtful that PHOs have powers to order that locks be fitted to the person's bedroom door, or that a person be sedated to keep them still.⁹¹ Such powers would be new to PHOs, and although the statutory list of PHO powers is clearly non-exhaustive, the principle of statutory interpretation *eiusdem generis*,⁹² is likely to mean that PHOs have powers only akin to those specifically enumerated. A further issue is that PHOs have limited enforcement powers under the Coronavirus Act 2020. Only police constables (and immigration officers) may use reasonable force against the potentially infectious person.⁹³ In a situation where reasonable force is required – for example, to detain a person, to return them to their room, or to stop them approaching other care home residents – a PHO could seek support from the police. However, except in rare situations, this sort of multi-team intervention would be impractical. A further issue is that many people, including professionals involved in implementing isolation, would consider using force against a walking resident with dementia unethical unless DoLS-like safeguards apply.⁹⁴

4.5.3 Legal lacuna

The limitations of the Coronavirus Act 2020 give rise to a lacuna. The lacuna arises where the social care home resident resists isolation, yet isolation is necessary and proportionate to protect other people. PHOs have powers to take action against any person (including those with and without mental capacity) in order to protect other people and the public health. However, as Section 4.5.2 explained, their powers are limited, not necessarily well known or understood, and not necessarily backed up with resources needed to implement them. From a legal perspective, unlike decision-makers under the DoLS procedure, they cannot authorise that a bedroom be locked or a care home resident be sedated to limit movement. Nor can they exercise reasonable force to ensure compliance with their direction. To some extent, this is understandable; there is greater justification to restrict or deprive a person of their liberty when it is done to protect their own best interests rather than other people. But given that the person concerned is a social care home resident, it would be better, all things considered, that the COVID-positive walker be managed inside the home with proper safeguards (e.g. a proper risk assessment, time limits and an individual care plan), rather than leave the person to walk about (putting other residents at risk) or have them transferred to alternative custody arrangements. This lacuna also raises the issue of how to resolve disagreements, in the absence of an appeal mechanism, in those cases where, for example, relatives may be of the opinion that the proposed actions are excessive and unnecessary.

4.5.4 Inherent judicial powers or legislative amendment?

To address the legal lacuna, the question is whether it would be better to: (i) amend the MCA to allow care and treatment for the protection of third parties; (ii) amend the MHA to allow compulsory treatment in care homes; (iii) seek orders pursuant to the courts' inherent jurisdiction; or (iv) amend the Coronavirus Act 2020 to extend the powers of PHOs.

Amending the MCA to introduce powers to prevent risks to others would be difficult without toppling the legislation's *raison d'être*; namely to support the *best interests of people lacking capacity*.⁹⁵ This would distance the MCA from the Convention on the Rights of Persons with Disabilities, and the focus required by Article 12 thereof on the will and preferences of the individual.⁹⁶ It is also notable that the Government lost an amendment in the House of Lords during the passage of legislation replacing DoLS with Liberty Protection Safeguards (LPS),⁹⁷ meaning that when LPS are introduced, the system will continue to be very firmly focused on procedures that permit deprivations of liberty only where there is a risk of harm to the individual deprived of liberty.⁹⁸

Another unviable approach would be to amend the MHA so that its compulsory powers of treatment extend to care home residents. Presently compulsory powers of treatment do not extend to people living in social care homes unless they are 'liable to be detained' under the MHA.⁹⁹ A person is 'liable to be detained' when an application to detain them in a 'hospital' or 'registered establishment' has been completed.¹⁰⁰ Very few care homes qualify as a hospital or registered establishment.¹⁰¹ Thus, at present, the MHA compulsory powers of treatment cannot be used to isolate a resident unless accompanied by an application to move the resident out of the care home and into a hospital or registered establishment. An amendment of the MHA could be drafted such that a care home resident could meet the definition of 'liable to be detained' without the assessor (who applies for the resident to be detained) intending that a move to a hospital or registered establishment *would actually take place*. Detention under s.3 MHA can last up to six months before review. This is too long for coronavirus isolation; and instead geared towards psychiatric treatment of mental health conditions. Even if amendments bring social care homes into the purview of the MHA, for powers to treat involuntarily to be applicable, restriction of walking would have to be considered 'medical treatment for mental disorder'. Some professionals might consider walking about to be a manifestation or symptom of dementia, and physical restriction, sedation, or cohorting to be a form of care to alleviate it.¹⁰² But in the main courts and professionals have moved towards narrower interpretations, and it is more likely to be said that going for a walk is a desire held by a person with dementia, and their determination a personality trait. To address isolation of COVID-positive residents in social care homes, the MHA would thus need extensive and multiple amendments. This would be problematic.¹⁰³ A variety of powers over the care home resident would follow from defining them as 'liable to be detained', extending far beyond the act of isolating them during the pandemic. And compulsory treatment of social care home residents *with* capacity could become more routine.

