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Case No: CO/2123/2020

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 27/04/2022

Before :

LORD JUSTICE BEAN
and
MR JUSTICE GARNHAM

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Between :

R (on the application of) **(1) DR CATHY GARDNER** **(2) MS FAY HARRIS**	**Claimants**
- and -	
(1) SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE **(2) NHS COMMISSIONING BOARD (NHS ENGLAND)** **(3) PUBLIC HEALTH ENGLAND**	**Defendants**

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Jason Coppel QC, Joseph Barrett, Rupert Paines and **Raphael Hogarth** (instructed by **Sinclairslaw**) for the **Claimants**
Sir James Eadie QC, Jonathan Auburn QC, Heather Emmerson, Hannah Slarks, Yaaser Vanderman and **Charles Bishop** (instructed by **Government Legal Department**) for the **First and Third Defendants**
Eleanor Grey QC and **Patrick Halliday** (instructed by DAC Beachcroft) for the **Second Defendant**

Hearing dates: 14 - 21 March 2022

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Approved Judgment

Lord Justice Bean :

This is the judgment of the court to which we have both contributed.

Introduction

1. About 20,000 residents of care homes in England died of COVID-19 during the first wave of the pandemic in 2020. Two of them were Michael Gibson, father of the first Claimant, and Donald Percival Maynard Harris, father of the second Claimant. Mr Gibson died in a care home in Oxfordshire on 3 April 2020, Mr Harris in a care home in Hampshire on 1 May 2020. The Claimants seek declarations that certain policy documents issued by the Defendants during the relevant period, and the policy decisions recorded in those documents, constituted breaches of their fathers' rights under the European Convention on Human Rights, or alternatively were unlawful and susceptible to judicial review on common law principles. The Claimants do not claim compensation, but seek appropriate declarations by the court.

2. This is an important and legitimate claim, but we must emphasise at the outset what it is and what it is not. It is not an inquest concerning the deaths of Mr Gibson and Mr Harris alone. On the other hand, the case is not a public inquiry but a judicial review. There has been no oral evidence. Evidence of opinion about the actions and decisions of the Defendants is not admissible: see below.

3. On 15 December 2021 the Rt Hon Baroness Hallett DBE, former Lady Justice of Appeal, was appointed to conduct a public inquiry under the Inquiries Act 2005 to examine the UK's preparedness for and response to the COVID-19 pandemic, and to learn lessons for the future. The draft terms of reference published on 10 March 2022 (two working days before the hearing of this claim) cover a large number of topics, one of which is:

    > "the management of the pandemic in care homes and other care settings, including infection prevention and control, the transfer of residents to or from homes, treatment and care of residents, restrictions on visiting, and changes to inspections".

4. The Claimants' fathers are put forward as representative of many other residents of care homes who died during the first wave of the pandemic. Since, however, both of them died in England, the decisions with which we have been concerned are those relating to England; and since the second of the two deaths occurred on 1 May 2020, we have not examined decisions made and documents published after that date save to the extent that they throw light on decisions made before that date.

The policies

5. Four policies promulgated before 1 May 2020 are identified in the Claimants' Amended Statement of Facts and Grounds as being subject to challenge in these proceedings. (A prior policy, the "*February PHE Policy*", while not the subject of direct challenge, is said to have provided "*important background and context for the decisions and policies which followed*".)

6. The first policy under challenge was one developed by the First and Third Defendants and entitled '*Guidance: Coronavirus (COVID-19) – Guidance on Residential Care Provision – Public Health England',* known in these proceedings as "The March PHE Policy". That policy was issued on 13 March 2020 and remained in force until 6 April 2020.

7. The Claimants say that the effect of this policy was to "seed" infection into care homes at a time when the government had considered that community transmission had been occurring for 2 weeks. The Claimants also assert that the policy failed to address the risk from visitors to care homes. The guidance provided that:

> "care home providers are advised to review their visiting policy, by asking no one to visit who has suspected COVID-19 or is generally unwell, and by emphasising good hand hygiene for visitors. Contractors on site should be kept to a minimum. The review should also consider the wellbeing of residents, and the positive impact of seeing friends and family."

8. Visits from persons who were infected with COVID-19 but did not have symptoms would, on this advice, continue. The Claimants submit that the policy not only failed to address risk of transmission from staff but increased it. The guidance on personal protective equipment ("PPE") was that if neither the worker nor the individual receiving care had symptoms then PPE was not required above normal good hygiene. The PPE guidance was not rectified or replaced even though the Guidance for infection prevention and control in healthcare settings ("the March NHS Guidance") published on the same day advised that PPE should always be worn by all healthcare workers. The policy also failed to address the risks arising from use of agency and bank staff. The March PHE policy stated that care home providers were advised to work with local authorities and establish plans for mutual aid, including sharing of the workforce between providers. Care homes were thus invited to take positive steps to increase the number of staff working across multiple facilities which increased the infection risk.

9. The Claimants also assert that the policy failed to address the risk of transmission from other residents, especially those being newly admitted or re-admitted. They say there was no testing, isolation or instruction to use PPE despite SAGE's conclusion on 10 March 2020 that community transmission was underway. Finally, they argue that the policy failed to provide adequate guidance on infection control measures to be adopted in care homes.

10. In defence of the March PHE Policy, the Defendants say that their understanding at that time was that "transmission occurred from symptomatic individuals." They point to concerns about *"potential physical and emotional impacts on residents and their families"* if visits were completely restricted.

11. On staffing, the Defendants point to potential concern regarding pressure on staffing numbers. On visitors, the Defendants submit that the first case of COVID in a care home was detected on 10 March 2020. The March PHE Policy advised that anyone with COVID-19 symptoms should not visit a care home. Formal restrictions on visitors were introduced on 2 April 2020. Prior to that care homes were asked to review their visiting policy which, the Defendants submit, was a reasonable approach.

In any event, argue the Defendants, early studies have found that allowing visitors into care homes had only a marginal impact.

12. The second policy the Claimants challenge is what has been called "the March Discharge Policy." That was made up of *'Next Steps on NHS Response to COVID-19'*, dated 17 March 2020 ("the March NHSE Instruction"), and *'COVID-19 Hospital Discharge Service Requirements'*, dated 19 March 2020 ("the March Discharge Requirements").

13. The Claimants submit that this directed the mass discharge of hospital patients into care homes without testing, isolation, appropriate guidance in relation to PPE or assessment of whether the care home could provide safe care. The effect of this was to transfer large numbers of infected patients into closed environments containing the segment of the population most vulnerable to being killed or harmed by COVID-19. This policy was maintained until 15 April 2020.

14. The Claimants complain that the policy prioritised freeing up hospital beds but failed to consider the risk this would create for care home residents. Care homes were under pressure to accept hospital discharges regardless of whether they were able to provide safe care. Furthermore, the failure to provide testing was not justifiable either by lack of knowledge of asymptomatic transmission or testing capacity. The failure to provide or recommend isolation was not justifiable; by this time the Government's household isolation policy required that any person who had been in contact with a COVID-19 positive case had to self-isolate for 14 days.

15. The Defendants submit that the policy required clinicians treating patients to decide whether a COVID-19 test was appropriate during their hospital stay, based on the case definition and symptoms. The decision on whether it was safe to discharge them would be based on individual assessments undertaken by a clinician working with local authorities. Furthermore, the policy aimed to free up NHS facilities for the most severely affected cases. That was an unimpeachable and vital aim. The Defendants did not protect the NHS at the expense of older people but protected the NHS in order to protect older people who are more vulnerable to COVID-19. This key objective was achieved and everyone who needed hospital treatment received it.

16. In any event, the Defendants submit, testing and isolation for discharges was introduced four weeks later. At the time complained of, sufficient testing capacity was simply not available. The COVID-19 test was a brand-new test and there was no infrastructure for mass production or delivery. On 1 March 2020, 2,100 tests were available each day. By the time the guidance was changed to permit routine testing of all hospital discharges, there were 38,766 tests available per day. The passage of four weeks, which the Claimants heavily criticise, is explained by practical constraints and scientific advice.

17. On mandatory isolation, the Defendants had to weigh the benefits and harms of imposing this degree of isolation on people who were this vulnerable. When new scientific advice emerged in April 2020 and the balance shifted, routine isolation for this cohort was introduced. Furthermore, it was not feasible to agree a nationwide blanket policy on alternative isolation facilities. Although funding was made available for this in the April Action Plan, it took time to establish an estate with external facilities for isolation. As to whether care homes were able to safely care for

discharges, this was all subject to individual risk assessments involving care homes and local authorities and it was for each care home to evaluate whether they had sufficient safeguards and isolation facilities in place.

18. The third policy about which complaint is made was the policy entitled '*Admission and Care of Patients During COVID-19 Incident in a Care Home'* dated 2 April 2020 ("the April Admissions Guidance").

19. The Claimants submit that this guidance failed to protect care home residents and prioritised the Defendants' objective of freeing up hospital beds. Negative tests were still not required before discharge into care homes, and care was to be provided as normal to asymptomatic individuals and those who had tested positive but were no longer showing symptoms. Further, the guidance mandated that staff should only wear PPE when caring for residents with symptoms. Guidance on infection control was still defective and inadequate, there was still no advice to stop all visitors (who were only discouraged), and still no revocation of the March PHE Policy encouraging sharing of staff.

20. On testing, isolation, hospital beds and asymptomatic individuals the Defendants repeat the arguments summarised above. Symptomatic staff members were given access to testing on 15 April 2020, and asymptomatic staff members became eligible for testing on 28 April 2020. As to PPE for staff, by 16 March 2020 the Government had mobilised a specialist PPE hotline for care homes. Furthermore, restricting movement of staff between care homes was very difficult as staff movement is built into the care system. It was not possible to stop this at once; such a change was being strongly resisted by the care sector and could have led to significant staff shortages in care homes. Finally, existing guidance on infection prevention and control was already present in care homes.

21. The fourth policy about which the Claimants complain was dated 15 April 2020 and was called the '*COVID-19: Our Action Plan for Adult Social Care'*, known in these proceedings as the April Action Plan. The Claimants submit this was the policy by which the first Defendant began the reversal of previous policies.

22. The April Action Plan established a new policy that required testing of all patients discharged to care homes from hospital. Where a test result was pending, the patient would be discharged and isolated pending a negative result. For individuals coming in from the community, the policy advised that care homes may wish to isolate patients for 14 days, but that was not mandatory.

23. The Claimants disagree with the Defendants' claim that the advice changed due to new cogent evidence regarding the risks of asymptomatic transmission. Even though the April Action Plan was an improvement, the measures were still not strong enough to protect care home residents. Testing was not implemented immediately and staff movement between care homes was still not addressed. The policy also did not immediately mandate testing or isolation of residents admitted from the community, and still had not established a mechanism for verifying whether care homes could safely implement isolation.

Narrative of relevant events

24. The resolution of this claim requires a close analysis of the history. We divide up the history by reference to the start dates of the four policies under challenge. We note, in particular, events relevant to the following issues: symptomatic and pre-symptomatic transmission and infection; discharge from hospitals; guidance on arrangements to be adopted by care home, testing, and PPE.

31 December 2019 to 12 March 2020

25. The history of COVID-19 begins on the last day of 2019. On 31 December 2019, the People's Republic of China informed the World Health Organization ("WHO") of cases of pneumonia of unknown microbial aetiology associated with Wuhan City, Hubei Province, China. On 7 January 2020, the Chinese authorities confirmed the identification of a new type of coronavirus, "SARS-CoV-2", which causes the disease COVID-19. There was little known about the disease at that time.

26. On 10 January 2020, the Third Defendant, Public Health England ("PHE"), published guidance for NHS Acute Trusts entitled '*COVID-19: infection prevention and control*.' PHE was an executive agency of the Department for Health and Social Care (DHSC) and its function is to protect and improve the health and well-being of the UK's population and to reduce health inequalities.

27. Already available to Government at the start of 2020 were three expert groups. The first was the Scientific Advisory Group for Emergencies, or "SAGE". SAGE was responsible for ensuring that a single source of co-ordinated scientific advice was provided to those making decisions within Government. When the emergency has a significant public health component, as it did in the case of SARS-CoV-2, SAGE is co-chaired by the Government Chief Scientific Adviser (who in 2020 was Sir Patrick Vallance), and the Chief Medical Officer, (Mr, now Sir, Chris Whitty). SAGE brings together expertise from a number of scientific disciplines including epidemiologists, clinicians, therapeutics and vaccine experts, public health experts, virologists, environmental scientists, data scientists, mathematical modellers and statisticians, genomic experts, and behavioural and social scientists.

28. The second group is the Scientific Pandemic Influenza Group on Modelling (or "SPI-M"). SPI-M gives expert advice to the DHSC and wider UK Government on scientific matters relating to the UK's response to an influenza pandemic (or other emerging human infectious disease). The advice is based on infectious disease modelling and epidemiology. During emergencies, such as the pandemic, SPI-M becomes an operational sub-group of SAGE ("SPI-M-O"). It has representatives from a range of UK institutions.

29. The third group is the New and Emerging Respiratory Virus Threats Advisory Group ("NERVTAG"). The role of NERVTAG is to act as an advisory group to the Chief Medical Officer, the DHSC and other Government departments, providing scientific risk assessment and mitigation advice on the threat posed by new and emerging respiratory viruses and on options for their management. During the pandemic NERVTAG provided advice to SAGE.

30. On 13 January 2020 NERVTAG held its first meeting on the Wuhan Novel Coronavirus (or *WN-CoV)*, as it was then called, and discussed UK readiness and planning. NERVTAG noted that "*the novel virus does not look to be very*

transmissible" and agreed with PHE's assessment that the risk to the UK population from this illness was "*very low*".

31. On 22 January 2020, the first formal meeting of SAGE in relation to COVID-19 took place. It was noted that there had been "*infection of healthcare workers and probably some sustained human-to-human transmission, but not geographical spread unconnected to Wuhan*". SAGE agreed that the Government should review its response in the case of either "*onward spread of WN-CoV person to person outside*" China or a severe confirmed case in the UK.

32. On 23 January PHE Colindale, one of the few high security facilities in the UK able to carry out PCR (polymerase chain reaction) testing, published the protocol for a diagnostic test they had developed for COVID-19.

33. On 24 January France informed the WHO of three cases of COVID-19. All of those involved had travelled from Wuhan.

34. On 28 January, the first version of a PHE paper entitled '*Are asymptomatic people with 2019nCoV infectious*' was provided to SAGE. Successive versions of the paper were produced in the ensuing period, each providing an updated analysis of the issue. The first edition said that "*The currently available data is not adequate to provide evidence for major asymptomatic / subclinical transmission of 2019nCoV.*" It said that more information on the issue was needed. SAGE's minutes that day recorded that "*there is limited evidence of asymptomatic transmission, but early indications imply some is occurring. PHE (is) developing a paper on this.*"

35. On 30 January, the WHO declared a public health emergency and the following day the first COVID-19 case was reported in England.

36. On 3 February SPI-M-O issued a "consensus statement", which said, at paragraph 7, that it was "*unclear whether outbreaks can be contained by isolation and contract [sic] tracing. If a high proportion of asymptomatic cases are infectious, then containment is unlikely via these policies*."

37. On 4 February SAGE considered the PHE paper on asymptomatic transmission. The minutes record: "*Asymptomatic transmission cannot be ruled out and transmission from mildly symptomatic individuals is likely*."

38. An adult social care ("ASC") National Steering Group was created to coordinate the response from adult social care providers around the country to COVID-19. Its first meeting was on 5 February 2020. The meeting discussed contingency planning, the joining up of advice across the sector, care home access to NHS 111 advice, and support for local authorities and providers in the event of staff shortages.

39. On 7 February the American Medical Association published a letter by Chang, Lin, Wei et al entitled "*Epidemiologic and Clinical Characteristics of Novel Coronavirus Infections Involving 13 Patients Outside Wuhan, China*". It discussed asymptomatic transmission and observed that:

> "The current coronavirus outbreak in China is the third epidemic caused by coronavirus in the 21st century, already

> surpassing SARS and MERS in the number of individuals infected. The higher number of infections may be attributable to late identification of the etiologic agent and the ability of the host to shed the infection while asymptomatic, rather than to greater infectivity of the virus compared with SARS." (Emphasis added).

40. On 11 February 2020 there were reports in the British press of the case of a Mr Steve Walsh who was diagnosed as suffering from COVID-19 on 6 February. It was reported that he was advised to attend an isolation room at hospital, despite showing no symptoms, and subsequently self-isolated at home as instructed. He was reported as saying "*When the diagnosis was confirmed, I was sent to an isolation unit in hospital, where I remain, and, as a precaution, my family was also asked to isolate themselves*."

41. The minutes of a SAGE meeting held on 11 February record the following observations as to infectivity:

> "Duration of infectivity: 14 days as upper limit (advice to self-isolate for 14 days still stands). Peak infectivity is probably around the start of symptom onset, average 2-6 days. …Virus shedding may reach significant levels just before onset of symptoms and continues for 1-2 days after (wide uncertainty)." (Emphasis added).

42. On 12 February the National Steering Group met to discuss guidance for ASC.

43. Over the fortnight from 12 February, three relevant scientific papers were published. It is not suggested that Ministers and senior officials should themselves have been keeping on top of the emerging science; but it can be expected that those scientists advising government would do so. First, on 19 February, a letter from Zou et al was published in the Massachusetts Medical Society entitled '*SARS-CoV-2 Viral Load in Upper Respiratory Specimens of Infected Patients.*' It discussed asymptomatic transmission observing:

> "The viral load that was detected in the asymptomatic patient was similar to that in the symptomatic patients, which suggests the transmission potential of asymptomatic or minimally symptomatic patients. These findings are in concordance with reports that transmission may occur early in the course of infection and suggest that case detection and isolation may require strategies different from those required for the control of SARS-CoV." (Emphasis added).

44. Second, on 21 February the American Medical Journal published a paper called '*Asymptomatic Transmission in China Confirmed?*' (Bai et al.). This reported that

> "… A familial cluster of 5 patients with COVID-19 pneumonia in Anyang, China, had contact before their symptom onset with an asymptomatic family member who had traveled from the epidemic center of Wuhan. The sequence of events suggests

> that the coronavirus may have been transmitted by the asymptomatic carrier." (Emphasis added).

45. Third, on 24 February '*Viral load of SARS-CoV-2 in clinical samples*' was published in the Lancet. The paper included the following:

> "Overall, the viral load early after onset was high... However, a sputum sample collected on day 8 post-onset from a patient who died had a very high viral load…Notably, two individuals, who were under active surveillance because of a history of exposure to SARS-CoV-2- infected patients showed positive results on RT-PCR a day before onset, suggesting that infected individuals can be infectious before they become symptomatic." (Emphasis added).