The inherent jurisdiction offers potential as a stop gap, but legal uncertainties could prove problematic. The Court of Protection does not have inherent jurisdiction; it has statutory powers under the MCA only. The High Court of England and Wales (like courts in many jurisdictions) has inherent jurisdiction connected with the principle of *parens patriae*; namely the power and duty of the state to act as guardian for those who are unable to care for themselves. A COVID-19 example arose in Ireland's High Court. The Court made temporary orders allowing a hospital to isolate an elderly patient lacking capacity. The patient initially came to hospital after a fall. He tested positive for COVID-19 during his hospital stay and had been wandering hospital corridors, coughing, failing to wash his hands, and responding aggressively to attempts by hospital staff to have him stay in his hospital room.¹⁰⁴

The case in Ireland involved a hospital in-patient, but orders could also be sought to isolate a social care home resident. In England, the court's inherent jurisdiction would only be relevant where there was no best interest argument (given that best interest cases fall under the MCA). This means inherent jurisdiction cases will be less common and potentially more complex than the case in Ireland.¹⁰⁵

Two difficult questions could arise with an inherent jurisdiction case in England. The first is whether it is appropriate and lawful for a court to use its inherent jurisdiction *against* the person's own best interests, and how this would align with the 'facilitative, not dictatorial' way in which inherent jurisdiction is supposed to operate according to the Court of Appeal in *Re DJ*.¹⁰⁶ The second question is whether the inherent jurisdiction is too arbitrary a mechanism to comply with the requirements of ECHR Article 5 if it is used to deprive the person of their liberty (especially if that person *has* decision-making capacity).¹⁰⁷

Ignoring the legal lacuna and operating a quasi-DoLS based approach is not recommended. Although a minority of residents have DoLS already in place with safeguards geared for deprivations of liberty involving physical restraints and sedation, these safeguards assume the deprivations are for the resident's own best interests. Furthermore, there will be other patients without a DoLS in place and for whom supervising authorities could not authorise DoLS safeguards because the DoLS procedure can only be activated where it serves the individual's own best interests. These residents will have insufficient safeguards in place if society turns a blind eye to the legal lacuna.

All things considered, we suggest the least-worst course of action is to amend the Coronavirus Act 2020, particularly as the lacuna is clearly linked to special characteristics of COVID-19 and the powers under the legislation are limited in time to a 'transmission control period' declared by the Secretary of State for Health and Social Care.¹⁰⁸ A draft clause is set out below, which could be inserted by amending legislation. The objective of the amendment is to enable PHOs and care homes to work together—in exceptional situations—to isolate a care home resident within the care home using hard strategies if necessary and proportionate to the risk of harm. No doubt the drafting could be improved by Parliamentary Counsel. It could also be part of a package of measures taken by the government to increase care home sector support for subsequent waves of the

pandemic, and amendments could also be added to address situations where social care home residents, without capacity, resist swabs for COVID-19 testing.¹⁰⁹

4.5.5 Proposed new paragraph 18a of the Coronavirus Act 2020 Schedule 21

Powers relating to care homes and residents

18a (1) This paragraph applies, during a transmission control period, to a person who is ordinarily resident in a care home (P) and where a public health officer has reasonable grounds to believe that P will resist proportionate measures to prevent the spread of coronavirus.

(2) A public health officer may at any time impose such requirements and restrictions set forth in sub-paragraph (3) on P as the officer considers safe, necessary, least restrictive of P, and proportionate—

- (a) in the interests of P,
- (b) for the protection of other people, or
- (c) for the maintenance of public health.

(3) Requirements and restrictions under this paragraph may include requirements—

- (a) for P to be isolated within a care home
- (b) for P to be subject to the physical restraints needed to secure the objectives in sub-paragraph (2)
- (c) for P to be given medication under the supervision of a medical professional where necessary to secure the objectives in sub-paragraph (2)
- (d) for P to be fitted with a wearable device to monitor their whereabouts.

(4) Any requirements or restrictions under sub-paragraph (2) must be reviewed by a public health officer within 7 days.

(5) Any requirements or restrictions under sub-paragraph (2) must be preceded by an individualised risk assessment, a written record of the reasons why they are considered to be necessary and proportionate, and the completion of an individual care plan.

(6) Prior to imposing the requirements and restrictions decided by the public health officer, the evidence in sub-paragraph (5) must be considered and the decision in sub-paragraph (2) confirmed as necessary and proportionate by a registered medical practitioner unless to do so would be impractical or would involve undesirable delay.

(7) The public health officer, or a person implementing the requirement or restrictions imposed by the public health officer, may use reasonable force.

(8) (1) A person on whom a requirement or restriction is imposed under sub-paragraph (2) may appeal against it (or against any variation of it or any extension of the period to which it relates) to a magistrates' court.