46. On 14 February the Third Defendant was commissioned to provide clinical advice for care settings.

47. On 20 February 2020, SAGE considered a paper by SPI-M-O, '*Consensus Statement on 2019 Novel Coronavirus (Covid-19)*.' This stated that:

> "There is insufficient data available to determine whether there is sustained transmission outside of the province of Hubei, but it is likely to be the case. … There were differing views within the group about the likelihood of sustained transmission in the UK both currently and in the near future. Some believe it is a realistic possibility that sustained transmission in the UK will become established in the coming weeks while others believe this likelihood is higher and that there may already be sustained transmission." (Emphasis added).

48. On 21 February, the Third Defendant began working with NHS laboratories to establish COVID-19 testing capacity outside PHE.

49. It is apparent that the Defendants were alive to the possibility of pre-symptomatic infection and transmission. On 24 February, the PHE National Infection Service produced a strategy document, *'Evidence of a Cluster of Covid 19 Cases in the UK'*. That document included the following:

> "Asymptomatic infection is now well documented, but there is very limited evidence of transmission from asymptomatic cases. It is assumed that the substantial majority of transmission is from symptomatic individuals with COVID-19." (Emphasis added).

50. The following day, 25 February, the Third Defendant issued '*Guidance for social or community care and residential settings on COVID-19*.' The Guidance made clear that it was:

> "intended for the current position in the UK where there is currently no transmission of COVID-19 in the community. It is

> therefore very unlikely that anyone receiving care in a care home or the community will become infected. This is the latest information and will be updated shortly."

51. The document provided guidance on measures care homes should take to protect residents so that they could plan and prepare. It said that that there was "*currently little evidence that people without symptoms are infectious to others*". The minutes of a SAGE meeting the same day record amongst the measures to limit spread the following: "*Extremely mild symptoms should be enough to trigger home isolation if this intervention is to be adopted*."

52. On 27 February, a preliminary case report on an early SARS-CoV-2 cluster in the UK, France, and Spain was published by Swiss Medical Weekly. It observed:

> "the fact that an asymptomatic or nearly asymptomatic index case could have transmitted the infection to so many people raises concerns about the feasibility of containing the spread of SARS-CoV-2."

53. On 27 February WHO guidance on PPE included advice that the use of PPE was required for those caring for confirmed cases or symptomatic persons; it gave no advice on the use of PPE where neither patients nor staff were symptomatic.

54. On 28 February the UK reported its first COVID-19 case of unknown origin, with no links to travel abroad.

55. On 1 March PHE produced a document entitled "*Laboratory testing capacity and prioritisation of testing*" which showed the daily capacity, and the percentage of that capacity being used, in each testing laboratory in England.

56. On 2 March SPI-M-O produced what was called a '*Consensus statement on 2019 Novel Coronavirus*,' which stated that it is "*highly likely that there is sustained transmission of COVID-19 in the UK at present*." It indicated that the current estimation of the incubation period (the period between an individual becoming infected and developing symptoms) was 5 days.

57. On 3 March the DHSC published an action plan (the "March Action Plan"), a "*a high-level document*" setting out the Government's response to the COVID-19 pandemic. It set out what was known about COVID-19 and how national and local organisations had planned for, and would respond to, an infectious disease outbreak, such as the current outbreak. The fundamental objectives of the action plan were to:

> "deploy phased actions to Contain, Delay, and Mitigate any outbreak, using Research to inform policy development. The different phases, types and scale of actions depends upon how the course of the outbreak unfolds over time. ..."

58. The first two phases of the response (the two relevant to these proceedings) were the "contain" phase, the objective of which was to "*detect early cases, follow up close contacts, and prevent the disease taking hold in this country for as long as is reasonably possible*" and the "delay" phase where the aim was to *"slow the spread in*

this country, if it does take hold, lowering the peak impact and pushing it away from the winter season."

59. On 4 March DHSC held an internal social care meeting, at which the Minister of State for Care ("MSC") emphasised the need for preparedness in adult social care.

60. On 6 March a study was published entitled '*Transmission interval estimates suggest pre-symptomatic spread of COVID-19*'. It concluded "*Estimated serial intervals are shorter than incubation periods in both Singapore and Tianjin, suggesting that pre-symptomatic transmission is occurring.*"

61. NERVTAG's eighth meeting was held on 6 March. The minutes of that meeting recorded an observation by Professor Neil Ferguson of Imperial College, a member of both SAGE and NERVTAG, that "*the WHO report highlighted that infectiousness seems to be just before and just after symptom onset, and this is consistent with the Chinese data and other respiratory infections.*" (Emphasis added).

62. Two days later, on 8 March 2020, three significant papers were published. The first was a study by Wei Xia et al. entitled '*Transmission Of Coronavirus Disease 2019 During the Incubation Period May Lead To A Quarantine Loophole'.* The results of this study were reported as indicating that "*the transmission of COVID-19 occurs among close-contacts during the incubation period, which may lead to a quarantine loophole. Strong and effective countermeasures should be implemented to prevent or mitigate asymptomatic transmission during the incubation period in populations at high risk*." (Emphasis added). The paper concluded that "*COVID-19 cases in the incubation period are potential infection sources, especially within three days prior to the symptom onset*."

63. Second was a study entitled '*Virological Assessment of Hospitalized Cases of Coronavirus Disease 2019*' by Wolfel et al.. In this paper it was noted that:

> "the majority of patients in the present study seemed to be already beyond their shedding peak in upper respiratory tract samples when first tested, while shedding infectious virus in sputum continued through the first week of symptoms… reports of COVID-19 cases with mild upper respiratory tract symptoms, suggesting a potential for pre or oligosymptomatic transmission…Pharyngeal virus shedding was very high during the first week of symptoms with a peak at…day 4."

64. The third was a published study entitled '*Estimating The Generation Interval For COVID-19 Based On Symptom Onset Data'* the results of which indicated that the "*proportion of pre-symptomatic transmission was 48% ... for Singapore and 52% for Tianjin, China*." As Professor Adam Gordon, Professor of Care of Older People at the University of Nottingham and Consultant Geriatrician at the Royal Derby Hospital, notes in his witness statement in these proceedings, this study suggested that pre-symptomatic transmission of COVID-19 constituted a very substantial proportion of all transmission.

65. Also on 9 March the Health Minister, Lord Bethell, said in the House of Lords that "*large numbers of people are infectious or infected but are completely asymptomatic and never go near a test kit*."

66. Meanwhile, on 8 March PHE indicated that demand for testing was projected to outstrip capacity within 6-8 weeks. On 10 March, the Third Defendant was informed of the first suspected COVID-19 outbreak in a care home. A prioritisation list for testing was endorsed by the Secretary of State on 11 March.

67. The rapid spread of COVID amongst the general population, and the growing threat that the resulting demand for hospital care would overwhelm the available provision, was causing Ministers and officials to consider the appropriate response. On 11 March, at a meeting between the Secretary of State, the Minister for Social Care, the Deputy Chief Medical Officer and officials, it was agreed that it was critical that discharges from hospital happened as quickly as possible. A draft prioritisation list for testing was drafted and then endorsed at a meeting with the First Defendant.

68. When answering questions in Parliament on March 11, the Secretary of State was asked a question about how Parliament would function during the pandemic. He replied that:

> "matters of how we work are of course for Parliament—for the Leader of the House, the Speaker and the Commission, all guided by the science. They are in constant contact with Public Health England to get the very best advice. As for when we are voting, this disease passes in very, very large part from people who have symptoms and we may not have symptoms. What really matters is making sure that as soon as people have symptoms potentially of Coronavirus, they get in contact with 111 or Public Health England."

(It is of note that, contrary to the suggestion of Professor Gordon in his second witness statement, the Secretary of State was not there referring to COVID passing from people who are asymptomatic. Instead, he was expressing concern about those who were symptomatic passing on the virus in Parliament.)

69. On 12 March the European Centre for Disease Prevention and Control (ECDC) published a paper entitled '*Novel coronavirus disease 2019 (COVID-19) pandemic; increased transmission in the EU-EEA and the UK- 6th update*.' It made a number of observations about asymptomatic transmission. It noted that "*over the course of the infection, the virus has been identified in respiratory tract specimens 1-2 days* <u>*before the onset of symptoms*</u>*...*". Referring to the Japanese National Institute of Infectious Diseases' field briefing entitled '*Diamond Princess COVID-19 cases update March 10, 2020*,' it observed that the virus has "*been detected in asymptomatic persons. On a rapidly evolving cruise ship outbreak where most of the passengers and staff were tested irrespective of symptoms, 51% of the laboratory confirmed cases were asymptomatic at the time of confirmation*".

70. Referring to a publication by the Instituto Superiore di Sanità in Italy it said "*44% of the laboratory confirmed cases have been asymptomatic*." The ECDC paper also

referred to the potential transmission from an asymptomatic person in a family cluster in China. It continued:

> "in addition to case reports, pre-symptomatic transmission has been inferred through modelling and the proportion of pre-symptomatic transmission was estimated to be around 48% and 62%.... major uncertainties remain in assessing the influence of pre-symptomatic transmission on the overall transmission dynamics of the pandemic."

71. That same day the Second Defendant was provided with a SPI-M model of the potential impact of COVID-19 on the NHS in England of the rapidly growing number of cases, and DHSC announced a move from the "contain" to "delay" phase of pandemic response. At a meeting between the Secretary of State, ministers and senior NHS and Government officials, various options to free up hospital capacity by discharging people into social care were considered. The preferred option was to offer free care to speed up discharge.

72. As at 12 March testing capacity was about 3,000 tests per day nationally. The testing prioritisation list was published that day.

13 March to 16 March

73. On the morning of 13 March, on BBC Radio 4's *Today* programme, Sir Patrick Vallance, the Government's Chief Scientific Advisor, said this about the means of transmission of the virus:

> "It looks quite likely that there is some degree of asymptomatic transmission. There's definitely quite a lot of transmission very early on in the disease when there are very mild symptoms".

74. Later that same day, the March PHE Policy was published. Aimed at "*local authorities, clinical commissioning groups and registered providers of accommodation for people who need personal or nursing care*", it set out "*key messages to support planning and preparation in the event of an outbreak or widespread transmission of COVID-19.*" It said that:

> "Care home providers are advised to work with local authorities to establish plans for mutual aid, including sharing of the workforce between providers, and with local and community health services providers, and with deployment of volunteers where that is safe to do so…To minimize the risk of transmission, care home providers are advised to review their visiting policy by asking no one to visit who has suspected COVID-19 or is generally unwell, and by emphasizing good hand hygiene for visitors. Contractors on site should be kept to a minimum. The review should also consider the wellbeing of residents and the positive impact of seeing friends and family."

75. The policy also provided that care homes "*are not expected to have dedicated isolation facilities for people living in the home but should implement isolation*

precautions when someone in the home displays symptoms of COVID-19 in the same way that they would operate if an individual had influenza." In relation to PPE, it said that "*if neither the care worker nor the individual receiving care and support is symptomatic, then no personal protective equipment is required above and beyond personal hygiene practices*."

76. That same day, '*Guidance for Infection Prevention and Control in Healthcare Settings*,' which provided guidance for healthcare workers, was published. It included the following:

> "Assessment of the clinical and epidemiological characteristics of SARS-CoV-2 cases suggest that, similar to SARS-CoV, patients will not be infectious until the onset of symptoms…there have been case reports that suggest infectivity during the asymptomatic period, with one patient found to be shedding virus before the onset of symptoms. Further study is required to determine the actual occurrence and impact of asymptomatic transmission."

77. The same day, anyone with symptoms was asked to self-isolate regardless of their travel or contact history.

78. Two days later, on 15 March, an important paper from Imperial College and Columbia University was published. '*Substantial undocumented infection facilitates the rapid dissemination of novel coronavirus*' by Li and Pei et al. discussed the transmission rate of undocumented infection. The authors noted that the:

> "high proportion of undocumented infections, many of which were likely not severely symptomatic, appear to have facilitated the rapid spread of the virus throughout China…in addition the best fitting model has a reporting delay of 9 days from initial infectiousness to confirmation; in contrast, line-list data from the same 10-23 January period indicates an average 6.6 day delay from initial manifestation of symptoms to confirmation. This discrepancy suggests that pre-symptomatic shedding may be typical among documented infections. The relative timing of onset and peak of viremia and shedding versus onset and peak of symptoms has been shown to potentially affect outbreak control success."

79. On 16 March, SAGE considered a number of modelling papers which led to the conclusion that a combination of case isolation, household isolation and social distancing of vulnerable groups would be unlikely to prevent critical care facilities being overwhelmed and that further interventions were needed. One of these models was described in the Imperial College COVID-19 Response Team's paper, entitled '*Report 9: Impact of non-pharmaceutical interventions (NPI) to reduce COVID-19 mortality and healthcare demand*.' The paper asserted that, even in the context of an effective mitigation strategy which included case isolation, household quarantine and social distancing of those aged over 70, hospital critical care capacity could become overwhelmed by a factor of eight. The paper continued:

> "In the UK, this conclusion has only been reached in the last few days, with the refinement of estimates of likely ICU demand due to COVID-19 based on experience in Italy and the UK (previous planning estimates assumed half the demand now estimated) and with the NHS providing increasing certainty around the limits of hospital surge capacity."

80. Also on 16 March Ministers agreed plans for the rapid expansion of hospital and "step down" capacity and the publication of the hospital discharge "action plan". There was also discussion of the Government's simplification of the financial regime for the social care funding of hospital discharges. In an oral statement to the House of Commons, the First Defendant announced that the NHS would be confirming these measures designed to free up hospital capacity "*later today*". The Government announced that those in the same household as a symptomatic case should isolate for 14 days. The Secretary of State also answered a question in Parliament, explaining that the point of the household isolation policy was to help reduce pre-symptomatic transmission. The Chief Scientific Advisor explained:

> "the reason it's 14 days is the seven days for the person who's got the infection, the incubation period that others may catch it, and the seven days after that."

81. The same day, SPI-M-O recorded the "consensus view" that the addition of general social distancing and school closures should take place as soon as practical. The point is made by the Claimant that these responses indicate a conclusion on the part of the Government that pre-symptomatic transmission was taking place.

17 March to 2 April

82. The NHS communication setting out the actions agreed with the Government to free up hospital capacity which was promised for 16 March was deferred until 17 March, after the Prime Minister's national televised address that evening in which he advised the UK population at large to stop all non-essential contact with others and all unnecessary travel. The Prime Minister said:

> "Today, we need to go further, because according to SAGE it looks as though we're now approaching the fast growth part of the upward curve. And without drastic action, cases could double every 5 or 6 days."

83. It was also on the 17 March that the first death of a care home resident in the UK from COVID-19 was confirmed.

84. Also that day, '*Next Steps on NHS Response to COVID-19'*, was published by the Second Defendant. This was the first of two elements that made up the March Discharge Policy. The second, the March Discharge Requirements, was published two days later.

85. Four academic papers of interest were published within a matter of days of the publication of the March Discharge Policy. They are described in the comprehensive second witness statement of Prof Adam Gordon on behalf of the Claimants. On 17

March, the Infectious Diseases Society of America published a study entitled '*Clinical Outcomes in 55 Patients with Severe Acute Respiratory Syndrome Coronavirus 2 who were Asymptomatic at Hospital Admission in Shenzhen, China'*. The study found that:

> "Many asymptomatic persons were actually a source of SARS-CoV-2 infection but were considered healthy before they underwent screening. The risk of viral spread from asymptomatic patients with infection suggest that prompt screening of family members of infected persons is important." (Emphasis added).

86. The following day '*Temporal dynamics in viral shedding and transmissibility of COVID-19*' by Lau et al was published. The abstract stated:

> "We report temporal patterns of viral shedding in 94 laboratory-confirmed COVID19 patients and modelled COVID-19 infectiousness profile from a separate sample of 77 infector-infectee transmission pairs. We observed the highest viral load in throat swabs at the time of symptom onset, and inferred that infectiousness peaked on or before symptom onset. We estimated that 44% of transmission could occur before first symptoms of the index." (Emphasis added).

87. The third paper was published the same day. The United States Center for Disease Control and Prevention ("CDC") published, '*COVID-19 in a Long-Term Care Facility—King County, Washington, February 27-March 9 2020'*. It considered the difficulties in protecting care home residents. The paper included the following:

> "Limitations in effective infection control and prevention and staff members working in multiple facilities contributed to intra- and interfacility spread… Information received from the survey and on-site visits identified factors that likely contributed to the vulnerability of these facilities, including 1) staff members who worked while symptomatic; 2) staff members who worked in more than one facility; 3) inadequate familiarity and adherence to standard, droplet, and contact precautions and eye protection recommendations; 4) challenges to implementing infection control practices including inadequate supplies of PPE and other items (e.g., alcohol-based hand sanitizer); 5) delayed recognition of cases because of low index of suspicion, limited testing availability, and difficulty identifying persons with COVID-19 based on signs and symptoms alone."

88. On 19 March 2020, a study entitled *'Serial Interval of COVID-19 among Publicly Reported Confirmed Cases'* was published. The study found: *"12.6% of case reports indicated pre-symptomatic transmission... ... the large number of reported asymptomatic transmission events is concerning."* (Emphasis added.)

89. Meanwhile, on 18 March, there were email exchanges between the Defendants' officials, acknowledging the importance of PPE supply and providing details of the National Supply Disruption Line; enquiries were made of the second Defendants about spare capacity in the care sector to support isolation; Ian Hall of the Association of Directors of Adult Social Services emailed NHS officials, noting that providers were cautious about accepting discharges due to lack of testing; a meeting of senior Government ministers, held to discuss discharge plans, confirmed (in the words of Mr Ian Dodge of the Second Defendants) that "*due pace would be given to discharging patients from hospital*", and that funding would be given to local authorities to meet social care pressures; and Ministers agreed that the March Hospital discharge requirements should be published the following day. By 18 March testing capacity had reached 5,000 tests per day.

90. On 19 March the March Discharge Requirements were issued. DHSC announced £1.6 billion funding for local authorities to support their pandemic response. It was expected that a majority of the funding would be used for social care. The March PHE Policy was updated to reflect the new Stay at Home guidance and other new guidance.

91. On 20 March NERVTAG considered asymptomatic transmission and requested an update to PHE's paper on the subject. NERVTAG reviewed the evidence for asymptomatic or subclinical transmission and concluded that:

> "There is plenty of information on asymptomatic people testing positive for SARS-CoV-2 but very little information regarding transmission. There is an ongoing process at PHE to track new information. There are sporadic reports, but the data are not very convincing." (Emphasis added)

92. According to the First and Third Defendants' witness Dr Susan Hopkins, by 20 March modelling suggested it was likely that NHS intensive care capacity would be exceeded by the end of the month within London, and in other regions 1 – 2 weeks later.