(2) An appeal may be brought on behalf of P where they lack the capacity to do so by any person or body engaged in caring for P or interested in their welfare.

(3) On an appeal under this paragraph the court may—

- (a) confirm the requirement or restriction (or variation or extension), with or without modification, or
- (b) quash the requirement or restriction (or variation or extension).

(9) For the avoidance of doubt, this paragraph is subject to the European Convention on Human Rights.

4.6 Human Dignity and Fundamental Rights: avoiding inhuman and degrading treatment

As explained above, hard strategies should only be contemplated where isolation and cohorting cannot be achieved by soft strategies and where it is consented to, or in the resident's best interests or necessary and proportionate for the protection of other people or the public health. Generally, the hardest strategy that will be necessary in any given situation is cohorting, surveillance, wearable trackers, locking a door on a compliant resident, or moving a resident. However, there will be occasions where this proves insufficient, and where a social care home will need to contemplate even harder strategies. These are most difficult cases. In severe cases, the person must walk and any attempt at isolation, let alone restraint, will inevitably lead to severe distress. This can arise when a resident's pain, discomfort or anxiety cannot be relieved in any way other than walking. Antipsychotic medication is another cause of this profound need to walk (akathisia).¹¹⁰ What, if anything, is the absolute limit with these residents during the pandemic, when one is seeking to save lives? Is it lawful to use pharmaceutical sedation over an extended period? To remove basic fundamental aids such as shoes, spectacles or walking frame? To pin a resident to their bed using a combination of abdominal and side straps, and rails, so that the resident cannot get out of bed or their chair?

In English law, the ECHR sets enforceable limits: actions taken by, or sanctioned by government policy, must not amount to inhuman or degrading treatment (Article 3, ECHR), put the resident's life in serious and imminent danger (Article 2, ECHR), or be an unnecessary or disproportionate interference with the resident's protected rights. In our view, the strategies queried in the paragraph above (extended sedation, removing basic aids such as spectacles, and pinning down) would amount to inhuman and degrading treatment. If the resident resists, they could also potentially amount to a breach of the government's positive obligation to protect life (Article 2, ECHR). However, government policy cannot sanction walking about when all other strategies fail to restrain a COVID-19 positive resident, because this would put other residents' lives at risk and breach *their* Article 2 rights. In these circumstances, additional resources *must* be found to provide more staff or more space for the walker. Ethically one hopes that additional financial resources are found long before a situation gets to this point. However, the ethical principle that resources be fairly allocated (ethical principle 10 in Section 3

above) is the principle that is least protected by law; the reason being that resource allocation is seen as a political rather than judicial decision.

5. Conclusion

The first surge of COVID-19 shook public confidence in the safety of care home residents. Many vulnerable residents died, and the first legal actions are now beginning to emerge in England.¹¹¹ This article set out to answer three questions: 1) in what circumstances is it lawful to isolate residents of social care homes to prevent transmission of COVID-19, in particular residents with a strong need to walk? (2) what types of strategies are lawful to curtail walking and achieve isolation and social distancing? (3) is law reform required? Answering these questions led us to advance seven arguments.

First, we noted that the pandemic raised issues for *all* social care home residents with independent mobility, with some situations being more challenging than others. Due to the highly diverse circumstances blanket rules are inappropriate. We recommended a principles-based approach coupled with case-by-case application of the principles for individual residents. We described a set of well-established ethical principles that provide guidance. These principles could steer developments internationally and in professional guidance. The English legal framework reflects these principles and takes them a step further by making them enforceable.

Second, we argued that applying the principles requires very careful consideration. A blanket policy on isolation is likely to be unlawful. The benefits of avoiding transmission vary; COVID-19 has high but not universal morbidity and mortality in care homes. One can thus predict that avoiding the virus will spare some residents bad cold-like symptoms, but in many cases save their life or the lives of others, or spare them or others from a disease causing severe discomfort, agitation and breathlessness.¹¹² Adding to the complexity, the detriments of *isolation* are highly variable for residents who walk about. For some residents, particularly the elderly, isolation that curtails walking for weeks or months will radically reduce their quality of life.

Third, there are soft and hard strategies to restrict walking about, and hard strategies should not be considered unless soft strategies have been exhausted. Soft strategies are based on non-harmful persuasion to isolate. They include repeated explanations about the purpose of social distancing, addressing unmet needs that might be the driving force for walking about (e.g. pain, hunger/thirst, boredom), enticing a resident back to their room, increasing stimulation in their own room and increasing staff:resident ratio. Hard strategies include cohorting, removal to other accommodation, physical restrictions and pharmaceutical interventions. These strategies involve potential harms and ethical concerns. Unfortunately, despite always using soft strategies in preference to harder strategies, it will be necessary to consider harder strategies for a significant number of people. Around 850,000 people (most of whom are aged 50 or over) are living with dementia in the UK, and Alzheimers UK predicts that this figure will rise to 1 million people by 2025. Of these, around a third (288,000) are currently living in residential care settings.¹¹³ Thus, even a small percentage for whom soft strategies are

insufficient equates to a significant number of individuals across the UK, and there will be many more across the world. The issues thus cannot be ignored.