93. On 21 March, the 'Parallel supply chain for PPE' was established and the WHO published IPC guidance to care homes: '*Infection Prevention and Control guidance for Long-Term Care Facilities in the context of COVID-19*.' The WHO document provided guidance where residents were thought to have, or had been diagnosed as having, COVID.

94. On 23 March, SAGE noted that there had been community transmission and some nosocomial (originating from hospital) clusters. Also on 23 March, the Prime Minister announced a nationwide lockdown, subsequently given effect by the Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 made on the 26 March 2020. The UK Senior Clinicians Group ("UKSCG") agreed that only "absolutely necessary" visitors should be allowed into care homes. PHE's first draft of the April Admissions Guidance ('*Interim advice on managing COVID-19 cases and outbreaks in care homes'*) was produced, which advised (inter alia) against transfer of COVID-positive patients into care homes without an existing outbreak.

95. The following day, on 24 March, version 7 of the PHE paper "*Are asymptomatic people with Covid-19 infectious?*" was produced. It described cases of asymptomatic infection, but said that these:

> "do not provide evidence for asymptomatic transmission of SARS-CoV-2…The currently available data remains inadequate to provide evidence for major pre-symptomatic/asymptomatic transmission of [Covid]. Major uncertainties remain in assessing the influence of pre-symptomatic transmission on the overall transmission dynamics of the pandemic. Detailed epidemiological information from more cases and contacts is needed to determine whether transmission can occur from asymptomatic individuals or during the incubation period on a significant scale." (Emphasis added)

96. Also on 24 March, the Second Defendant's first draft of the April Admissions Guidance was circulated to officials of the Second and Third Defendants for comment. PHE had been working on their own draft new guidance and work was done to produce a single joint document. The PHE draft advised (inter alia) against transfers of asymptomatic patients to care homes with a suspected outbreak and against transfers of confirmed cases who had not yet completed their isolation to a care home without a suspected outbreak. The second Defendant's Deputy Chief Nursing Officer raised objections to the draft advice that care homes should close to new admissions after an outbreak of two or more cases, and to the advice that staff were split between those with and without COVID-19. The second Defendants' officials raised concerns that the guidance would lead to the care home sector being "*too risk adverse*" (sic).

97. On 25 March Professor Andrew Hayward of SAGE and Professor Hopkins of the third Defendants prepared a draft paper on PPE use "during periods of widespread community transmission of COVID-19". The paper included the following:

> *"Current guidance is focused around health and care workers in contact with known or suspected cases but wearing…masks only during these exposures does not take account of the fact that patients may transmit prior to symptom onset".*

98. Also on 25 March, the Third Defendant circulated to the Second Defendant a proposed re-draft of the guidance. The original PHE advice against transfers of asymptomatic patients to care homes without an outbreak was removed. That draft was sent to the Minister for Social Care for approval. The Minister expressed a preference not to discharge COVID-19-positive people to care homes but was advised that discharge would occur when clinically appropriate.

99. There were a number of significant events on 26 March. First, the First Defendant reported that hospitals were running at 70% capacity.

100. Second, the testing prioritisation list was updated. In addition to the priority groups listed, the updated list said that priority testing for viral clearance should "*focus on*" those who were severely immunocompromised and who were being stepped down to

a setting where isolation was not possible, patients being discharged to a residential or care facility; and patients who required multiple admissions and attendances. According to the evidence of Mr Tom Surrey, a senior civil servant in the DHSC, the effect of the update was to advise that, where capacity allowed, testing of those already confirmed as COVID-19 positive should be prioritised for patients being discharged to a residential or care facility.

101. Third, a further draft of the April Admissions Guidance was produced. This version included the statement that:

> "This means some patients with non-urgent needs will be discharged into care homes for their recovery periods. Residents may also be admitted to a care home from a home setting. These patients may have COVID-19; may be symptomatic or may be asymptomatic. All of these patients can be safely cared for in a care home if this guidance is followed."

102. Fourth, Scotland's March Admissions Guidance was published. It provided that:

> "If a patient being discharged from hospital is known to have had contact with other COVID- 19 cases and is not displaying symptoms, secondary care staff must inform the receiving facility of the exposure. The receiving facility should ensure the exposed individual is isolated for 14 days following exposure to minimise the risk of a subsequent outbreak within the receiving facility."

103. Fifth, Professor Yvonne Doyle of the Third Defendant, gave evidence to the Health and Social Care Select Committee of the House of Commons. The following exchanges took place:

> "May I ask you for some of the latest medical opinion, if I may put it that way? For how many days do we think people might be able to spread the virus while they are still asymptomatic?
>
> Professor Doyle:… On your question about how many days, we know that the incubation period ranges between three and five days. For people who are asymptomatic, they <u>may have been asymptomatic for some period before symptoms appeared.</u> We are still learning—this is a crucial issue for us— about those who are asymptomatic and never develop symptoms. <u>We think that about 30% of people may be in that category</u>. They have harboured the virus, but we do not know whether they adequately or effectively can transmit. Three to five days is when we begin to see people becoming unwell.
>
> Chair: <u>When you say that the incubation period is three to five days, what you are saying is that people could be spreading the virus to others for up to five days before they show any symptoms?</u>

> Professor Doyle: Yes, that is correct. As I said, we are still learning about that. It ranges over quite a long range, but in the majority of cases that we are analysing, about five days is the period.
>
> Chair: …At the start, you said that you could pass on the virus when you are asymptomatic, for potentially up to five days. Does that mean that, today, NHS staff are likely to be passing on the virus to their patients?
>
> Professor Doyle: This is something we are learning about. In theory, when people are incubating viruses, they can be infectious. We still have to chart the nature of this virus, and how infectious it is and at what point. We are working on first principles that it could be, and that is the precautionary principle. People tend to be most infectious—we have noticed this from the testing, and indeed from the clinical feedback we are getting from colleagues—at the beginning of this disease, particularly if they are severely unwell, and that does tail off. That is the issue about what happens between seven and 14 days; other important things do happen between seven and 14 days with those who are hospitalised. So, the answer in theory is yes, and at the beginning, particularly when people are symptomatic at the beginning, they may be at their most infectious, but we are still learning." (Emphasis added).

104. On 27 March, testing capacity had increased to 10,000 tests per day and testing was expanded to NHS staff with symptoms, and member of their families with symptoms. DHSC was notified by the third Defendants of a rapid increase in reported cases in the care home sector.

105. Also on that date, a paper entitled '*Asymptomatic and Presymptomatic SARS-CoV-2 Infections in Residents of a Long-Term Care Skilled Nursing Facility — King County, Washington, March 2020*' by Kimball et al was published as a pre-print. The study found as follows:

> "…Approximately half of all residents with positive test results did not have any symptoms at the time of testing, suggesting that transmission from asymptomatic and presymptomatic residents, who were not recognized as having SARS-CoV-2 infection and therefore not isolated, might have contributed to further spread.... If asymptomatic or presymptomatic residents play an important role in transmission in this population at high risk, additional prevention measures merit consideration, including using testing to guide cohorting strategies or using transmission-based precautions for all residents of a facility after introduction of SARS-CoV-2. Limitations in availability of tests might necessitate taking the latter approach at this time…these findings …suggest that these residents have the potential for substantial viral shedding. This analysis suggests that symptom screening could initially fail to identify

> approximately one half of SNF residents with SARS-CoV-2 infection. Unrecognized asymptomatic and presymptomatic infections might contribute to transmission in these settings.
>
> During the current COVID-19 pandemic, … all long-term care facilities should take proactive steps to prevent introduction of SARS-CoV-2, including restricting visitors except in compassionate care situations, restricting nonessential personnel from entering the building, asking staff members to monitor themselves for fever and other symptoms, screening all staff members at the beginning of their shift for fever and other symptoms, and supporting staff member sick leave, including for those with mild symptoms. Once a facility has a case of COVID-19, broad strategies should be implemented to prevent transmission, including restriction of resident-to-resident interactions, universal use of facemasks for all health care personnel while in the facility, and if possible, use of CDC-recommended PPE for the care of all residents (i.e., gown, gloves, eye protection, N95 respirator, or, if not available, a face mask) ...In settings where PPE supplies are limited, strategies for extended PPE use and limited reuse should be employed... As testing availability improves, consideration might be given to test-based strategies for identifying residents with SARS-CoV-2 infection for the purpose of cohorting, either in designated units within a facility or in a separate facility designated for residents with COVID-19. During the COVID-19 pandemic, collaborative efforts are crucial to protecting the most vulnerable populations."

106. That same day, an initial draft of the *'Guidance for Stepdown of infection control precautions within hospitals and discharging COVID-19 patients from hospital to home settings' ("the April PHE Guidance")* was presented to UK CMOs and senior clinicians by the Second and Third Defendants, with a proposal to consider isolation, in relation to those who had tested positive for COVID-19, for either 7 or 14 days depending on the individual, or a precautionary 14-day approach for all patients discharged to care settings.

107. On 28 March the Minister for Social Care expressed several concerns about the draft of the April Admissions Guidance she had been sent, including on the principle of discharge of COVID-19-positive patients into care homes.

108. On 30 March the DHSC published a COVID-19 public information and advice campaign that stated: "*anyone can spread it*". On the following day, the Second Defendant was asked by SAGE to conduct further investigation of this issue.

109. Also on 31 March 2020, a study entitled '*Quantifying SARS-CoV-2 transmission suggests epidemic control with digital contact tracing'* by Ferretti et al appeared in the 'Science' journal. The study suggested that:

> "between a third and a half of transmissions occur from pre-symptomatic individuals. This is in line with estimates of 48%

> of transmission being pre-symptomatic in Singapore and 62% in Tianjin, China and 44% in transmission pairs from various countries. Our infectiousness model suggests that the total contribution to R0 from pre-symptomatics is 0.9 …, almost enough to sustain an epidemic on its own. For SARS, the corresponding estimate was almost zero, immediately telling us that different containment strategies will be needed for COVID-19. Transmission occurring rapidly and before symptoms, as we have found, implies that the epidemic is highly unlikely to be contained by solely isolating symptomatic individuals." (Emphasis added).

110. That same day an NHS Paper went to SAGE on Nosocomial Transmission, which noted that "*a key additional risk is transmission of coronavirus from non-diagnosed COVID-19 positive patients or staff, i.e. those who are asymptomatic or pauci-symptomatic*." Also on 31 March an ECDC Technical Report, '*Infection Prevention and control and preparedness for COVID-19 in healthcare settings*' was published. This noted increasing evidence of asymptomatic and pauci-symptomatic transmission.

111. In the final stages of drafting the April Admissions Guidance, a paragraph that read "*any patient who has exhibited symptoms of COVID-19 whilst in hospital will be tested*" was removed. A PHE official noted that this was thought to result in bed-blocking and indicated that there was no expectation people would be tested on discharge. An email was sent to Ministers providing a further version and a summary of the contents of the April Admissions Guidance. It said that the guidance could be published the following day subject to their approval. A briefing document, entitled 'Making optimal use of social care funding to support COVID', was produced asking for approval of the proposed approach in NHS England.

2 April to 14 April

112. The third policy under challenge, the April Admissions Guidance (entitled '*Admission and Care of Patients During COVID-19 Incident in a Care Home*'), was published on 2 April. It provided guidance to care homes on the admission and management of those admitted to homes from hospitals. It also provided general infection control advice.

113. Also on 2 April, a new draft (version 9) of *'Are asymptomatic people with COVID-19 infectious*' was produced by PHE, with input from others. The paper concluded that available evidence to date suggested that some asymptomatic/presymptomatic transmission was occurring, but the scale of such transmission remained uncertain.

114. The same day, WHO published '*Coronavirus disease 2019 (COVID-19) Situation Report – 73'*, which stated "*There are few reports of laboratory-confirmed cases who are truly asymptomatic, and to date, there has been no documented asymptomatic transmission. This does not exclude the possibility that it may occur*."

115. Also on 2 April, the First Defendant announced a national testing programme initially aimed at testing frontline workers. He indicated that the UK would carry out 100,000 tests per day by the end of the month.

116. On 3 April, PHE began two studies in care homes; the first an enhanced surveillance study; the second a whole genome sequencing study in 6 care homes (the "Easter 6 Study"). Available data was analysed and indicated asymptomatic transmission. Preliminary findings were shared with the UKSCG and DHSC on 16 April 2020. The data was presented to NERVTAG on 23 April 2020.

117. On 4 April the Third Defendant published *'COVID-19: management of exposed staff and patients in health and social care settings*' and the First Defendant published '*Coronavirus (COVID-19): scaling up our testing programmes*.'

118. On 6 April the Centre for Evidence-based Medicine published the article '*Covid-19: what proportion are asymptomatic?*' which summarised data from 20 studies on asymptomatic infection. The paper suggested that between 5% and 80% of people testing positive for SARS-CoV-2 may be asymptomatic, that symptom-based screening would miss cases, perhaps a lot of them, that some asymptomatic cases would become symptomatic over the next week and that children and young adults could be asymptomatic.

119. On 7 April, there was a meeting at which Ministers considered the number of outbreaks in care homes, discharges and reducing the spread through testing and PPE.

120. On 8 April, the International Long-Term Care Policy Network published a briefing note on British care guidance. It referred to the growing asymptomatic transmission evidence base.

121. On 9 April the PHE Guidance was published, setting out existing guidance on isolation and infection control.

122. On 10 April the 'COVID 19: Personal Protective Equipment Plan' was published. This document set out guidance on the use of PPE and identified the Government's plans for distribution and future supply of PPE. The same day, DHSC officials sent to Ministers the draft of a "pack" entitled '*COVID-19 Social Care Strategy – proposed approach*'. Slides which made up part of the pack contained recommendations that all patients discharged to care homes be either quarantined in an NHS hospital or tested on admission, and all entrants be quarantined in social care for 14 days in dedicated isolation wings.

123. On 12 April, a statement was added to the "landing page" for PPE guidance, clarifying that the UK was experiencing sustained community transmission, and that PPE should be used for all episodes of care.

124. On 13 and 14 April 2020, Ministers discussed a proposed adult social care strategy. They reached agreement that the April Action Plan should be published. On 13 April 2020, recognising the growing scientific consensus that COVID-19 could be spread via asymptomatic people, it was agreed that asymptomatic people being discharged from hospitals to care homes should be tested.

125. At its meeting on 14 April, SAGE noted that "*Care homes…remain a concern*". Discussing the value of facemasks, SAGE observed that the "*fundamental difference with COVID-19 [compared with other diseases] is the shedding of virus during asymptomatic and presymptomatic infection*."

15 April to 1 May

126. On 15 April, the April Action Plan was published. It mandated the testing of all patients discharged to care homes from hospital and testing of all symptomatic care home residents and care home staff.

127. On 16 April, the Third Defendants circulated a paper entitled '*Summary of evidence on controlling the spread of COVID-19 in care home settings*' to the UKSCG. It noted growing international evidence of asymptomatic transmission of COVID-19 in care homes and recommended that all symptomatic staff be tested and isolated; all routine visits be stopped; and all new admissions or transfers back to care homes from hospital or the community be tested. The Second Defendants informed all acute hospitals of the new policy on testing.

128. On 17 April, a series of documents was published including '*Care homes strategy for Infection Prevention & Control of Covid-19 based on clear delineation of risk zones'*, '*Considerations for acute personal protective equipment (PPE) shortages*', '*IPC Highlights Quick Reference guide'*, and '*How to work safely in care homes*'.

129. On 18 April, '*Personal protective equipment (PPE) – resource for care workers working in care homes during sustained COVID-19 transmission in England'* was published.

130. On 19 April, PHE produced '*Preventing infection with SARS-CoV-2 in care home/residential settings: Reactive to Proactive engagement with care homes'*. This recommended measures to minimise the introduction of Covid-19 into care homes.

131. On 22 April, the '*How to work safely in care homes*' documents were updated. At a meeting, the Minister for Social Care agreed to move forward with policies such as restricting movement of staff between care homes.

132. On 23 April, data from the Easter Six study was presented to NERVTAG. The UKSCG discussed the PHE '*Preventing infection'* paper. A ministerial submission went to the Minister for Social Care, the Secretary of State and the Parliamentary Under Secretary of State, which recommended prioritising the testing of asymptomatic staff and residents in care homes where an outbreak had been recorded within 14 days.

133. On 24 April, interim results and analysis from the enhanced care home outbreak study and the Easter 6 study were presented at NERVTAG.

134. On 27 April, there was a meeting with Ministers, after which DHSC officials were asked to come up with proposals restricting care home workers to working in one home.

135. On 28 April, the Cabinet Office sent the Secretary of State and other colleagues a list of actions arising from a "deep dive." These included that DHSC prioritise testing all care home workers, and that DHSC and MHCLG provide a plan for operationalising the proposals on restricting workforce movement, infection control, isolation and testing. Ministers agreed to the recommended actions in '*Social Care: Update and Next steps'*, including restricting staff rotation and mandatory isolation of new

residents. Routine testing of all staff and CQC registered care home residents whose primary demographic is residents over 65 or with dementia was also agreed.

136. On 29 April, the Second Defendant sent a letter to all NHS Trusts concerning support for care homes.

137. On 30 April, the MSC asked for the plans circulated in the letter the day before to be developed into a comprehensive support plan for publication. The Prime Minister's Implementation Unit began a rapid review into care home policy and staff movement.

138. On 1 May, DHSC began piloting the testing of whole care homes.

The litigation history

139. The claim was issued on 12 June 2020. By a decision made on the papers on 3 September 2020 Murray J ordered that the permission application was to be heard in open court. It came before Linden J on 19 November 2020. He granted permission on all grounds. He rejected an argument by the Defendants that the claim was academic, saying (in our view rightly):

> "There is a live dispute between the parties as to whether the Defendants were in breach of any of the duties alleged. The Claimants seek a remedy in respect of those alleged breaches in the form of declaratory relief and just satisfaction in the form of an acknowledgment of the wrong that they say was done to them and their fathers. It cannot be said, as a general proposition, that the adjudication of past alleged breaches of duty which have not been repeated is always academic or a hypothetical exercise in the context of judicial review."

140. Linden J also said:

> "I also emphasise that nor will the process of determining the claim be in the nature of a public inquiry. As Mr Coppel QC accepts, the claim will stand or fall on whether the Claimants are able to establish the specific breaches of legal duties alleged rather than being a process in which the court second-guesses the decisions of the Defendants or the rights and wrongs of their actions in some more general sense."

141. He granted a costs-capping order, holding that these were "public interest proceedings" within the terms of s 88 of the Criminal Justice and Courts Act 2015. He said:-

> "This case is about the legal duties of Government towards a particular vulnerable sector of society in the context of a pandemic whether under the European convention on Human rights, general public or equality law. The proceedings raise issues of law of real and general importance. It is important that those issues are resolved and these proceedings are an entirely appropriate way to raise them. The issues affect a very large

> number of people, either directly because they are or may be cared for in care homes, or indirectly because they are relatives or friends of people who are cared for in care homes. I accept that if relief is granted it will only formally apply to the Claimants, but it is likely to be of comfort to many others and it may assist in future dealings with the present pandemic and other analogous or similar situations."

142. The Claimants applied for an order for cross-examination of the Defendants' witnesses and for extensive specific disclosure. These applications were refused on the papers by Cheema-Grubb J on 5 August 2021. They were renewed to an oral hearing and again refused by Eady J on 27 August 2021. Eady J's refusal to order further disclosure (though not her refusal of an oral for cross-examination) was the subject of an application for permission to appeal which was refused by Elisabeth Laing LJ on 22 August 2021.

143. On 5 November 2021 we gave a ruling on a number of interlocutory issues: [2021] EWHC 2946 (Admin). We held that evidence of opinion contained in the witness statements (predominantly, though not invariably, on the Claimants' behalf) was inadmissible, as were, with one exception (the evidence of Professor Doyle referred to above) no longer in issue, statements made in Parliament.

The parties

144. The Secretary of State for Health and Social Care has responsibility for policy in the field of adult social care in England. From 9 July 2018 to 26 June 2021 the office was held by the Rt Hon Matt Hancock MP. The Minister for Social Care, that is to say the Minister of State with responsibility for care and mental health, between 13 February 2020 and 16 September 2021 was Helen Whately MP. The Secretary of State is also responsible in law for the Third Defendant, Public Health England. The Secretary of State is not, however, directly responsible for the acts and decisions of the Second Defendant, generally known as NHS England. NHS England is a statutory corporation with its own Board.

145. We were told that some 97% of care homes in England are in the private or third sector: that is to say they are not operated by any of the Defendants to this claim. The Secretary of State does have power under s 20 of the Health and Social Care Act 2008 to impose requirements on care homes by regulations: indeed, he has a duty to impose requirements that he considers necessary to secure that services provided in care homes "cause no avoidable harm to the persons for whom the services are provided": s 20 (1). No such regulations were introduced during the first wave of the pandemic and it has not been suggested that they should have been: the time scale would have made this impracticable even if it had otherwise been desirable, and for a period after 26 March 2020 Parliament was not able to meet. The s 20 power was used to introduce a vaccine mandate for certain staff in the health care sector at a much later stage when vaccines had become available.

146. We have therefore had to keep in mind that the Defendants had the power of persuasion and guidance in relation to care homes, but not of compulsion. In particular, they had no power in law to require care homes to admit patients, nor to require them to remain open.

Heads of claim

147. The claim was originally brought under ECHR Articles 2, 3, 8, and 14, at common law, under ss 19 and 29 of the Equality Act 2010 and under s 147 of the same Act, the public sector equality duty ("the PSED"). The claims under Articles 3 and 14 and ss 19 and 29 of the 2010 Act were not pursued before us, and as will appear we do not consider that Article 8 or the PSED really add anything of substance. The focus of the argument before us has been on Article 2 and on judicial review at common law.

148. The Statement of Facts and Grounds served on 31 July 2020 ran to 100 pages. The bundles, even without the voluminous authorities, contain thousands of pages. On 1 December 2020 the Court of Appeal (Lord Burnett of Maldon CJ, King and Singh LJJ) handed down judgment in *R(Dolan) v Secretary of State for Health and Social Care* [2020] EWCA Civ 1605; [2021] 1 WLR 2326 (a challenge to the lawfulness of the lockdown in the early stage of the pandemic) in which, at paragraphs [119]-[120], they deprecated the length and complexity of the grounds of challenge in that case. Despite the skill with which the claim was presented, the obvious importance of the subject matter, and the fact that some of the pleaded heads of claim were not pursued, we consider that in this case too a more focussed approach would have been preferable.

149. During the interlocutory hearing before us in October 2021 we asked each party to provide a case summary limited to five pages, which did assist in at least listing the issues. We set out what is said in the Claimants' case summary about the two main categories of their claims. Under the heading "The ECHR Challenge" Mr Coppel, Mr Barrett, and Mr Hogarth say:

> "2. In brief summary, Cs complain that Ds (a) decided to take steps which would introduce, or risk introducing, Covid into care homes, and (b) otherwise failed to take any or any adequate steps to prevent Covid from entering care homes (through staff, visitors and new admissions). They purportedly relied instead upon strict infection control within care homes as the principal or only means of protecting care home residents from Covid. This was, and proved to be, a wholly inadequate means of protecting care home residents in circumstances where:
>
> (1) Ds knew or ought to have known that care home residents were particularly vulnerable to serious illness and death if Covid entered their home.
>
> (2) Ds knew or ought to have known that a high proportion of care homes are unsuitable environments for, and/or lack expertise or training in, strict infection control.
>
> (3) Ds knew or ought to have known that many care homes were experiencing shortages of PPE which would inhibit them in implementing adequate infection control, and that many care homes lacked the expertise and training to use effectively such PPE as they had.

(4) Ds knew that there were no reliable safeguards in place to verify whether care homes were able to provide the necessary levels of infection control.

(5) Ds' guidance to care homes– including in relation to isolation of new admissions and use of PPE – was wholly or principally reliant on a "symptoms-based approach", and made no (or no sufficient) provision to protect against pauci-symptomatic, pre-symptomatic and true asymptomatic transmission of Covid. The Defendants knew or ought to have known that such guidance was inadequate to protect care home residents from Covid. There is evidence that the April Admissions Guidance, which wrongly advised care home operators that residents could be cared for safely provided its terms were followed, was issued with the objective of persuading care homes to accept new admissions in circumstances where they would otherwise have declined to do so because of safety concerns.

(6) Covid testing was not made available for persons discharged from hospitals into care homes even where there was sufficient capacity for such tests to be conducted.

(7) Ds failed to take any or any sufficient steps to reduce the movement of staff between care homes; indeed, sharing of staff between care homes was positively encouraged until the May Support Policy (on 15 May 2020). This was a serious failing given that care home staff were an obvious source of infection and Covid testing was not first made routinely available to staff until after 15 April 2020.

(8) Ds failed to take sufficient steps to restrict visitors to care homes."

150. Under the heading "Public Law Complaints" they say:

"10. Cs' public law claims are, in summary:

(1) Failure to take into account relevant considerations, namely (a) failure to assess the risk to the lives of care home residents which would be caused by the March Discharge Policy and the April Admissions Guide, and to weigh that risk against the benefits which were perceived for these policies; (b) failure to consider adopting a policy of testing hospital discharges before admission to a care home or (at the very least) of providing that tests on discharges should be conducted wherever capacity allowed; (c) failure to consider the likelihood of transmission from persons without symptoms until mid-April 2020; (d) failure

> to consider the unsuitability of the care home environment for isolation and infection control.
>
> (2) Failure to conduct a sufficient enquiry, through not considering those matters, and also failing to consult expert advisors on their implications (in particular NERVTAG).
>
> (3) Taking into account irrelevant considerations, namely (a) taking into account and pursuing, by the April Admissions Guidance, the objective of overriding the legitimate concerns of care home operators for the protection of their residents, and (b) (in the case of D2), pursuing the objective of seeking to preserve for the long term what it regarded as the benefits of the March Discharge Policy (and thereby blocking measures to protect care home residents which D2 perceived to jeopardise those benefits, such as the use of NHS facilities for isolation of patients who could not be safely isolated in the care home to which they were to be discharged).
>
> (4) Irrationality, by Ds (a) adopting the March Discharge Policy without taking any additional steps to safeguard the vulnerable care home residents who would be exposed to Covid-19 infection as a result, (b) (on their factual case) deciding that it was preferable to introduce Covid-19 infection into the resident population of a care home rather than temporarily to isolate a hospital discharge in a single room with care support, (c) (on their factual case) deciding that there was insufficient risk of transmission from asymptomatic persons in case homes whilst adopting other measures – shielding, household isolation, school closures, national lockdown – which were premised on the opposite view, and (d) prioritising available testing capacity for school children, whilst not prioritising hospital discharges into the uniquely vulnerable care home population.
>
> (5) Breach of the duty of transparency, by misleading the public in stating that "from the start we've tried to throw a protective ring around our care homes" and "we brought in the lockdown in care homes ahead of the general lockdown".

The Claimants' submissions

151. The Claimants submitted that the Defendants had a positive obligation to take appropriate steps to safeguard the lives of those within England and do all that could have been required to prevent life from being avoidably put at risk. Although the ECHR case was founded on Article 2 and Article 8, the greater part of the submissions by far were based on Article 2. The reason for inclusion of Article 8 was to meet some of the Defendants' threshold objections to the applicability of the Article 2 operational duty. No such threshold objections arose under Article 8.

152. The Claimants submitted that both the 'systems duty' and 'operational duty' applied and were breached by the Defendants during the first wave of the pandemic. The systems duty required the Defendants to put in place a legislative and administrative framework designed to protect against risks to life, whilst the operational duty required the State to take practical steps to safeguard people's right to life from specific dangers in circumstances where there was a link to the State's responsibility. The Defendants were also subject to a "negative" or "*Munjaz"* duty not to act in a manner or implement policies which would expose those within the jurisdiction to a significant risk of a breach of their Article 2 rights (*R (Munjaz) v Ashworth Hospital* [2006] 2 AC 148).

Systems duty

153. On the systems duty, Mr Coppel first took the court to *Kolyadenko v Russia* [2013] 56 EHRR 2, a case about flooding from a reservoir. The court found at [157]-[158] that the primary duty under the positive obligation was to have a legislative and administrative framework in place to provide effective deterrence against threats to the right to life which must include practical measures to ensure the effective protection of citizens whose lives might be endangered. Mr Coppel accepted that the present claim was not an industrial activities or man-made hazards case but submitted that the duty applied in the context of any activity, whether public or private, in which the right to life might be at stake. In this case, the activity in question was the operation and regulation by the State of care homes caring for vulnerable people. The virus, in the context of the vulnerable care home population, created a risk of a magnitude which the State, in its various regulations and interventions, was obliged to act against and from which care home residents should have been protected.

154. Mr Coppel then relied on *Budayeva v Russia* (2014) 59 EHRR 2 as an example of a case that concerned naturally occurring phenomena in which the Article 2 duty was engaged and breached. In *Budayeva* the court looked at the particular practical measures and steps which the State had taken to protect against mudslides, which were said to create a foreseeable, mortal risk to the residents of the affected villages. Despite the broad margin of appreciation, the court held that sufficient steps had not been taken. Mr Coppel submitted that *Kolyadenko* and *Budayeva* demonstrated that Article 2 did require the Government to protect the population from a serious threat to life from the pandemic and *a fortiori* to protect the uniquely vulnerable care home population, whose treatment was heavily regulated by the State.

155. Mr Coppel also submitted that the present case was not simply a positive obligations case like *Budayeva* or *Kolyadenko* in that it was not simply about taking positive steps to protect the population against a naturally occurring phenomenon. Rather, this was also a case where the Defendants had actually taken particular action which increased the risk to life and put care home residents in harm's way: for example, the Discharge Policy and the April Admissions Guidance seeking to give reassurance to care homes to admit new residents, and the unsafe guidance which encouraged the sharing of staff. These were steps which positively increased the risk to life.

Operational duty

156. On the operational duty, Mr Coppel took the court to *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2. *Rabone* concerned a voluntary psychiatric patient

who committed suicide after having been allowed to leave hospital when she was at real and immediate risk of death by suicide. The claim was against the NHS trust which it was said had been responsible, in part under Article 2. Lord Dyson at [12], set out the distinction between the systems and operational duty. Then from [21] onwards, Lord Dyson attempted to discover the essential features of cases where the ECtHR had recognised the existence of an operational duty.

157. On whether a risk is real and immediate, Mr Coppel relied on *Rabone* at [35]-[38] which considered an escalating 5%-20% risk of suicide to be a sufficiently real risk. On immediacy of the risk, Mr Coppel relied on the *phrase "present and continuing"* in *Rabone* at [39] to capture the essence of the immediacy necessary for the operational duty to apply.

158. On the standard of scrutiny/margin of appreciation, the NHS Trust relied on a broad margin of discretion, but this was rejected by Lord Dyson at [43]. Mr Coppel submitted that for the operational duty, reasonableness was the standard and there was not a wide margin. He argued that the Article 2 operational duty was owed to all residents of care homes because they were vulnerable to the pandemic and the standard applied to every decision would be reasonableness, as it would be in a negligence action. He accepted that consideration of disproportionate burden was important when it came to establishing whether the operational duty applied. But once the duty was held to apply, the standard would be one of reasonableness.

159. On the question of whether the duty could only be owed to an identified individual, Mr Coppel submitted that that was at most a factor to be considered but not a necessary condition for the existence of the duty. Other cases demonstrated that the duty was not limited to identified individuals. For example, in *Oneryildiz v Turkey* (2005) 41 EHRR 20 the duty was held to apply to the inhabitants of a slum area around a municipal rubbish tip.

160. Mr Coppel was asked whether it was possible in theory to extend that duty to the entire population. Mr Coppel differentiated the residents of care homes from the rest of the population by the fact that care homes were residences, the individuals in question in practice could not leave and were compulsorily detained there during the lockdown, they were highly vulnerable to the virus with a 30% mortality rate, and were subjected to a high level of regulatory control by the State which had actively put them in harm's way.

161. On Article 8, Mr Coppel relied on *Stoicescu v Romania* (26 July 2011, unreported) which concerned a woman who had been attacked by stray dogs in Bucharest and suffered debilitating health conditions. The claim succeeded even when the Romanian government had no reason to think that this particular individual was at greater risk of being attacked by dogs than anybody else who lived in Bucharest. The authorities had broad and detailed information on the threat posed by stray dogs in Bucharest but did nothing to combat it. Mr Coppel further submitted that *Stoicescu* was important because it added a broader approach to the engagement of the duty, demonstrating a positive obligation being owed to the entirety of the population of Bucharest to protect them from the known risk of stray dogs.

162. Mr Coppel advanced three reasons to support the relevance of Article 8 to the present case.

i) First, Article 8 was useful to meet the Defendants' threshold objections to the applicability of Article 2.

ii) Second, Article 8 protected the Convention right to respect for the home and this case concerned many people who became sick and died in their own homes.

iii) Thirdly, Article 8 was the *lex specialis* which the ECtHR had recourse to when there were concerns about the provision of information to the public regarding a threat to life. Mr Coppel relied on *Vilnes v Norway* (5 December 2013, unreported).

163. Finally, Mr Coppel relied on *Munjaz* at [28]-[29] to establish the Defendants' obligations not to adopt policies which exposed patients to a significant risk of treatment prohibited by Article 3, and by extension, Article 2.

164. Mr Coppel distinguished decisions such as *R (Maguire) v HM Senior Coroner for Blackpool* [2021] QB 409 which were, in essence, about alleged medical negligence in care settings. This case was concerned with the Secretary of State exercising his statutory and regulatory responsibility to protect residents of care homes at large.

Intensity of review/margin

165. Mr Coppel accepted that there was consistent reference in the case law to margin and the need to avoid imposing disproportionate burdens on the State but submitted that there are qualifications to this general starting point.

166. Firstly, whatever the breadth of margin in cases such as *Kolyadenko, Budayeva* and *Stoicescu* the court nevertheless scrutinised the evidence in detail and gave thorough consideration to the adequacy of the practical measures adopted by the State.

167. Secondly, there are differences of approach to margin depending on which aspect of the Convention claim is being considered. For example, when looking at the Article 8 provision of information it is difficult to discern a margin of appreciation being applied, with the court opting for a straightforward application of reasonableness. Furthermore, once the operational duty is held to apply, the standard is one of reasonableness: see, for example, *Watts v United Kingdom* (2010) 51 EHRR SE5.

Public law

168. As a preliminary point, Mr Coppel submitted that the ability to pursue the claims had been hampered by the refusal of the First and Third Defendants to identify the advice and materials which were considered by the relevant decision maker, the Secretary of State, in the case of each policy. He was the decision maker and the public law duties fell on him personally to consider relevant considerations, exclude the irrelevant ones and be sufficiently informed. Usually, the court had a record of what the Secretary of State had been told through ministerial submissions, and that would be a good guide as to what was and wasn't considered. Whilst there were some ministerial submissions among the documents in this case, there was no formal submission in relation to the policies in question. Mr Coppel submitted that the materials before the

court were simply inadequate and put the court in a particularly difficult position in relation to the public law claims.

Relevant considerations

169. Looking at the evidence before the court, Mr Coppel submitted that there were clear instances of obviously relevant considerations not being taken into account. Firstly, there was a failure to assess the risk to the lives of care home residents which would be caused by the Discharge Policy and the April Admissions Guidance and to weigh that risk against the benefits which were perceived for these policies. There was a dispute of fact between the parties on this point. The Defendants asserted there was a careful balancing of risk at all stages whereas the Claimants argued that there was no evidence on the documents of that having happened.

170. Second, there was no consideration given to amending the testing priority policy to include discharges from hospitals or to provide that tests on discharges should be conducted wherever capacity allowed.

171. Third, there was a failure to consider the likelihood of the risk of transmission from the asymptomatic until some point in mid-April 2020. The precautionary principle was an obviously relevant consideration on this point.

Sufficient inquiry

172. Mr Coppel submitted there had been a breach of the *Tameside* duty to conduct sufficient inquiry. In relation to care homes the Defendants failed to consult the expert committees (SAGE, NERVTAG and SPI-M) who had been convened to provide advice on pandemic-related scientific matters.

Irrelevant considerations

173. Mr Coppel submitted that the Defendants had taken into account irrelevant consideration during negotiations on the April Admissions Guidance. It was an illegal and irrelevant objective to seek to persuade care homes to override their legitimate concerns for the safety of their residents.

Rationality

174. Mr Coppel submitted that the failure to take protective steps in the March Discharge Policy was irrational. Mr Coppel did not accept that the Defendants ever weighed up the benefits and drawbacks of advising isolation to all new entrants. But even if they did, to advise against isolation and (as he put it) to "prefer" introducing COVID into care homes was irrational and contrary to every other public policy at the time.

175. Mr Coppel submitted that the April Admissions Guidance was similarly irrational. If the Defendants' purpose was to educate care homes on the reasoning and evidence behind the Government's policies, how could they then produce a document which said nothing about the evidence which the Defendants actually had about the risk from asymptomatic individuals? This was truly irrational in the public law sense.