Fourth, in England, the final decision on isolation, the decision-maker, the means of achieving it, and the legal justification differ depending on:

- a. whether the social care home resident has the mental capacity to make their own decision and is consenting or not;
- b. the resident's personal circumstances and whether preventing them from walking about is in their best interests;
- c. whether the restrictions amount to what the law terms 'a deprivation of liberty';
- d. whether the purpose of isolation is to protect third parties rather than the resident's best interests;
- e. whether the strategy for isolation respects human dignity.

Fifth, where the goal is to protect *other* people, the legal justification for isolation must be carefully analysed. Borderline cases could arise where a COVID-positive resident lacking capacity expressly refuses to isolate. In this case, isolation is not manifestly in the interests of the resident whose liberty is restricted, but rather third parties and the public health. Tenuously it could be argued that isolation protects the COVID-positive resident from retaliation by other angry residents. Alternatively it might be said that it is in the walking resident's interest to act altruistically to protect other people, or to act as a 'reasonable citizen'. However, this reasoning must be approached with considerable caution. While self-defence from hypothetical attack, altruistic protection of others, and reasonableness are likely to be in an incapacitated resident's interests, it may not be in their *best* interest, all matters considered, to be restrained or sedated contrary to their express refusal. An evaluation of best interests must give appropriate weight to different issues, and balance the certain and possible gains against certain and possible losses.¹⁴⁴

Sixth, there is a lacuna in the English legal framework, and potentially other countries as well where the underlying reason for preventing walking is to protect third parties and the public health, rather than to protect the person whose liberty is restricted. In England, PHOs' powers are legislatively limited, and under-resourced. Unlike DoLS decision-makers, PHOs cannot authorise that a bedroom be locked or a care home resident be sedated. Nor can PHOs exercise reasonable force. Although the court's inherent jurisdiction might fill the gap, this is uncertain. Whether and how to fill this gap is an issue that Parliament should consider carefully. With the necessary safeguards, we recommend an amendment to the Coronavirus Act 2020.

Seventh, in some cases the stakes will be very high. A COVID-19 positive resident may be extremely agitated being locked in a room, yet refuse to stop walking about. Would it be acceptable during the pandemic to take steps that would ordinarily be regarded as reckless and unacceptable in order to protect the lives of others? In our view, some actions are exceptionally permissible in the conditions of the pandemic, but actions taken by, or sanctioned by government policy, must not amount to inhuman or degrading treatment, put the resident's life in serious and imminent danger, or be an unnecessary or disproportionate interference with the

resident's protected rights. In our legal (and ethical) view, extended sedation, removing basic aids such as spectacles, and pinning down would amount to inhumane and degrading treatment. If the resident resists, putting them at risk of serious physical harm from a fall, they could also amount to a breach of the government's positive obligation to protect life (Article 2 of the European Convention on Human Rights). In these circumstances, additional resources *must* be found to provide more staff or more space for the walker.

Through this analysis we showed that English law goes a long way towards providing a suitable legal framework to manage the potential spread of COVID-19 in social care homes. However, the law is complex and strained by the challenges of COVID-19 infections.¹¹⁵ Residents, their families and social care home staff would all benefit from greater clarity about the issues that need to be balanced, and the legal powers available in different situations. Furthermore, a legal framework also provides some protection against undue and excessive restrictions. Current DHSC guidance is a good start, however it is not sufficiently clear for the sorts of situations that arise in social care homes with residents who walk about, and arguably overstates the applicability of existing MCA DoLS safeguards, the *Ferreira* principle, the MHA, and the Coronavirus Act. As a result, a large amount of isolation and cohorting has probably been going on that restricts the residual liberty of residents in social care homes without clear authority. Some patients are probably being isolated, possibly sedated, when it is not in their best interests. DoLS applications and reviews seem not to be happening as often as they should, meaning some residents are being isolated without appropriate safeguards, and there is a gap in the law which means that physical restriction and sedation cannot lawfully take place when a COVID-positive social care home patient resists isolation and poses risks to other residents.

This article elucidates the issues not to lay blame. Instead it seeks to provide a better, clearer ethical and legal framework for future waves of the pandemic; to discourage care homes from areas of legal 'thin ice'; and to avoid draconian restrictions becoming normalised in care homes as a result of the pandemic whilst protecting vulnerable people from COVID-19. We have also described a legislative amendment to close the English legal lacuna, at the same time stressing that it is important that coercive powers are time-limited and supported by appropriate ethical guidance. The objective is not to make physical restraint and sedation administratively easier, but to have systems available for the full range of dilemmas raised by COVID-19 so that conscientious decision-makers can balance competing issues, and take action with appropriate safeguards to protect the rights of residents.