176. Mr Coppel also submitted it was irrational to rely on Professor Ferguson's modelling paper (which was premised on asymptomatic transmission and infection) to introduce

household isolation, school closures and the national lockdown but at the same time proceed on a symptoms based approach for care homes.

Public sector equality duty (PSED)

177. Mr Coppel submitted that this was an ideal context for scrutiny of decision-making for compliance with the PSED. The PSED was a procedural obligation, qualitatively different from and more onerous than the Defendants' public law obligations. It created a mandatory relevant consideration and imposed strict obligations on a decision maker to at least have regard to those matters. If the Defendants said that they recognised the risk to care home residents but had to balance it against more pressing matters, the decision maker had to have regard to the potential implications for the protected group of the decisions being proposed. Care home residents were a paradigmatically protected group comprised of the elderly and the disabled.

178. Mr Coppel emphasized that the explanation of the PSED in cases such as *R (Bracking) v SSWP* [2014] Eq LR 60 constructed a more rigorous duty than, for example, the duty to take relevant considerations into account because it had to be exercised with an open mind, was non delegable, and required a proper application of the potential impact of the principle on equality objectives. The PSED did not simply require the Defendants to bear in mind that the elderly were more vulnerable to COVID but a more comprehensive consideration of the risks or potential risks to this protected group.

179. Mr Coppel took the court to the *Runnymede* case (*R (Good Law Project and Runnymede Trust) v Prime Minister and Secretary of State for Health and Social Care* [2022] EWHC 298 (Admin)), a challenge to the making of urgent and important appointments to key posts in the pandemic including the Director of Testing for NHS Test and Trace and the interim chair of the National Institute for Health Protection. Mr Coppel submitted that *Runnymede* was important as it concerned the same Defendant making similar arguments about the urgency of the pandemic and its impact on decision making. The Divisional Court (Singh LJ and Swift J) held that the PSED required some evidence of what precisely the decision maker did to discharge the obligation when deciding the method by which each relevant appointment was to be made. In finding a breach, the court held at [116] that it had seen no evidence from anyone saying exactly what was done to comply with the PSED when decisions were taken on how each appointment was to be made. Mr Coppel submitted that this demonstrated that even in the pandemic context, the court had to carefully consider the evidence and see an explanation of what exactly was done to comply with the duty. The Defendants' assertion that the *raison d'etre* of their policies was protection of the elderly and vulnerable was simply not good enough to show compliance with the PSED.

180. Mr Coppel took issue with the Defendants' submission that the PSED had been discharged simply because they knew their decisions affected the elderly and disabled, which did not require them to produce a separate document stating they had regard to the fact. This posed a real danger of diluting the substantive effect of the PSED. Mr Coppel took the court to *Bracking* at [26], which held that "*A minister must assess the risk and extent of any adverse impact and the ways in which such risk may be eliminated before the adoption of a proposed policy and not merely as a rearguard*

action." Mr Coppel submitted that it was not enough to simply assert that the impact on the affected group was at the heart of the decision making.

Causation

181. On causation, Mr Coppel submitted (and it was accepted by all parties) that he did not need to show on the balance of probabilities that either the Claimants' fathers or anyone else died because of anything the Defendants did. Rather, for the purposes of the ECHR claim, he had to show that care home residents were put at greater risk of harm as a result of the actions and inactions complained about. To question whether the high death toll in care homes was technically caused by the Defendants' policies was not the correct question: the correct question was an increased risk to life. However, in any event the most recent and authoritative study showed that the discharge of hospital patients into care homes did put residents of those homes at significantly greater risk.

Approach to evidence

182. On the correct approach to evidence and fact finding, Mr Coppel took the court to *R (National Association of Health Stores) v Department of Health* [2005] EWCA Civ 154. The case concerned a challenge to the minister's adoption of regulations banning a herbal remedy called kava-kava where there was an issue about whether the minister had been told about an important scientific study. An issue arose as to whether the minister himself was made aware of the study or whether it was sufficient that his advisers were aware of the study. Keene LJ held that it was the knowledge of the minister that was important, and that the court would consider whether the decision maker had taken into account relevant considerations or failed to take into account relevant ones.

183. Mr Barrett, supporting Mr Coppel's arguments, then submitted that the First and Third Defendants had chosen to file witness statements that were systematically non-compliant with CPR Practice Direction 32. Those statements did not identify the source or basis of the evidence they purported to give, such that no probative weight could be afforded to that evidence in relation to the matters of fact they established.

184. Mr Barrett referred to *Attorney General v BBC* [2022] EWHC 380 (QB), an application for an injunction to restrain the BBC from broadcasting a programme about covert human intelligence sources. One factual issue in the application was whether briefings that had been given by the Government to the newspapers had been given with or without authority from the relevant department. The Defendants filed a witness statement of a departmental lawyer stating what her instructions were about the issue of authorisation but failing to identify the source of her information. Chamberlain J held that the witness statement was inadequate to negative the inference that the briefings had been given by a Government source.

185. Mr Barrett submitted that a corporate entity can only operate through real people and where a source is not identified the court must consider whether to place any weight on the evidence, especially when it touched on a central issue. He submitted that these principles applied *a fortiori* to a government defendant in the context of a judicial review challenge to a ministerial decision of matters of significant public importance. Whilst Mr Barrett accepted that in judicial review proceedings the general approach to

conflicts of evidence was to accept the evidence of the defendant, he argued that this rule was based on the court being able to fairly and safely assess the sources of evidence being advanced. Typically, this was done either by direct evidence from a senior civil servant who was present and closely involved in the ministerial decision and advice given to the minister, or by second hand evidence which must be compliant with PD32 and identify its sources of information. In these proceedings a key factual dispute for each of the impugned decisions was what documents and advice Mr Hancock was given or not given, and what were Mr Hancock's reasons for his final decisions.

Submissions for the Secretary of State and Public Health England

ECHR Art 2

186. Sir James Eadie QC began his legal submissions with *Rabone,* which created the distinction between the systemic duty and operational duty arising under Article 2. Sir James submitted that the distinction arose in particular out of the healthcare line of cases as the ECtHR had been nervous about importing negligence from the healthcare context into Article 2. As a result, a distinction arose between the need to have a broad structural framework of laws in place to hold healthcare professionals to appropriate standards, as opposed to the *Osman* type duty.

187. The question in relation to the operational duty here was: when, by reference to what principles, did the operational duty arise in a context such as ours? The general principles came from *Osman* at [115]-[116]. The duty only arose in *"certain and well defined circumstances where, exceptionally, the State is required to take positive steps to protect life."* The duty must not be interpreted in a way that imposed an impossible or disproportionate burden on the authorities.

188. Sir James reminded the Court that the trigger for the application of an operational duty derived from *Osman* at [116] and was summarised by Lord Dyson in *Rabone* at [12]. The three criteria were: a real and immediate risk to life; actual or constructive knowledge of the State of that risk; and a sufficient connection or link to the responsibility of the State. Sir James submitted that there were two elements in relation to the real and immediate risk to life. One was the nature of the risk, and the second was the category of persons to whom the duty is capable of being owed.

189. As to the nature of the risk, not every alleged risk required a State to take operational measures to prevent the risk materialising. The risk had to be substantial or significant (*Rabone* at [38]). As to the category of people – the courts have always been assiduous to ensure the need to identify with some precision the persons to whom the duty is owed because this is one of the ways in which practical effect is given to the injunction in *Osman* at [116] that a disproportionate burden cannot be imposed on the State.

190. Sir James then took the court to *Maguire,* which concerned the death of a young woman with Down's Syndrome and learning disabilities who had been living in a care home pursuant to a standard authorisation granted under the Mental Capacity Act 2005. The Court of Appeal held that the State's obligations under Article 2 were not triggered by the mere fact of her vulnerability and deprivation of liberty.

191. Sir James submitted that the basic analytical taxonomy of the Court of Appeal's judgment in *Maguire* was to break down the Strasbourg case law into three broad categories of cases in the context of health and social care. In cases involving alleged medical negligence and bad management of the patient's care in the care home, the State's obligations were primarily regulatory in nature, i.e. a duty to take necessary measures to ensure implementation, including supervision and enforcement. Sir James submitted this was not an obligation of result, but an obligation of means, in other words an obligation to have in place a structure capable of holding professionals to account. In the context of medical negligence, State responsibility arises only in very exceptional circumstances such as when the individual patient's life has knowingly been put at risk by denial of emergency treatment (*Maguire* at [22]-[25]).

192. In self-harm cases (*Maguire* at [30]-[32], considering *Fernandez de Oliveira*), the question for the existence of an operational duty in suicide/self-harm cases was whether the authorities knew or ought to have known that the person posed a real and immediate risk of suicide.

193. The third category concerns vulnerable people under the direct care of the State where the State ends up putting their lives at risk. The court in *Maguire* at [97] analysed this category of cases and concluded that they did not support a conclusion that for all purposes an operational duty is owed to those in a vulnerable position in care homes. For an example of when such a duty would arise, Sir James referred the court to the discussion of *Dumpe v Latvia* in *Maguire* at [36] and [72]. Sir James submitted that the only thing which drew a care home case into Article 2 territory was when the State had knowledge of appalling conditions in State care but failed to do anything about it, which could be likened to a recklessness test. Sir James submitted that these cases demonstrated an attempt to work through the rigorous principles that applied in the context of health and social care in Article 2. It was only in exceptional situations that the operational duty was held to arise, subject to strict conditions.

194. Sir James then submitted that the present case was not within any of the established categories where the operational duty was held to arise in a health and social care context. It was not a medical treatment case, nor a denial of life saving treatment case, nor an institutional case where the State was responsible for giving rise to the conditions creating the risk to life. Most care home residents were not under the control of the State at all.

195. Sir James submitted there was no relevant State responsibility triggering the operational duty in this case. The mere fact that the Government had put in place COVID policies to assist in the treatment and care of those in care homes at the time did not supply the necessary element of State responsibility. Furthermore, the mere fact that a sector was regulated in a legal sense did not mean that the individuals who resided in a regulated institution were controlled by the State.

196. Even if, for the sake of argument, this case was to be analysed as a medical negligence case, the challenge still failed. It would be incoherent to subject the State to stricter controls when it was managing a virus that threatened the entire population than when it was managing individual medical negligence cases.

197. Sir James considered that the operational duty in Article 2 was not established by a general analysis, but by specific contexts which established State responsibility. It

was inappropriate to simply point to *Oneryildiz, Kolyadenko, Stoicescu* etc. when those cases had their own specific features. The closest cases to the present context were *Maguire* and *R (Morahan) v West London Assistant Coroner* [2021] QB 1205.

198. Sir James cast some doubt on the utility of *Watts,* given that it failed on the facts at the admissibility stage and predated the key authorities on Article 2 such as *Rabone* and *Maguire.* There was no consideration or application of principle as to the nature and scope of the duty in *Watts* and why the operational duty might be applicable. *Watts* also could not be authority for the proposition that the court did not consider a margin of appreciation was necessary as it was an admissibility decision: so the court did not consider margin at all.

199. Sir James did not accept that *Munjaz* was of any relevance to this case. Sir James submitted that the *Munjaz* principle in essence was about not promulgating policies which created an unacceptable risk of a breach of Article 2 or Article 3. It was not about the State attempting to do the best it could in responding to an Article 2 crisis.

200. Sir James also did not accept that repackaging the Article 2 claim as Article 8 was of any assistance to the Claimants. There was no basis on which the Claimants could succeed under Article 8 if they failed under Article 2. It would be illogical to impose precisely the same protective obligations where the only right that was involved was the lesser species of right under Article 8.

201. Sir James suggested that there was a great deal of overlap between the systemic and operational duties and that they were governed by similar principles. Sir James emphasised that the *Osman* thresholds and safeguards could not be watered down simply by reference to the systemic duty rather than the operational duty. The nature of both duties was similar and should demonstrate a coherency of principle and approach at the entry points; failure to establish the application of an operational duty could not be remedied by introducing a systemic duty through the back door.

Breach of Article 2 duty

202. Sir James submitted that the standard for breach of duty was one of reasonableness as per *Osman* at [116] and *Rabone* at [12] and that the court must be rigorous to exclude hindsight in carrying out the analysis of reasonableness.

203. Sir James made four basic points on reasonableness:

i) First, the court had to be astute not to impose disproportionate burdens on the State;

ii) Second, the test of reasonableness permitted the government a range of reasonable responses as the operational duty, once triggered, would always involve alternative reactive methods and judgements that fed into the protective steps taken. In principle, the authorities had a choice as to what practical steps to take to address the risk (*Budayeva* at [134]);

iii) Third, the court had to take into account a range of factors, including the ease or difficulty of taking precautions and the resources available (*Rabone, Budayeva* [134]-[137]);

iv) Fourth, there were judgements involved in the early days of the pandemic that could not produce any right or wrong answers. The more difficult the decision-making in a rapidly changing situation with a novel threat, with ambiguities in the science, and highly complex issues involving different balancing exercises, the wider the range of reasonable responses. Sir James considered this point to be of critical significance. It was not a semantic debate about margin or reasonableness but about the basic constitutional responsibilities between court and State.

Margin

204. Sir James submitted that all the Strasbourg cases emphasised the margin of appreciation; and particularly in the context of the pandemic, the domestic courts had given the Government a wide margin: he referred to *Dolan* and to *Richards v Environment Agency* [2022] EWCA Civ 26 at [66], [72].

205. Margin is in essence a reflection of the breadth of the range of reasonable decision-making open to the Government in context which has certain features, which were present in this case:

i) First, the situation was one of exceptional crisis, there was an extraordinarily serious threat to public health affecting the entirety of the population which developed at considerable speed. Matters were in a state of flux in the first wave in terms of understanding how the disease operated. The developing policy responses had to take all of this into account whilst being bound by severe practical constraints;

ii) Second, the situation required expert evaluation of science which was complex, uncertain and rapidly evolving;

iii) Third, almost every decision involved the weighing of different rights and interests across the range of those potentially affected, such as those in need of emergency treatment in hospital against those well enough to be released back into the community or care homes;

iv) Fourth, these judgements were rendered all the more difficult in light of the practical and logistical difficulties;

v) Fifth, there were no right or wrong answers, every single decision involved multifaceted judgements.

206. Sir James disagreed with Mr Coppel's reliance on *Munjaz* to demonstrate that the court did not look at margin but simply reasonableness. Lord Dyson in *Rabone* acknowledged that the general approach was to consider reasonableness and all the circumstances of the case, but it was common ground that the decision under scrutiny in *Rabone* was one that no reasonable practitioner could have made. On those facts it was unsurprising that Lord Dyson rejected the proposition on margin that was being advanced on behalf of the doctor. But he certainly was not suggesting that once a case was in *Munjaz* territory there would be no margin at all.

207. Sir James also did not accept that there was a different approach to margin between Article 2 and Article 8. It would be incoherent if such significant distinctions of principle were applied to the same legal complaints, based on the same facts depending on how it was packaged. If margin applied, it applied because of the nature of the judgements and the decision making that were in view.

Public law

208. As an overarching point, Sir James submitted that the public law claims were largely parasitic on the ECHR claims. If the Claimants failed on Article 2, it would be difficult for public law (as he put it) to 'come galloping to the rescue' on the same facts.

Rationality

209. On rationality, Sir James took the court to *R (Law Society) v Lord Chancellor* [2019] 1 WLR 1649 at [41]: *"If the alleged technical error is not incontrovertible but is a matter on which there is room for reasonable divergence of expert opinion, an irrationality argument will not succeed."*

210. Sir James submitted that the Defendants put in place a very wide range of additional steps, kept them constantly under review and revised them when experts considered it necessary, all for the purpose of seeking to ensure that vulnerable care home residents were kept as safe as possible. Further, the Defendants weighed the advice at the time in relation to non-symptomatic individuals against the need to free up hospital beds against severe practical constraints. It was also not irrational for the Defendants to adopt school closures and the national lockdown as those were different situations based on different balancing exercises in order to control transmission across society. Testing was extremely scarce and the Defendants followed scientific advice as to the best way to prioritise the available capacity.

Relevant considerations

211. On the issue of evidence, Sir James submitted that the Government was entitled to rely on documents that were considered and relied upon by officials when providing advice to decision makers and this was in no way prohibited by *National Association of Health Stores.* Further, there had been a clear explanation as to why in the context of such urgent decision making there was a paucity of the sort of documents that would ordinarily be available.

212. Sir James submitted that it could not be sensibly suggested that the Defendants did not take into account the risk to the lives of care home residents in the March Discharge Policy or April Admissions Guidance. That risk was absolutely at the heart of everything the Government did in this area. On considering options for prioritising testing, the Government received clear scientific advice and followed it. On considering the risk of transmission from people without symptoms, and the suitability of care homes for infection control, Sir James submitted that had been thoroughly covered in the evidence. Sir James did not consider anything was achieved by repackaging the ECHR claims in public law terms.

The PSED

213. Sir James submitted that the approach to considering the PSED, having regard to the nature of the function and the context and avoiding formalism, was well established in the case law. The fact of the pandemic was the key context here. Sir James considered that the very nature of the exercise in this case had directed the mind of the decision maker to the protected groups. In that situation it was entirely artificial and unnecessary for the decision maker to produce a separate document or have separate regard to the PSED.

214. Sir James distinguished the present case from *Runnymede*. Even though *Runnymede* was a pandemic case, it was in the context of appointment policies and those policies did not involve what the present context and decision making involved. Every relevant decision in this case was being directly focussed on the vulnerable group, the elderly and infirm. The decision makers knew the residents of care homes were elderly and infirm, so they did not need to produce a separate document stating they had had regard to that fact.

Approach to evidence

215. Sir James submitted that extensive evidence had been filed by the Government in defending this claim in compliance with its duty of candour. The Defendants had done their best to explain to the court how and why an absolute panoply of decisions were taken as they were.

216. Sir James doubted the relevance of *Attorney General v BBC* to the facts of the present case. The present case concerned a proper attempt by Government to pull together into an intelligible corporate statement its evidence on an extraordinarily complex range of issues. The GLD lawyer in *AG v BBC* had made a statement saying that the disclosures to the *Telegraph* had been made without authority. It was in that context that Chamberlain J wanted to know who the GLD lawyer had asked, as there had to be someone who had such authority in each department. Sir James submitted that this was a million miles away from a general proposition that in judicial review there was a need to identify, in relation to every sentence or every proposition in a corporate witness statement, who specifically the source of information might be.

Submissions for the Second Defendant (NHS England)

217. Eleanor Grey QC for the Second Defendant generally relied on Sir James's submissions on the law except on points which specifically concerned the Second Defendant.