Conflicts: no conflicts

Acknowledgements for sources of funding: none

Conflicts: Special Adviser to the Joint Committee on Human Rights for its inquiry: The Government's response to COVID-19: human rights implications

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³⁹Whilst locking a room does not involve touching the patient's body, it would amount to unlawful detention (also known as false imprisonment) and would likewise be unlawful. See e.g. *R v Deputy Governor of Parkhurst Prison, ex parte Hague* [1992] 1 AC 58.

⁴⁰For the definition of hospitals, see s. 34 and 145 MHA.

⁴¹See ss. 58, 62, and 63. Medical treatment for mental disorders is defined in s. 145(4) and includes treatment of manifestations and symptoms; Curdice, M. and James, L. (2016). Faith, ethics and Section 63 of the Mental Health Act 1983. 40(2) *BJPsych Bulletin* 77-81; Ruck Keene, A. and Burnell, H. (2014). Section 63 Mental Health Act 1983 and the overdosing patient. 20 *Clinical Risk* 111-3.

⁴²Brown, C., Ruck Keene, A., Hooper, C. R., and O'Brien, A. (2020). Isolation of patients in psychiatric hospitals in the context of the COVID-19 pandemic: An ethical, legal, and practical challenge. 71 *International Journal of Law and Psychiatry*.

⁴³S 2 and 3 MCA; Chapter 5 Mental Capacity Act 2005 Code of Practice.

⁴⁴S 1 MCA.

⁴⁵S 5 MCA. If a person has made a valid and applicable advance decision to refuse specific treatment, including for COVID-19, it cannot be provided. Likewise, if the resident has a person appointed under a personal welfare lasting power of attorney or a court appointed deputy with a specific authority in relation to the proposed treatment, who is refusing consent to that treatment, then that treatment cannot be provided. <https://www.gov.uk/government/publications/coronavirus-COVID-19-looking-after-people-who-lack-mental-capacity/the-mental-capacity-act-2005-mca-and-deprivation-of-liberty-safeguards>

dols-during-the-coronavirus-COVID-19-pandemic. Department of Health & Social Care. (15 June 2020). The Mental Capacity Act (2005) (MCA) and deprivation of liberty safeguards (DoLS) during the coronavirus (COVID-19) pandemic.

⁴⁶See above Section 2.4.

⁴⁷See above Section 4.4.1. Compliance matters clinically because additional actions are not required to isolate or cohort.

⁴⁸Whether COVID-cohorting involves no greater liberty restrictions than the resident experienced prior to the pandemic is discussed in Section 4.4.2.

⁴⁹MHRA. January 2018). *Bed rails: management and safe use* (2020) <https://www.gov.uk/guidance/bed-rails-management-and-safe-use> (last accessed 4 November 2020); NHS Improvement. *Never Events List* (p12).

⁵⁰*AG v BMBC & Anor* [2016] EWCOP 37; Ruck Keene, A. (11 July 2016). Covert medication and deprivation of liberty. *Mental Capacity Law and Policy*.

⁵¹Corbett, A., Burns, A., Ballard, C. (2014) Don't use antipsychotics routinely to treat agitation and aggression in people with dementia. *British Medical Journal* Nov 3;349:g6420

⁵²S 4 MCA.

⁵³Blackhouse, T. (2020). A mismatch between research evidence and the information needs of care homes during COVID-19: the case of restraint. *NIHR*.

⁵⁴Song, Y. et al. (2020). Benefits of Exercise on Influenza or Pneumonia in Older Adults: A Systematic Review. *International Journal of Environmental Research and Public Health*. 17, 2657. doi:10.3390/ijerph17082655

⁵⁵Wide, but not limitless. An interest that has no tangible or intangible benefit to P should not be considered.

⁵⁶Para 5.48 MCA Code of Practice.

⁵⁷*Birmingham City Council v SR* [2019] EWCOP 28; *Secretary of State for the Home Department v Skripal* [2018] EWCOP 6; *Re G (TJ)* [2010] EWHC 3005 (Court of Protection); MCA Code of Practice 5.47-5.48.

⁵⁸E.g. *Storck v Germany* [2005] ECHR 406, at [74] and [89].

⁵⁹*Guzzardi v Italy* (1980) 3 EHRR 333; *H.M. v Switzerland* [2002] ECHR 157; *H.L. v UK* [2004] ECHR 471; *Storck v Germany* [2005] ECHR 406.

⁶⁰*Austin v UK* [2012] ECHR 459.

⁶¹2014] UKSC 19.

⁶²The majority held that the following factors are **not** relevant to a finding of a deprivation of liberty: (1) compliance by the individual; (2) the normality of the placement; or (3) the purposes of the placement.

⁶³Department of Health and Social Care. (15 April 2020). Coronavirus (COVID-19): looking after people who lack mental capacity.

[64] 2017] EWCA Civ 31.

⁶⁵The Court adopted the old-fashioned terminology of the European Convention on Human Rights.

⁶⁶*Cheshire West* distinguished: *R (on the application of Ferreira) v HM Senior Coroner for Inner London South* paras 81-88, 91, 93, 95.

⁶⁷Arguably, the same outcome could have been achieved with different (and better) reasoning. For a critical review of the reasoning (not the outcome), see: Neil Allen. (2017). Case-note on *R (Ferreira) v HM Senior Coroner for Inner South London and others*. 39 *Essex Chambers*.

⁶⁸*Ferreira*, at para [88].

⁶⁹*Ferreira* very clearly would not apply to cohorting COVID-positive residents because it does not treat a life-threatening illness in the persons whose liberty is restricted.

⁷⁰Art 5(1) ECHR: Everyone has the right to liberty and security of person. No one shall be deprived of liberty save in the following cases, and in accordance with a procedure prescribed by law: ... (e) the lawful detention of persons for the prevention of spreading infectious diseases, of persons of unsound mind.

⁷¹Both are covered by Art 5(1)(e) ECHR.

⁷²See Sections 4.5.3 and 4.5.4.

⁷³See Court of Protection Handbook, accessible at <https://courtofprotectionhandbook.com/legislation-codes-of-practice-forms-and-guidance/>. Sections 15-17 of the Mental Capacity Act provide a set of powers for the Court of Protection.

“Section 15 deals with declarations, including declarations as to the lawfulness or otherwise of any act which has been or is to be done. Section 16 enables the court, by making an order, to make personal welfare decisions for a person without capacity, and, by section 17, the court’s power in this regard extends to giving or refusing consent to the carrying out or continuation of a treatment by a person providing health care for the patient. Section 16(3) makes it clear that the court’s powers under section 16 are subject to the provisions of the Act and, in particular, to section 1 and to section 4. What governs the court’s decision about any matter concerning the patient’s personal welfare is therefore the patient’s best interests (*NHS Trust v Y* [2018] UKSC 46 para 39). The procedures for seeking court orders under s. 16(2)(a) are sometimes referred to as *Re X*, or COPDOL 11 procedures. Through this procedure, the court of protection can authorise a deprivation of liberty and appropriate safeguards outside hospitals and care homes (ie in any setting where the DoLS authorisation procedure in Schedule A1 to the MCA 2005 cannot be used). Outside of care homes and hospitals (for example, wanderers living in private homes, a different pathway is required involving application to the Court of Protection (CoP). Application to the CoP is also required for 16 and 17 year old group home residents. Ruck Keene, A., Butler-Cole, V., Allen, N., Pratley, M., and Bicarregui, A. (December 2017). Mental capacity law guidance note: Judicial authorisation of deprivation of liberty. 39 *Essex Chambers*.

⁷⁴Social Care Institute for Excellence. (2017). Monitoring MCA implementation. *SCIE*.

⁷⁵For general information, see <https://www.scie.org.uk/mca/dols/at-a-glance>. At the time of writing, the DoLS procedure is scheduled to be replaced by the Liberty Protection Safeguards (‘LPS’) in April 2022. See also Mental Capacity Law and Policy. Liberty Protection Safeguards resource. Accessible at <https://www.mentalcapacitylawandpolicy.org.uk/resources-2/liberty-protection-safeguards-resources/>. The LPS system will allow deprivations of liberty to be authorised by a ‘responsible body’ (e.g. a hospital manager in a hospital, the local authority in the case of a care home, or a CCG for care outside of a hospital) (see Schedule AA1 paras 17-20 Mental Capacity (Amendment) Act 2019).

⁷⁶*Munjaz v UK* (Application no. 2913/06)

⁷⁷Although the European Court of Human Rights ruled in *Munjaz* that there was no further deprivation of liberty when a patient in a high security hospital was held in ‘seclusion’ for periods of 1-2 weeks, the court emphasised that he was already subject to the extensive restrictions of a high security hospital [para 69], and his seclusion was not solitary confinement but actually involved continual presence of staff, meals in the ward, regular visits and extended periods of social interaction [paras 72]. There was only one day when Colonel Munjaz was denied any association with other people [para 72]. The difference for residents locked in during the pandemic has been stark.

⁷⁸Department of Health & Social Care. (15 June 2020). The Mental Capacity Act (2005) (MCA) and deprivation of liberty safeguards (DoLS) during the coronavirus (COVID-19) pandemic.