ECHR

218. NHS England is a statutory corporation with its own legal personality. Therefore, in contrast to the First and Third Defendants where the Secretary of State was the decision-maker, the body responsible for NHS policy-making is not the CEO (at that time Sir Simon Stevens) but the NHS Board.

219. Ms Grey submitted that if no Article 2 duty was owed by the Secretary of State and Public Health England for all the reasons developed by Sir James, then no such duty would be owed by the NHS. Furthermore, Ms Grey relied on the absence of functions or powers that the NHS exercised over private care homes. It would be illogical to

hold that NHS England could be under a systemic duty to establish a framework for care homes when they had no regulatory role in relation to them. This in turn was relevant to the operational duty, which relies on the assumption of State responsibility, and proximity between the State authority and potential victims.

220. Alternatively, Ms Grey submitted that if a duty was owed then it had been discharged by NHS England working in conjunction with the Secretary of State, PHE and stakeholders.

221. Ms Grey further submitted that the *Munjaz* duty was triggered in the context of a policy that led to exposure to acts comprising either inhuman or degrading treatment or a risk to life. Therefore, the negative duty in *Munjaz* was entirely remote from facts dealing with the extent of the positive duty to take measures to protect life from a natural hazard. Ms Grey submitted that it was not possible to sidestep the strict controls on the application of Article 2 by developing a case under the negative duty under *Munjaz*. The present case was about the positive duty to protect people from a natural hazard, and it would be artificial and wrong to characterise such actions as negative ones.

222. Ms Grey submitted that Article 8 added nothing to the claim.

Public law

Relevant considerations

223. Ms Grey submitted that the allegation of a failure to assess the risk to the lives of care home residents caused by the NHS discharge and admissions guidance was simply wrong on the facts. That assessment was at the heart of the decision making. In any event, Ms Grey submitted that NHS England was entitled to rely upon the assessment and the advice from Public Health England and expert scientific groups on the spread of COVID-19 and Infection Prevention and Control (IPC) measures (*Richards v Environment Agency*). These measures were constantly being kept under review and NHS England could not have been expected to sidestep the expert advice from these sources.

<u>*Discussion*</u>

Article 2

224. A convenient introduction to this topic is the judgment of Lord Dyson JSC in *Rabone v Pennine Care NHS Trust* [2012] UKSC 2; [2012] 2 AC 72 in which he said at paragraph [12]:

> “Before I come to the issues that arise on this appeal, I need to set the scene by making a few introductory comments about article 2 of the Convention which provides: "Everyone's right to life shall be protected by law". These few words have been interpreted by the European Court of Human Rights ("the ECtHR") as imposing three distinct duties on the State: (i) a negative duty to refrain from taking life save in the exceptional circumstances described in article 2(2); (ii) a positive duty to

> conduct a proper and open investigation into deaths for which the State might be responsible; and (iii) a positive duty to protect life in certain circumstances. This latter positive duty contains two distinct elements. The first is a general duty on the State "to put in place a legislative and administrative framework designed to provide effective deterrence against threats to the right to life": see *Oneryildiz v Turkey* (2005) 41 EHRR 20 (para 89) applying, *mutatis mutandis*, what the court said in *Osman v United Kingdom* (2000) 29 EHRR 245 (para 115). The second is what has been called the "operational duty" which was also articulated by the court in the *Osman* case."

225. We are not concerned in the present case with the negative duty to refrain from taking life, nor with the duty of proper investigation, but with the two aspects of the positive duty to protect life in certain circumstances, the first of which is generally known as the systemic or systems duty.

The systems duty

226. The systems duty requires the State to have a regulatory framework in place designed to provide effective measures to protect life. It was correctly described by Sir James as a *"high level structural duty"* rather than an obligation of result. In *Fernandes de Oliveira v Portugal,* 31 January 2019, the Grand Chamber of the ECtHR said at [105] that in the particular context of healthcare it requires the State to "*make regulations compelling hospitals, whether private or public, to adopt appropriate measures for the protection of patients' lives."* The Court continued at [107]:

> "The question whether there has been a failure by the State to comply with its above-mentioned regulatory duties calls for a concrete rather than an abstract assessment of any alleged deficiency. The Court's task is not normally to review the relevant law and practice *in abstracto*, but to determine whether the manner in which they were applied to, or affected, the applicant or the deceased gave rise to a violation of the Convention (see *Lopes de Sousa Fernandes*, cited above, § 188). Therefore, the mere fact that the regulatory framework may be deficient in some respects is not sufficient in itself to raise an issue under Article 2 of the Convention. It must be shown to have operated to the patient's detriment."

227. Although Mr Coppel is right to say that there is some overlap between the systems and operational duties, we consider that there is no arguable case that the systems duty has been breached. There is nothing wrong with the framework for the issuing of guidance or policy documents by the Defendants (nor with the allocation of responsibilities between them). The complaint in this case is of the documents' contents. It was rightly not argued that the absence during the relevant period of a statutory power of any of the Defendants to compel private sector care homes to take particular steps in relation to the admission or treatment of residents represented a breach of the systems duty.

The operational duty

228. In the Detailed Grounds of Defence of the First and Third Defendants Sir James and his juniors record at paragraph 47 that:-

> "it is common ground that three key factors must be present in order for the Article 2 operational duty to apply:
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> (1) a real and immediate risk to life;
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> (2) actual or constructive knowledge of the State of the risk;
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> (3) a sufficient connection or link with the responsibility of the State ("the *Rabone* criteria")."

229. Mr Coppel argues that these three factors are sufficient in order for the operational duty to be engaged. If the third factor is interpreted in such a way as to hold that protective measures relating to private sector care homes involve a sufficient connection or link with the responsibility of the State, that would mean that the scope of the Article 2 operational duty has developed from being concerned with a risk to the life of an identified individual or group of individuals to one owed, presumably by the authorities of each Member State of the Council of Europe, to very large numbers of elderly people. It is necessary to examine some of the leading cases to see whether Article 2 has so far been held to be of such width.

230. We begin with *Osman v UK* (2000) 29 EHRR 245. This was a case about the alleged failure of the police to protect the Osman family who had been subjected to threats and harassment from a third party, culminating in the murder of Mr Osman and the wounding of his son. The Grand Chamber said at [115]-[116]:

> "115. The Court notes that the first sentence of Article 2 § 1 enjoins the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction (see the *L.C.B. v. United Kingdom* judgment of 9 June 1998, *Reports of Judgments and Decisions* 1998-III, p. 1403, § 36). It is common ground that the State's obligation in this respect extends beyond its primary duty to secure the right to life by putting in place effective criminal-law provisions to deter the commission of offences against the person backed up by law-enforcement machinery for the prevention, suppression and sanctioning of breaches of such provisions. It is thus accepted by those appearing before the Court that Article 2 of the Convention may also imply *in certain well-defined circumstances* a positive obligation on the authorities to take preventive operational measures to protect an individual whose life is at risk from the criminal acts of another individual. The scope of this obligation is a matter of dispute between the parties.
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> 116. For the Court, and bearing in mind the difficulties involved in policing modern societies, the unpredictability of human conduct and the operational choices which must be

made in terms of priorities and resources, such an obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities. Accordingly, not every claimed risk to life can entail for the authorities a Convention requirement to take operational measures to prevent that risk from materialising. Another relevant consideration is the need to ensure that the police exercise their powers to control and prevent crime in a manner which fully respects the due process and other guarantees which legitimately place restraints on the scope of their action to investigate crime and bring offenders to justice, including the guarantees contained in Articles 5 and 8 of the Convention.

In the opinion of the Court where there is an allegation that the authorities have violated their positive obligation to protect the right to life in the context of their above-mentioned duty to prevent and suppress offences against the person (see paragraph 115 above), it must be established to its satisfaction that the authorities knew or ought to have known at the time of the existence of *a real and immediate risk to the life of an identified individual or individuals* from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk. The Court does not accept the Government's view that the failure to perceive the risk to life in the circumstances known at the time or to take preventive measures to avoid that risk must be tantamount to gross negligence or wilful disregard of the duty to protect life (see paragraph 107 above). Such a rigid standard must be considered to be incompatible with the requirements of Article 1 of the Convention and the obligations of Contracting States under that Article to secure the practical and effective protection of the rights and freedoms laid down therein, including Article 2 (see, *mutatis mutandis*, the above-mentioned *McCann and Others* judgment, p. 45, § 146). For the Court, and having regard to the nature of the right protected by Article 2, a right fundamental in the scheme of the Convention, it is sufficient for an applicant to show that the authorities did not do all that could be reasonably expected of them to avoid a real and immediate risk to life of which they have or ought to have knowledge. This is a question which can only be answered in the light of all the circumstances of any particular case."

231. If the court in *Osman* was right to say in 1998 that the Article 2 operational duty arises only in *"certain well-defined circumstances"* it cannot be said that those circumstances remain well-defined nearly a quarter of a century later. The court's tendency, as Baroness Hale of Richmond JSC observed in *Rabone* at [96], is to state the principle in very broad terms, without defining precisely the circumstances in which it will apply.

232. As Lord Dyson noted in *Sarjantson v Chief Constable of Humberside Police* [2013] EWCA Civ 1252; [2014] QB 411 at [22], the post-*Osman* jurisprudence shows that the Strasbourg court *"has not limited the scope of the Article 2 duty to circumstances where there is or ought to be known a real and imminent risk to the lives of identified or identifiable individuals."* In *Sarjantson* the Court of Appeal held that where the police are informed about an incident of violent disorder, the *Osman* duty may arise regardless of whether they know or ought to know the names or identities of actual or potential victims of the criminal activity; it is sufficient that they know or ought to know that there are such victims.

233. At paragraphs [15]-[16] of *Rabone* Lord Dyson set out some of the circumstances in which the operational duty had by that time (February 2012) been held to exist:-

> "15.The court has held that there is a duty on the State to take reasonable steps to protect prisoners from being harmed by others including fellow prisoners (*Edwards v United Kingdom* (2002) 35 EHRR 487) and from suicide (*Keenan v United Kingdom* (2001) 33 EHRR 913). The same duty exists to protect others who are detained by the State, such as immigrants who are kept in administrative detention (*Slimani v France* (2006) 43 EHRR 49) and psychiatric patients who are detained in a public hospital (*Savage v South Essex Partnership NHS Foundation Trust* [2009] AC 681). The operational duty is also owed to military conscripts. Specifically, there is a duty to protect a conscript against the risk of suicide (*Kilinc v Turkey* (Application No 40145/98, BAILII: [2005] ECHR 367)). I have already referred to the circumstances in *Osman* itself, where the deceased and his family were vulnerable to attack by a third party. It would seem that the ECtHR considered that these might in principle have been sufficient to give rise to the operational duty, but the claim failed on the particular facts.
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> 16. More recently, the court has expanded the circumstances in which the duty is owed so as to include what may generally be described as dangers for which in some way the State is responsible. Thus in *Oneryildiz*, the applicant had lived with his family in a slum bordering on a municipal household refuse tip. A methane explosion at the tip resulted in a landslide which engulfed the applicant's house killing his close relatives. The Grand Chamber held at para 101 that the Turkish authorities knew or ought to have known that the tip constituted a real and immediate risk to the lives of persons living close to it. They consequently:
>
> > "had a positive obligation under article 2 of the Convention to take such preventive operational measures as were necessary and sufficient to protect those individuals, especially as they themselves had set up the site and authorised its operation, which gave rise to the risk in question."

234. At [21]-[23] of *Rabone* Lord Dyson, having referred to *Powell v United Kingdom* (2000) 30 EHRR CD 62, said:

> "21. It is, therefore, necessary to attempt to discover the essential features of the cases where Strasbourg has so far recognised the existence of an operational duty. It is clear that the existence of a "real and immediate risk" to life is a necessary but not sufficient condition for the existence of the duty. This is because, as the Court of Appeal said, a patient undergoing major surgery may be facing a real and immediate risk of death and yet *Powell* shows that there is no article 2 operational duty to take reasonable steps to avoid the death of such a patient.
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> 22. No decision of the ECtHR has been cited to us where the court clearly articulates the criteria by which it decides whether an article 2 operational duty exists in any particular circumstances. It is therefore necessary to see whether the cases give some clue as to why the operational duty has been found to exist in some circumstances and not in others. There are certain indicia which point the way. As Miss Richards and Mr Bowen submit, the operational duty will be held to exist where there has been an assumption of responsibility by the State for the individual's welfare and safety (including by the exercise of control). The paradigm example of assumption of responsibility is where the State has detained an individual, whether in prison, in a psychiatric hospital, in an immigration detention centre or otherwise. The operational obligations apply to all detainees, but are particularly stringent in relation to those who are especially vulnerable by reason of their physical or mental condition: see, for example, *Keenan* (prisoner suffering from a mental disorder) and *Tarariyeva v Russia* (2009) 48 EHRR 609 (person detained in a prison hospital suffering from a serious physical illness). The significance of the assumption of responsibility was summarised by Lord Rodger in *Mitchell v Glasgow City Council* [2009] AC 874, para 66:
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> > "The obligation of the United Kingdom under article 2 goes wider, however, In particular, where a State has assumed responsibility for an individual, whether by taking him into custody, by imprisoning him, detaining him under mental health legislation, or conscripting him into the armed forces, the State assumes responsibility for that individual's safety. So in these circumstances police authorities, prison authorities, health authorities and the armed forces are all subject to positive obligations to protect the lives of those in their care.
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> 23. When finding that the article 2 operational duty has been breached, the ECtHR has repeatedly emphasised the vulnerability of the victim as a relevant consideration. In

> circumstances of sufficient vulnerability, the ECtHR has been prepared to find a breach of the operational duty even where there has been no assumption of control by the State, such as where a local authority fails to exercise its powers to protect a child who to its knowledge is at risk of abuse as in *Z v United Kingdom* Application No 29392/95, BAILII: [2001] ECHR 333 (10 May 2001). It is not relevant for the present purposes that this was a complaint of breach of article 3 rather than article 2.
>
> 24. A further factor is the nature of the risk. Is it an "ordinary" risk of the kind that individuals in the relevant category should reasonably be expected to take or is it an exceptional risk? Thus in *Stoyanovi v Bulgaria* (Application No 42980/04, BAILII: [2010] ECHR 1782) 9 November 2010, the ECtHR rejected an application made by the family of a soldier who died during a parachute exercise. At paras 59 to 61, the court drew a distinction between risks which a soldier must expect as an incident of his ordinary military duties and "'dangerous' situations of specific threat to life which arise exceptionally from risks posed by violent, unlawful acts of others or man-made or natural hazards". An operational obligation would only arise in the latter situation.
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> 25. All of these factors may be relevant in determining whether the operational duty exists in any given circumstances. But they do not necessarily provide a sure guide as to whether an operational duty will be found by the ECtHR to exist in circumstances which have not yet been considered by the court. Perhaps that should not be altogether surprising. After all, the common law of negligence develops incrementally and it is not always possible to predict whether the court will hold that a duty of care is owed in a situation which has not been previously considered. Strasbourg proceeds on a case by case basis. The jurisprudence of the operational duty is young. Its boundaries are still being explored by the ECtHR as new circumstances are presented to it for consideration. But it seems to me that the court has been tending to expand the categories of circumstances in which the operational duty will be found to exist."

235. *Oneryildiz* v *Turkey* is one of the examples cited to us by Mr Coppel of environmental cases in which State authorities had failed to take steps to protect people living in the vicinity of a hazard from a real and immediate risk to life posed by the hazard. In *Budayeva v Russia* (2014) 59 EHRR 2 the court found Russia in breach of its operational duty to protect the lives of the residents of the small town of Tyrnauz from mudslides. There was a history of repeated failures to heed warnings of the danger. The court said:-

> "128. The Court reiterates that Article 2 does not solely concern deaths resulting from the use of force by agents of the

State but also, in the first sentence of its first paragraph, lays down a positive obligation on States to take appropriate steps to safeguard the lives of those within their jurisdiction (see, for example, *L.C.B. v. the United Kingdom*, cited above, p. 1403, § 36, and *Paul and Audrey Edwards v. the United Kingdom*, no. 46477/99, § 54, ECHR 2002-II).

129. This positive obligation entails above all a primary duty on the State to put in place a legislative and administrative framework designed to provide effective deterrence against threats to the right to life (see, for example, mutatis mutandis, *Osman v. the United Kingdom*, judgment of 28 October 1998, Reports 1998 VIII, p. 3159, § 115; *Paul and Audrey Edwards*, cited above, § 54; *İlhan v. Turkey* [GC], no. 22277/93, § 91, ECHR 2000-VII; *Kılıç v. Turkey*, no. 22492/93, § 62, ECHR 2000-III; and *Mahmut Kaya v. Turkey*, no. 22535/93, § 85, ECHR 2000-III).

130. This obligation must be construed as applying in the context of any activity, whether public or not, in which the right to life may be at stake (see *Öneryıldız v. Turkey* [GC], no. 48939/99, § 71, ECHR 2004 XII). In particular, it applies to the sphere of industrial risks, or "dangerous activities", such as the operation of waste collection sites in the case of *Öneryıldız* (ibid. §§ 71 and 90).

131. The obligation on the part of the State to safeguard the lives of those within its jurisdiction has been interpreted so as to include both substantive and procedural aspects, notably a positive obligation to take regulatory measures and to adequately inform the public about any life-threatening emergency, and to ensure that any occasion of the deaths caused thereby would be followed by a judicial enquiry (*Öneryıldız*, cited above, §§ 89-118).

132. As regards the substantive aspect, in the particular context of dangerous activities the Court has found that special emphasis must be placed on regulations geared to the special features of the activity in question, particularly with regard to the level of the potential risk to human lives. They must govern the licensing, setting up, operation, security and supervision of the activity and must make it compulsory for all those concerned to take practical measures to ensure the effective protection of citizens whose lives might be endangered by the inherent risks. Among these preventive measures, particular emphasis should be placed on the public's right to information, as established in the case-law of the Convention institutions. The relevant regulations must also provide for appropriate procedures, taking into account the technical aspects of the activity in question, for identifying shortcomings in the processes concerned and any errors committed by those

responsible at different levels (see *Öneryıldız*, cited above, §§ 89-90).

133. It has been recognised that in the context of dangerous activities the scope of the positive obligations under Article 2 of the Convention largely overlap with those under Article 8 (see *Öneryıldız*, cited above, §§ 90 and 160). Consequently, the principles developed in the Court's case-law relating to planning and environmental matters affecting private life and home may also be relied on for the protection of the right to life.