⁷⁹Outside the DoLS procedure, s4B of the Mental Capacity Act also allows a deprivation of liberty where an application has been brought to the Court of Protection in order to give emergency life sustaining treatment or to do any vital act (to prevent serious deterioration). When the Mental Capacity (Amendment) Act 2019 commences, s4B will also allow deprivation of liberty on an emergency basis (when it is not reasonably practicable to apply for P to be detained under Part 2 of the Mental Health Act or to make an application to the court/local authority). Possibly, isolation might be justified as a life sustaining preventative treatment for social care home residents given their propensity to serious COVID-19 infections. However, this is tenuous, and would not apply to a COVID-positive resident. In any event it does not change the need to apply to the Court of Protection.

⁸⁰Mr Justice Hayden. (4 May 2020). Open letter to Directors of Adult Social Services. We also have no idea how many applications there were for reviews of existing DoLS authorisations. This is highly significant because most residents who walk about in care homes with impaired decision-making capacity are, or should be, already subject to a DoLS authorisation.

Care Quality Commission. (2020). The impact of COVID-19 on the use of Deprivation of Liberty Safeguards. Accessible at: <https://www.cqc.org.uk/publications/major-reports/impact-covid-19-use-deprivation-liberty-safeguards> (accessed 13/08/20).

This suggests that supervisory bodies have not been able to meet all their responsibilities.

⁸¹Note also decreased reporting of the outcome of applications: <https://www.cqc.org.uk/publications/major-reports/impact-covid-19-use-deprivation-liberty-safeguards>. This suggests that supervisory bodies have not been able to meet all their responsibilities.

⁸²See Department of Health & Social Care. (2020). The Mental Capacity Act (2005) (MCA) and deprivation of liberty safeguards (DoLS) during the coronavirus (COVID-19) pandemic. Accessible at <https://www.gov.uk/government/publications/coronavirus-COVID-19-looking-after-people-who-lack-mental-capacity/the-mental-capacity-act-2005-mca-and-deprivation-of-liberty-safeguards-dols-during-the-coronavirus-COVID-19-pandemic>. See also accompanying FAQ style guidance: <https://www.gov.uk/government/publications/coronavirus-COVID-19-looking-after-people-who-lack-mental-capacity/the-mental-capacity-act-2005-mca-and-deprivation-of-liberty-safeguards-dols-during-the-coronavirus-COVID-19-pandemic-additional-guidance>. See flowchart: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/888311/annex-a-decision-making-flowchart.pdf (accessed 1 June 2020)

⁸³Regulation 6 provides ‘(1) during the emergency period, no person may leave [or be outside of]¹ the place where they are living without reasonable excuse... (3) For the purposes of paragraph (1), the place where a person is living includes the premises where they live together with any garden, yard, passage, stair, garage, outhouse or other appurtenance of such premises.

⁸⁴Asymptomatic carriage is not a known or studied feature of influenza. Personal communication with PHO.

⁸⁵Resuscitation UK guidelines advised health care staff to treat all persons as potential carriers of COVID-19 infection, meaning that appropriate PPE had to be donned before commencing chest compressions for CPR. See Resuscitation Council UK. (2020) Statements on COVID-19: In-hospital Settings. RCUK. Accessible at <https://www.resus.org.uk/COVID-19-resources/statements-COVID-19-hospital-settings> (last accessed 11/08/20).

⁸⁶When a resident refuses to be swabbed, the question of restraint arises. Although a swab is a relatively quick procedure, restraint for an invasive medical procedure can cause significant anxiety, distress and an aggressive response. PHOs are not authorised to use force. And social care home staff would only be authorised to use reasonable force if the swab is in the resident’s best interest. See NHS England. (30 April 2020). Supporting patients of all ages who are unwell with coronavirus (COVID-19) in mental health, learning disability, autism, dementia and specialist inpatient facilities. See also Ruck Keene, A., Allen, N. Scott, K. and Kohnen. (2020). Rapid Response Guidance Note: Testing for COVID-19 and Mental Capacity. 39 *Essex Chambers*.

⁸⁷Sch 21 para 14: (2) A public health officer may at any time during the transmission control period impose such requirements and restrictions on the person as the officer considers necessary and proportionate—

- (a) in the interests of the person,
- (b) for the protection of other people, or
- (c) for the maintenance of public health.

(3) Requirements under this paragraph may include requirements—

- (a) to provide information to the public health officer or any specified person;
- (b) to provide details by which the person may be contacted during a specified period;
- (c) to go for the purposes of further screening and assessment to a specified place suitable for those purposes and do anything that may be required under paragraph 10(1);
- (d) to remain at a specified place (which may be a place suitable for screening and assessment) for a specified period;
- (e) to remain at a specified place in isolation from others for a specified period.

(4) Restrictions on a person under this paragraph may include restrictions, for a specified period, on—

- (a) the person's movements or travel (within or outside the United Kingdom);
- (b) the person's activities (including their work or business activities);
- (c) the person's contact with other persons or with other specified persons.

⁸⁸And para 52 for Wales.

⁸⁹Para 59(7) of Schedule 21 of the Coronavirus Act 2020.

⁹⁰As of mid-May, two months after COVID-19 infections noticeably took hold in England, PHO powers had only been used 4 times in any setting. Series, L. (22 June 2020). Coronavirus – use of public health powers of detention. *The Small Places*. Accessible at: <https://thesmallplaces.wordpress.com/2020/06/22/coronavirus-use-of-public-health-powers-of-detention/> (accessed 13/08/2020).

⁹¹Although, the word 'include' in Sch 21 para 14(2) and (3) could be said to mean that the subsequent lists are non-exhaustive, the examples provided are not similar to locking a bedroom or giving a drug.

⁹²Meaning of or as the same kind.

⁹³Sch 21 para 20(4)

⁹⁴Another issue with the Coronavirus Act 2020 is that there is inadequate guidance and procedures for a person with impaired decision-making capacity to challenge a restriction or deprivation of liberty. For example, who could bring a claim on their behalf, and how would they do so? It seems the only form of legal aid available is Exceptional Case Funding, which is means tested. If Schedule 21 powers are being used to deprive someone of their liberty, there needs to be non-means-tested legal aid available to comply with ECHR Article 5(4): *Ullrich v Austria* [2013] EWHC 4289 (COP).

⁹⁵S 1(5) MCA.

⁹⁶Art 12(4) Convention on the Rights of Persons with Disabilities.

⁹⁷Ruck Keene, A. (2019). LPS – where are we, and where are we going? *Mental Capacity Law and Policy*.

⁹⁸The initial drafting of the Mental Capacity (Amendment) Bill 2019 was vague so that regulated actions could have been justified on the basis of risk of harm to self or others.

⁹⁹S 56 MHA.

¹⁰⁰s.2 MHA; See also The Masked AMHP (2014). "Detained" and "Liable to be detained": Is there a difference? *The Masked AMHP*. Accessible at <https://thefmaskedamhp.blogspot.com/2014/08/detained-and-liable-to-be-detained-is.html?m=1> (accessed 11/08/20).

¹⁰¹Ss 34 and 145 MHA.

¹⁰²See definitions of medical treatment in s.145(1) and s. 145(4) MHA

¹⁰³Detention under s.2 can last 72 hours and cannot normally be extended or renewed. This is too long for isolating COVID-positive residents, and possibly too short for those who are COVID-negative. Furthermore s.2 detention is for 'assessment' and possible treatment, whereas there is generally no need to 'assess' the resident's mental impairment once it has been determined that isolation is necessary.

¹⁰⁴O'Faolain, A. and Managh, R. (14 April 2020). Court gives hospital powers to isolate uncooperative mentally impaired COVID-19 patient. *Irish Times*. Personal communication with Counsel for the hospital, D Leahy 19 May 2020.

¹⁰⁵Ireland has more frequent IJ cases than England because it doesn't yet have a statutory framework in place other than the Lunacy Act/Wardship. The Irish case also included an argument that isolation was in the interests of the elderly man himself, as well as other people. The patient-centred argument for the Dublin patient was that if he was not isolated, he might be harmed by other hospital patients who decided to retaliate or defend themselves.

¹⁰⁶2012] EWCA Civ 253.

¹⁰⁷*Wakefield MDC and Wakefield CCG v DN and MN* [2019] EWHC 2306 (Fam). See also Ruck Keene, A. et al. (2020). Guidance Note: Using the Inherent Jurisdiction in Relation to Adults. 39 *Essex Chambers*.

¹⁰⁸As defined by clause 4 of Schedule 21 of the Coronavirus Act 2020.

- ¹⁰⁹Ruck Keene, A., Allen, N. Scott, K. and Kohn, N. (2020). Rapid Response Guidance Note: Testing for COVID-19 and Mental Capacity. 39 *Essex Chambers*
- ¹¹⁰Salem, H. (2017) Revisiting Antipsychotic-induced Akathisia: Current Issues and Prospective Challenges. *Current Neuropharmacology*. 15(5) 789-98.
- ¹¹¹Booth R. (12 June 2020). Matt Hancock faces legal action from daughter of Covid-19 care home victim. *The Guardian*.
- ¹¹²Ting, R., Higginson, I., Sleeman, K. (2020). Palliative care for patients with severe covid-19. *British Medical Journal* 370 doi: doi:10.1136/bmj.m2710
- ¹¹³MHA, Facts & Stats <https://www.mha.org.uk/news/policy-influencing/facts-stats/> (Accessed 18/08/20).
- ¹¹⁴*Re A (Male Sterilisation)* [2000] 1 FLR 549 Thorpe LJ at [560].
- ¹¹⁵Ruck Keene, A. (2020). Capacity in the time of Coronavirus. 70 *International Journal of Law and Psychiatry*.