134. As to the choice of particular practical measures, the Court has consistently held that where the State is required to take positive measures, the choice of means is in principle a matter that falls within the Contracting State's margin of appreciation. There are different avenues to ensure Convention rights, and even if the State has failed to apply one particular measure provided by domestic law, it may still fulfil its positive duty by other means (see, among other cases, *Fadeyeva v. Russia*, no. 55723/00, § 96, ECHR 2005 IV).

135. In this respect an impossible or disproportionate burden must not be imposed on the authorities without consideration being given, in particular, to the operational choices which they must make in terms of priorities and resources (see Osman, cited above, pp. 3159-60, § 116); this results from the wide margin of appreciation States enjoy, as the Court has previously held, in difficult social and technical spheres (see *Hatton and Others v. the United Kingdom* [GC], no. 36022/97, §§ 100-01, ECHR 2003-VIII, and *Öneryıldız*, cited above, § 107). This consideration must be afforded even greater weight in the sphere of emergency relief in relation to a meteorological event, which is as such beyond human control, than in the sphere of dangerous activities of a man-made nature.

136. In assessing whether the respondent State had complied with the positive obligation, the Court must consider the particular circumstances of the case, regard being had, among other elements, to the domestic legality of the authorities' acts or omissions (see *López Ostra v. Spain*, judgment of 9 December 1994, Series A no. 303 C, pp. 46-47, §§ 16-22, and *Guerra and Others v. Italy*, judgment of 19 February 1998, Reports 1998 I, p. 219, §§ 25-27), the domestic decision-making process, including the appropriate investigations and studies, and the complexity of the issue, especially where conflicting Convention interests are involved (see *Hatton* and others, cited above, § 128, and *Fadeyeva*, cited above, §§ 96-98).

> 137. In the sphere of emergency relief, where the State is directly involved in the protection of human lives through the mitigation of natural hazards, these considerations should apply in so far as the circumstances of a particular case point to the imminence of a natural hazard that had been clearly identifiable, and especially where it concerned a recurring calamity affecting a distinct area developed for human habitation or use (see, mutatis mutandis, *Murillo Saldias* and others, cited above). The scope of the positive obligations imputable to the State in the particular circumstances would depend on the origin of the threat and the extent to which one or the other risk is susceptible to mitigation."

236. In *Kolyadenko v Russia* [2012] ECHR 355 the applicants' homes had been flooded, and they complained that they had been put at risk of drowning, as a result of the discharge of water from a local reservoir in Vladivostok. The Russian government had attempted to resist admissibility of the claim under Article 2 because each of the applicants had either not been at home at the time of the flood or had been at home but had not been injured by the floods. In rejecting the State's argument, the First Section of the ECtHR said:

> "157. The Court reiterates that the positive obligation to take all appropriate steps to safeguard life for the purposes of Article 2 (see paragraph 151 above) entails above all a primary duty on the State to put in place a legislative and administrative framework designed to provide effective deterrence against threats to the right to life (see *Öneryıldız*, cited above, § 89, and *Budayeva and Others*, cited above, § 129).
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> 158. The Court considers that this obligation must be construed as applying in the context of any activity, whether public or not, in which the right to life may be at stake, and *a fortiori* in the case of industrial activities, which by their very nature are dangerous. In the particular context of dangerous activities special emphasis must be placed on regulations geared to the special features of the activity in question, particularly with regard to the level of the potential risk to human lives. They must govern the licensing, setting up, operation, security and supervision of the activity and must make it compulsory for all those concerned to take practical measures to ensure the effective protection of citizens whose lives might be endangered by the inherent risks (see *Öneryıldız*, cited above, §§ 71 and 90).
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> 159. Among these preventive measures particular emphasis should be placed on the public's right to information, as established in the case-law of the Convention institutions. The relevant regulations must also provide for appropriate procedures, taking into account the technical aspects of the activity in question, for identifying shortcomings in the processes concerned and any errors committed by those

> responsible at different levels (see *Öneryıldız*, cited above, §§ 89- 90, and *Budayeva and Others*, cited above, § 132).
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> 160. As to the choice of particular practical measures, the Court has consistently held that where the State is required to take positive measures, the choice of means is in principle a matter that falls within the Contracting State's margin of appreciation. There are different avenues to ensure Convention rights, and even if the State has failed to apply one particular measure provided by domestic law, it may still fulfil its positive duty by other means. In this respect an impossible or disproportionate burden must not be imposed on the authorities without consideration being given, in particular, to the operational choices which they must make in terms of priorities and resources; this results from the wide margin of appreciation States enjoy, as the Court has previously held, in difficult social and technical spheres (see *Budayeva and Others*, cited above, §§ 134-35).
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> 161. In assessing whether the respondent State complied with its positive obligation, the Court must consider the particular circumstances of the case, regard being had, among other elements, to the domestic legality of the authorities' acts or omissions, the domestic decision-making process, including the appropriate investigations and studies, and the complexity of the issue, especially where conflicting Convention interests are involved. The scope of the positive obligations imputable to the State in the particular circumstances would depend on the origin of the threat and the extent to which one or the other risk is susceptible to mitigation (see *Budayeva and Others*, cited above, §§ 136-37)."

237. Another Strasbourg case on environmental and similar hazards cited to us by Mr Coppel, although it concerned Article 8 rather than Article 2, was *Stoicescu v Romania* (2011), unreported. In that case, heard by the Third Section, the authorities in Bucharest had failed over a protracted period to take any measures to tackle the physical threat to the inhabitants posed by stray dogs. The applicant was attacked, bitten and knocked to the ground by a pack of stray dogs, suffered serious injuries, and after two or three years, had become totally immobile in consequence. The income of her and her husband was wholly insufficient to pay for the medical treatment prescribed. The court upheld the Article 8 claim. It said at paragraph 59:

> "59. It is not the Court's task to substitute itself for the competent domestic authorities in determining the best policy to adopt in dealing with problems of public health and safety such as the issue of stray dogs in Romania. In that connection it accepts that an impossible or disproportionate burden must not be imposed on the authorities without consideration being given in particular to the operational choices which they must make in terms of priorities and resources (see *Osman* cited above, § 116, and *Hajduová v. Slovakia*, no. 2660/03, § 47, 30

> November 2010); this results from the wide margin of appreciation States enjoy, as the Court has previously held, in difficult spheres such as the one in issue in the instant case (see, mutatis mutandis, *Hatton and Others v. the United Kingdom* [GC], no. 36022/97, §§ 100-101, ECHR 2003-VIII, and *Oneryildiz* cited above, § 107).
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> In assessing compliance with Article 8, the Court must make an overall examination of the various interests in issue, bearing in mind that the Convention is intended to safeguard rights that are "practical and effective". This is also true in cases where a general problem for the society reaches a level of gravity such that it becomes a serious and concrete physical threat to the population.
>
> The Court must also look behind appearances and investigate the realities of the situation complained of. That assessment may also involve the conduct of the parties, including the means employed by the State and their implementation. Indeed, where an issue in the general interest is at stake, which reaches a degree of gravity such that it becomes a public health issue, it is incumbent on the public authorities to act in good time, in an appropriate and consistent manner (see, mutatis mutandis, *Hutten-Czapska v. Poland* [GC], no. 35014/97, § 168, ECHR 2006-VIII). In its assessment, the Court accepts that the measures and actions to be adopted and taken are not an obligation of result, but an obligation of means."

238. *Oneryildiz, Budayeva, Kolyadenko* and *Stoicescu* all concern failures by municipal authorities to take any steps to mitigate a physical threat, whether from dangerous activities, man-made hazards or a naturally occurring hazard. All have in common that the threat was to inhabitants of a particular locality (generally a small area, though given the size of the city of Bucharest *Stoicescu* is perhaps an exception); and also that in each case the authorities failed over a significant period, despite ample notice, to take any effective steps to deal with the problem. They cannot be prayed in aid in support of the existence of an Article 2 operational duty to the entire population of any Member State to protect it from the COVID-19 pandemic. Indeed, Mr Coppel did not suggest that the duty is as wide as that. Rather he submits that the duty was owed to residents of care homes for the elderly, such as Mr Gibson and Mr Harris, because of their exceptional vulnerability to fatal infection by COVID-19.

239. That brings us to the cases concerned with medical treatment and the care of the vulnerable. Mr Coppel submits that the medical treatment cases are irrelevant to the present claim, but we consider that they do provide some guidance.

240. *Lopes de Sousa Fernandez v Portugal* (2017) 66 EHRR 28 was a Grand Chamber decision concerned with denial of access to medical treatment. The court held that in cases involving alleged medical negligence the State's positive obligations were regulatory, including *"necessary measures to ensure implementation, including supervision and enforcement."* It continued by noting at [183] that medical negligence cases in which States have been held liable under Article 2 are "exceptional ones in

which the fault attributable to the health care providers went beyond a mere error or medical negligence. It added:

> "188. For the Court's examination of a particular case, the question whether there has been a failure by the State in its regulatory duties calls for a concrete assessment of the alleged deficiencies rather than an abstract one. In this regard, the Court reiterates that its task is not normally to review the relevant law and practice in abstracto, but to determine whether the manner in which they were applied to, or affected, the applicant gave rise to a violation of the Convention (see *Roman Zakharov v. Russia* [GC], no. 47143/06, § 164, ECHR 2015 and the cases cited therein). Therefore, the mere fact that the regulatory framework may be deficient in some respect is not sufficient in itself to raise an issue under Article 2 of the Convention. It must be shown to have operated to the patient's detriment (compare and contrast Z v. Poland, cited above, §§ 110-12, and *Arskaya*, cited above, §§ 84-91).
>
> 189. It must, moreover, be emphasised that the State's obligation to regulate must be understood in a broader sense which includes the duty to ensure the effective functioning of that regulatory framework. The regulatory duties thus encompass necessary measures to ensure implementation, including supervision and enforcement.
>
> 190. On the basis of this broader understanding of the State's obligation to provide a regulatory framework, the Court has accepted that, *in the very exceptional circumstances described below, the responsibility of the State under the substantive limb of Article 2 of the Convention may be engaged in respect of the acts and omissions of health-care providers*.
>
> 191. The first type of exceptional circumstances concerns a specific situation where an individual patient's life is knowingly put in danger by denial of access to life-saving emergency treatment (see, for example*, Mehmet Şentürk and Bekir Şentürk*, and, by contrast, *Sayan*, both cited above). It does not extend to circumstances where a patient is considered to have received deficient, incorrect or delayed treatment.
>
> 192. The second type of exceptional circumstances arises where a systemic or structural dysfunction in hospital services results in a patient being deprived of access to life-saving emergency treatment and the authorities knew about or ought to have known about that risk and failed to undertake the necessary measures to prevent that risk from materialising, thus putting the patients' lives, including the life of the particular patient concerned, in danger (see, for example, *Asiye Genç* and *Aydoğdu*, both cited above).

> 193. The Court is aware that on the facts it may sometimes not be easy to distinguish between cases involving mere medical negligence and those where there is a denial of access to life-saving emergency treatment, particularly since there may be a combination of factors which contribute to a patient's death.
>
> 194. However, the Court reiterates at this juncture that, for a case to fall into the latter category, the following factors, taken cumulatively, must be met. Firstly, the acts and omissions of the health-care providers must go beyond a mere error or medical negligence, in so far as those health-care providers, in breach of their professional obligations, deny a patient emergency medical treatment despite being fully aware that the person's life is at risk if that treatment is not given (see Mehmet Şentürk and Bekir Şentürk, cited above, § 104).
>
> 195. Secondly, the dysfunction at issue must be objectively and genuinely identifiable as systemic or structural in order to be attributable to the State authorities, and must not merely comprise individual instances where something may have been dysfunctional in the sense of going wrong or functioning badly (see, in particular, Aydoğdu, cited above, § 87, and, by contrast, Eugenia Lazăr, cited above, §§ 69-70).
>
> 196. Thirdly, there must be a link between the dysfunction complained of and the harm which the patient sustained. Finally, the dysfunction at issue must have resulted from the failure of the State to meet its obligation to provide a regulatory framework in the broader sense indicated above (see paragraph 189 above and, for example, Mehmet Şentürk and Bekir Şentürk, cited above, § 96, and Aydoğdu, cited above, §§ 87-88)." (Emphasis added)

241. In *Nencheva v Bulgaria* (Application no. 48609-06, unreported, 18 June 2013) and also in *Centre for Legal Resources on behalf of Campianu v Romania* (2014) 37 BHRC 423; BAILII [2014] ECHR 789 the Strasbourg court was concerned with State-run care homes where appallingly substandard conditions had been tolerated over a significant period. *Nencheva* involved a municipal home for children with severe mental disorders. The Fourth Section said at [121]-[122]:

> "121. The Court therefore takes it as established that the public authorities, at several levels, had exact knowledge of the reality of the danger as regards the state of health of the children living in the Dzhurkovo home. The Court notes that the headmistress had incessantly pointed out the seriousness of the living conditions and the difficulty of providing the children with the necessary care, and called for the help of numerous public or humanitarian structures (see paragraphs 32-37 above). The Court therefore takes it as established that the public authorities, at several levels, had exact knowledge of the reality of the danger as regards the state of health of the children living

> in the Dzhurkovo home. Moreover, at that time the mortality rate in the home was considerably higher than usual (see paragraph 59 above).
>
> 122. It should then be noted that - and this is a crucial element in the case - the occurrence of the tragic events was not sudden, one-off and unforeseen, as in the case of an event of force majeure to which the State might not be able to cope. The cases of death followed one another and the drama of the home was thus spread over time. Indeed, fifteen children and young adults, seven of whom were the children of the applicants, died between 15 December 1996 and 14 March 1997, that is to say during a period of approximately three months. This element should have seemed suspicious at the very least and required an explanation."

242. *Campeanu* was a case relating to a young adult with profound intellectual disability (an IQ of 30) who suffered from HIV. He was put in a series of State-run institutions, culminating in a neuro-psychiatric hospital (the PMH) where conditions had been known to the authorities to be appalling for some time. The Grand Chamber said:

> "141. …"Despite the Government's assertions that the living conditions at the PMH were adequate……., the Court notes that at the relevant time, the domestic authorities had acknowledged before the various international bodies the deficiencies at the PMH regarding the heating and water systems, the living and sanitary conditions and the medical assistance provided…"
>
> The Court observes that in the case of *Nencheva and Others* (cited above) the Bulgarian State was found to be in breach of its obligations under Article 2 for not having taken sufficiently prompt action to ensure effective and sufficient protection of the lives of young people in a social care home. The Court took into consideration the fact that the children's death was not a sudden event, in so far as the authorities had already been aware of the appalling living conditions in the social care home and of the increase in the mortality rate in the months prior to the relevant time (ibid., §§ 121-123).
>
> 143. The Court finds that, similarly, in the present case the domestic authorities' response to the generally difficult situation at the PMH at the relevant time was inadequate, seeing that the authorities were fully aware of the fact that the lack of heating and appropriate food, and the shortage of medical staff and medical resources, including medication, had led to an increase in the number of deaths during the winter of 2003.
>
> The Court considers that in these circumstances, it is all the more evident that by deciding to place Mr Câmpeanu in the

> PMH, notwithstanding his already heightened state of vulnerability, the domestic authorities unreasonably put his life in danger. The continuous failure of the medical staff to provide Mr Câmpeanu with appropriate care and treatment was yet another decisive factor leading to his untimely death.
>
> 144. The foregoing considerations are sufficient to enable the Court to conclude that the domestic authorities have failed to comply with the substantive requirements of Article 2 of the Convention, by not providing the requisite standard of protection for Mr Câmpeanu's life."

243. In *Dumpe v Latvia*, 16 October 2018, by contrast, the applicant's son, who suffered from Down's Syndrome and epilepsy, had been in State care for several years and eventually died from heart failure, but was also suffering from undernourishment, acute hepatitis B and organ dystrophy. An investigation identified serious failings and shortcomings in the medical care provided, though not such as to give rise to criminal liability. There was no suggestion of intentional killing. The Fifth Section of the Strasbourg court rejected the claim of a breach of the State's Article 2 duty.

244. *Watts v United Kingdom* (2010) 51 EHRR SE5 was relied on by Mr Coppel as an example of a case where it was held that an Article 2 duty was owed to an elderly resident of a care home. The court said at [82]-[83]:

> "82. The court observes at the outset that article 2 imposes both negative and positive obligations on the State. The negative obligation prohibits the intentional and unlawful taking of life by agents of the state. The positive obligation . . . requires that they take appropriate steps to safeguard the lives of those within their jurisdiction (see *LCB v United Kingdom* (1999) 27 EHRR 212, para 36; and *Edwards v United Kingdom* (2002) 35 EHRR 19, para 54). This implies, *in appropriate circumstances*, a positive obligation on the authorities to take preventive operational measures to protect an individual whose life is at risk. Although the court originally explained that this positive obligation arose when there was a risk to life 'from the criminal acts of another individual' (see *Osman v United Kingdom* (2000) 29 EHRR 245 at para 115), it has since made it clear the positive obligations under article 2 are engaged in the context of any activity, whether public or not, in which the right to life may be at stake (see *Öneryildiz v Turkey* (2005) 41 EHRR 20, para 71).
>
> 83. For the court to find a violation of the positive obligation to protect life, it must be established that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk. The court reiterates that the scope of any positive obligation must be interpreted in a way which does not impose

> an impossible or disproportionate burden on the authorities, including in respect of the operational choices which must be made in terms of priorities and resources. Accordingly, not every claimed risk to life can entail for the authorities a Convention requirement to take operational measures to prevent that risk from materialising."

245. Baroness Hale's commentary on this passage from *Watts* in her concurring judgment in *Rabone* at [97]-[99] is instructive:

> "97. Such broad statements of principle are hard to interpret and even harder to apply. It is tempting for a common lawyer to treat them as if they were Lord Atkin's statement of the neighbour principle in *Donoghue v Stevenson* [1932] AC 562, p 580: the duty arises in the circumstances explained in para 82 of *Watts* and is breached in the circumstances explained in para 83. But is the court in fact laying down a broad principle that, in the context of any public or private activity in which the right to life may be at stake, the State has a duty, if the authorities know or ought to know of a real and immediate risk to the life of a particular individual, to take such measures as might reasonably be expected of them to avoid that risk?
>
> 98. This is certainly how the decision in Mrs Watts' case reads. Mrs Watts was complaining that the local authority's decision to close the care home in which she had lived for five years violated this duty because it put her life at risk. The court accepted that the badly managed transfer of elderly residents could have a negative impact on their life expectancy and thus that article 2 was "engaged" (para 88). However, what the authorities had to do about it would depend upon the extent of the risk, on which in that case the evidence was equivocal. Bearing in mind the choices which had to be made by the authorities in providing residential care for the elderly and the careful steps which had been taken to minimise any risk to this applicant's life, the authorities had met their positive obligations in that case (para 92).
>
> 99. On the other hand, is the reference to "in appropriate circumstances" (in *Watts*, para 82, among others) designed to set limits to the situations in which the operational duty can even arise? After all, in Mrs Watts' case, the activity which gave rise to the risk to life – moving the elderly residents out of their home - was one in which the authorities were themselves engaged. In that respect, it is like the case of *Öneryildiz v Turkey*, cited by the court for the broader proposition, where the authorities were responsible for the municipal rubbish tip which endangered the lives of local residents. Another example where the duty not only arose but was violated is *Branko Tomašic and Others v Croatia*, Application No 46598/06, 15 January 2009. Shortly after his release from prison a man shot

> dead his former co-habitant, their child and himself. The risk to life was well known to the authorities when they released him from prison, but he had received no adequate psychiatric treatment while inside and there was no power to detain him for treatment after his sentence expired. They had not, therefore, done all that could reasonably be expected to guard against the risk. In the context of state activities constituting a risk to life, therefore, the court may have reached the point where the operational duty is engaged, but the circumstances will be carefully scrutinised to see what, reasonably, the authorities could be expected to do about it, bearing in mind the gravity of the risk and the problems they face in responding to it."

246. *R (Maguire) v Blackpool and Fylde Coroner* [2021] QB 409 contains an analysis of Article 2 case law by the Court of Appeal (Lord Burnett of Maldon CJ, Ryder and Nicola Davies LJJ) which, until and unless the Supreme Court (which has recently given permission to appeal in *Maguire*) decides otherwise, is to be treated as authoritative. The issue was whether the Article 2 operational duty had been owed to Jackie Maguire, an adult with learning difficulties, who lived in a residential care home and was subject to a deprivation of liberty authorisation under the Mental Health Act 1983 granted by the local authority. At [72]-[73] the court said:

> "72. The Divisional Court was right to identify the unifying feature of the application of the operational obligation or duty to protect life as one of State responsibility. That, for example, is the theme which emerges from the Strasbourg authorities discussed in *Tyrell* and supports the conclusion that the article 2 procedural obligation does not apply to cases of deaths in custody arising from natural causes. In both *Nencheva* and *Câmpeanu*……the substantive article 2 duty owed to the people concerned was to protect from a type of harm entirely within the control of those who cared for them. They were in the institutions to be cared for. In *Nencheva* the Bulgarian State was in breach of its positive obligation for failing to take prompt action to protect the lives of young people in a residential care home where 15 disabled children died. The authorities were aware of the appalling conditions in the care home and of an increased mortality rate (paras 121-123). In *Câmpeanu,* the Grand Chamber concluded that the domestic authorities knew that the facility in which the deceased was kept lacked proper heating and food, had a shortage of medical staff and resources and inadequate supplies of medication. That led to an increased mortality rate…"
>
> 73. Both the prison cases and those concerning conditions within an institution where vulnerable people are cared for demonstrate that the article 2 substantive obligation is tailored to harms from which the authorities have a responsibility to protect those under its care. It cannot be supposed that if a child in a care home or an adult in a position such as Mr Câmpeanu

> had suffered an isolated medical emergency that the substantive obligation would have applied to the manner in which that was dealt with. The reasoning of the Strasbourg Court which supported the imposition of the operational duty would not apply."

247. At [96]-[97] the court concluded:

> "96. The question whether an operational duty under article 2 was owed to Jackie is not an abstract one which delivers a "yes" or "no" answer in all circumstances. She was a vulnerable adult incapable of looking after herself and lacking capacity to make decisions about her care. As the decisions of the Strasbourg Court in *Nencheva* and *Câmpeanu* show, the article 2 operational duty is owed to vulnerable people under the care of the state for some purposes. If a death in this jurisdiction in a hospital or care home for which the state was responsible resulted from conditions described in either of those cases, the substantive or operational duty under article 2 ECHR would be engaged. So too if the state was aware of the shortcomings, through regulatory inspections, and did not act on them. There would be a direct analogy in the latter situation with the failure of social services to protect children over a prolonged period when they knew of serious abuse (*Z v. United Kingdom* discussed in para. 46 above). The potential application of the operational duty discussed in *Watts v. United Kingdom* (see para. 45 above) when moving vulnerable elderly people from one home to another on account of the exceptional risk involved is another example of the operational duty arising within a defined area of activity.
>
> 97. The approach illuminated by those cases (and the prison cases) does not support a conclusion that for all purposes an operational duty is owed to those in a vulnerable position in care homes, which then spawns the distinct procedural obligation (with all its components) in the event of a death which follows either alleged failures or inadequate interventions by medical professionals. On the contrary, as *Dumpe* most clearly demonstrates, it is necessary to consider the scope of any operational duty. Had Mr Dumpe's death followed ill-treatment or neglect of the sort considered by the Strasbourg Court in *Nencheva* and *Câmpeanu* the position would have been different. The circumstances of the death would be judged by reference to the operational duty."

248. In *R (Morahan) v West London Assistant Coroner* [2021] QB 1205 Popplewell LJ, with whom Garnham J and the Chief Coroner agreed, considered the analysis of the Article 2 operational duty to be found in *Maguire*. He said:

> "65. I derive three important and related points from this analysis. First, the existence or otherwise of the operational

> duty is not to be analysed solely by reference to the relationship between the state and the individual, but also, and importantly, by reference to the type of harm of which the individual is foreseeably at real and immediate risk. This follows from the operational duty to protect life having the unifying feature of being one of state responsibility, and the need to focus on the scope of the duty which may be owed. There may be an operational duty to protect against some hazards but not others."
>
> 66. Secondly, the foreseeable real and immediate risk of the type of harm in question is a necessary condition of the existence of the duty, not merely relevant to breach. Without identifying such foreseeable risk of the type of harm involved, it is impossible to answer the question whether there is an operational duty to take steps to prevent it.
>
> 67. Thirdly, in cases where vulnerable people are cared for by an institution which exercises some control over them, the question whether an operational duty is owed to protect them from a foreseeable risk of a particular type of harm is informed by whether the nature of the control is linked to the nature of the harm. A prison's control over its inmates gives rise to an obligation to protect its detainees against suicide risks because, as Baroness Hale observed in *Rabone*, the very fact of incarceration increases such a risk. The control is linked to the risk. So too in the case of detained mental patients, where the detention gives rise to the increased risk of suicide whatever the nature of the mental condition being treated………Where, however, there is no link between the control and the type of harm, to impose an operational duty to protect against the risk would be to divorce the duty from its underlying justification as one linked to state responsibility. It would also undermine the requirement identified in *Osman* that the positive obligations inherent in article 2 should not be interpreted so as to impose a disproportionate burden on a state's authorities. The control by the state could not justify the imposition of the duty by reference to state responsibility if the risk were of a type of harm which is unconnected to the control which the state has assumed over the individual. A psychiatric hospital owes no duty to protect a patient, whether voluntary or detained, from the risk of accidental death from a road traffic accident whilst on unescorted leave."

249. Mr Coppel relied also on *R (Munjaz) v Mersey Care NHS Trust* [2006] 2 AC 148, a case about the policy of seclusion (in effect solitary confinement) of a psychiatric patient detained at a high security hospital. The House of Lords, while dismissing the claim for judicial review, held that the defendant Trust was under a duty not to adopt a policy which exposed the claimant to a significant risk of treatment prohibited by ECHR Article 3. It is convenient shorthand for public lawyers to refer to "the *Munjaz*

duty", and we are content to assume that it exists where the significant risk is to life rather than one of inhuman or degrading treatment. But we do not consider that *Munjaz* creates a further subspecies of Article 2 duty, or that it is a basis on which to bypass the other Strasbourg and domestic case law to which we have referred, so as to hold that the Defendants (or any of them) owe an Article 2 duty to the whole population of England, or even (focusing on the claim in respect of Mr Gibson) the whole population of private sector care homes for the elderly in England, not to adopt any policy which exposes them to a significant risk to life.

Conclusion on the Article 2 operational duty

250. We draw the following from the domestic and Strasbourg cases which we have cited:

i. a real and immediate risk to life is a necessary but not sufficient factor for the existence of an Article 2 operational duty;

ii. generally, the other necessary factor is the assumption by the State of responsibility for the welfare and safety of particular individuals, of whom prisoners, detainees under mental health legislation, immigration detainees and conscripts are paradigm examples since they are under State control;

iii. however, the duty may exist even in the absence of an assumption by the State of responsibility, where State or municipal authorities have become aware of dangerous situations involving a specific threat to life which arise exceptionally from risks posed by the violent and unlawful acts of others (*Osman*) or man-made hazards (*Oneryildiz, Kolyadenko*) or natural hazards (*Budayeva)*, or from appalling conditions in residential care facilities of which the authorities had become aware (*Nencheva, Campeanu)*;

iv. *Watts* suggests that, in appropriate circumstances (which remain so far undefined), the operational duty may also arise where State or municipal authorities engage in activities which they know or should know pose a real and immediate risk (according to *Maguire,* an exceptional risk) to the life of a vulnerable individual or group of individuals.

251. In *R (AB) v Secretary of State for Justice* [2021] UKSC 28; [2021] 3 WLR 494 Lord Reed PSC, with whom the other Justices agreed, said that counsel for the appellant was asking the Supreme Court to make what Lord Reed characterised as *"a major departure from the principles currently laid down in the Convention jurisprudence."* He continued:

> "54. It is of course possible that the European court may choose to develop its jurisprudence in this way, if a suitable case comes before it. But it is not the function of this court to undertake a development of the Convention law of such a substantial nature. The general approach to be adopted by

domestic courts applying the Human Rights Act was explained by Lord Bingham of Cornhill in *R (Ullah) v Special Adjudicator* [2004] UKHL 26; [2004] 2 AC 323, para 20 ("*Ullah*"), expressing the unanimous view of the House. As he said, the House had previously held that "courts should, in the absence of some special circumstances, follow any clear and constant jurisprudence of the Strasbourg court". That, as he explained, reflected the fact that the Human Rights Act was intended to give effect in domestic law to an international instrument, the Convention, which could only be authoritatively interpreted by the Strasbourg court. Accordingly, domestic courts were required "to keep pace with the Strasbourg jurisprudence as it evolves over time: no more, but certainly no less".

55.Lord Bingham expanded on that rationale in *R (SB) v Governors of Denbigh High School* [2006] UKHL 15; [2007] 1 AC 100, para 29. Citing earlier statements to the same effect in earlier decisions of the House of Lords, he observed that "the purpose of the Human Rights Act 1998 was not to enlarge the rights or remedies available to those in the United Kingdom whose Convention rights have been violated but to enable those rights and remedies to be asserted and enforced by the domestic courts and not only by recourse to Strasbourg". There should therefore be a correspondence, in general, between the rights enforced domestically and those available in Strasbourg. Parliament can of course legislate to provide for rights more generous than those guaranteed by the Convention, but it did not do so when it enacted the Human Rights Act.

56.An important additional rationale, which follows from the objective of the Human Rights Act as explained in *Ullah* and *Denbigh High School*, was identified by Lord Brown of Eaton-under-Heywood in *R (Al-Skeini) v Secretary of State for Defence (The Redress Trust intervening)* [2007] UKHL 26; [2008] AC 153, para 106. Referring to Lord Bingham's statement that domestic courts should keep pace with the Strasbourg jurisprudence, "no more, but certainly no less", he commented:

> "I would respectfully suggest that last sentence could as well have ended: 'no less, but certainly no more'. There seems to me, indeed, a greater danger in the national court construing the Convention too generously in favour of an applicant than in construing it too narrowly. In the former event the mistake will necessarily stand: the member state cannot itself go to Strasbourg to have it corrected; in the latter event, however, where Convention rights have been denied by too narrow a construction, the aggrieved individual *can* have the decision corrected in Strasbourg."

57. As Lord Brown explained, the intended aim of the Human Rights Act - to enable the rights and remedies available in Strasbourg also to be asserted and enforced by domestic courts - is particularly at risk of being undermined if domestic courts take the protection of Convention rights further than they can be fully confident that the European court would go. If domestic courts take a conservative approach, it is always open to the person concerned to make an application to the European court. If it is persuaded to modify its existing approach, then the individual will obtain a remedy, and the domestic courts are likely to follow the new approach when the issue next comes before them. But if domestic courts go further than they can be fully confident that the European court would go, and the European court would not in fact go so far, then the public authority involved has no right to apply to Strasbourg, and the error made by the domestic courts will remain uncorrected.

58. The approach to this issue laid down in *Ullah*, *Denbigh High School* and *Al-Skeini* has been repeatedly endorsed at the highest level. For example, in *R (Animal Defenders International) v Secretary of State for Culture, Media and Sport* [2008] UKHL 15; [2008] AC 1312, Baroness Hale of Richmond stated at para 53:

> "The Human Rights Act 1998 gives effect to the Convention rights in our domestic law. To that extent they are domestic rights for which domestic remedies are prescribed: *In re McKerr* [2004] 1 WLR 807. But the rights are those defined in the Convention, the correct interpretation of which lies ultimately with Strasbourg: *R (Ullah) v Special Adjudicator* [2004] 2 AC 323, para 20. Our task is to keep pace with the Strasbourg jurisprudence as it develops over time, no more and no less: *R (Al-Skeini) v Secretary of State for Defence (The Redress Trust intervening)* [2008] 1 AC 153, para 106."

In *Manchester City Council v Pinnock (Secretary of State for Communities and Local Government intervening)* [2010] UKSC 45; [2011] 2 AC 104, a nine-member constitution of this court unanimously stated at para 48:

> "Where, however, there is a clear and constant line of decisions [of the European court] whose effect is not inconsistent with some fundamental substantive or procedural aspect of our law, and whose reasoning does not appear to overlook or misunderstand some argument or point of principle, we consider that it would be wrong for this court not to follow that line."

In *Smith v Ministry of Defence* [2013] UKSC 41; [2014] AC 52, Lord Hope, with whom Lord Walker, Lady Hale and Lord Kerr agreed, summarised the position at para 43:

> "Lord Bingham's point [in *Ullah*, para 20] was that Parliament never intended by enacting the Human Rights Act 1998 to give the courts of this country the power to give a more generous scope to the Convention rights than that which was to be found in the jurisprudence of the Strasbourg court. To do so would have the effect of changing them from Convention rights, based on the Treaty obligation, into free-standing rights of the court's own creation."

59. It follows from these authorities that it is not the function of our domestic courts to establish new principles of Convention law. But that is not to say that they are unable to develop the law in relation to Convention rights beyond the limits of the Strasbourg case law. In situations which have not yet come before the European court, they can and should aim to anticipate, where possible, how the European court might be expected to decide the case, on the basis of the principles established in its case law. Indeed, that is the exercise which the High Court and the Court of Appeal undertook in the present case. The application of the Convention by our domestic courts, in such circumstances, will be based on the principles established by the European court, even if some incremental development may be involved. That approach is discussed, for example, in *Rabone v Pennine Care NHS Trust (INQUEST intervening)* [2012] UKSC 2; [2012] 2 AC 72, paras 112 and 121, *Surrey County Council v P* [2014] UKSC 19; [2014] AC 896, para 62, *Kennedy v Charity Commission* [2014] UKSC 20; [2015] AC 455, paras 145-148, and *Moohan v Lord Advocate (Advocate General for Scotland intervening)* [2014] UKSC 67; [2015] AC 901, para 13."

252. There is no authority of the Strasbourg court which has gone as far as holding that a State is under an operational duty to take all reasonable steps to avoid the real and immediate risk to life posed by an epidemic or pandemic to as broad and undefined a sector of the population as residents of care homes for the elderly. There is no clear and consistent line of Strasbourg authority which indicates that such a duty exists and we cannot be at all confident – indeed we gravely doubt – that the ECtHR would be willing to declare that it does. We should keep pace with the Strasbourg jurisprudence, but not run past it and disappear into the distance. The Defendants did not, in our view, owe the Article 2 operational duty for which the Claimants contend.

253. In the circumstances the "disproportionate burden" and "margin" issues do not arise; and it is also unnecessary for us to consider the causation argument put pithily by Ms Grey in these terms: *"COVID-19 is a virulent and dangerous disease, but the risk to*

life which it presents was not created, nor disproportionately increased, by the March Hospital Discharge Policy"

254. We dismiss the Article 2 claim.

Article 8

255. *Vilnes v Norway* (5 December 2013, unreported) was relied on by Mr Coppel as showing that a claim may succeed under Article 8 despite having been rejected under Article 2. The case concerned the publication of decompression tables by deep sea diving companies to regulate the frequency of diving shifts and enable divers' bodies to recover. The applicants argued that the diving tables were insufficiently conservative and put their health at risk. The Article 2 claim failed, but the Article 8 claim succeeded because the State had given the diving companies too wide a latitude in keeping their decompression tables private to serve their business interests, which prevented the applicants from being able to assess the potential health risks for themselves.

256. The present case is not about the provision of information to care home residents about the risk to their lives from the pandemic, but about the substance of policy decisions and the documents embodying them to which we shall come when dealing with the public law claim. Putting the issue of provision of information to one side, we accept Sir James' straightforward submission that it would be anomalous for a claimant to escape the limits Strasbourg has placed on the extent of the Article 2 duty by repackaging the case under Article 8; and no Strasbourg or domestic authority cited to us suggests that we should.

257. We therefore turn to the claims at common law. Before doing so we will consider the issues about the evidence, particularly the witness statements filed on behalf of the Secretary of State, which were raised by Mr Coppel and Mr Barrett.

Issues about the First Defendant's evidence

258. In this case, by contrast with most judicial review cases where the Defendant is a Secretary of State, the decisions under challenge were taken by the Secretary of State (Mr Hancock) personally rather than by an official for whom the Secretary of State was responsible in law. This does not mean, of course, that only Mr Hancock could give evidence of how the decisions under challenge came to be made. The main witness statements on behalf of the Secretary of State come from Mr Surrey, who joined the DHSC with effect from 30 March 2020. As we have noted, Mr Barrett argues that in many places the witness statement does not comply with the Practice Direction to CPR 32 in that the source of the information or belief of the witness is not identified. Given the circumstances it would be far too technical to hold that the relevant passages in Mr Surrey's evidence are inadmissible. The point, as we see it, goes to weight rather than to admissibility. A statement on the lines of "it was felt that..." which does not indicate who was involved is not of much assistance.

259. It is not enough for the Defendants to rely on a general proposition that where there are disputes of fact between the evidence for the Claimant and the evidence for the Defendants in judicial review the dispute must always be resolved in favour of the Defendants. In judicial review claims evidence of the Defendant's witnesses,

particularly if it is in generalised terms, may be contradicted by contemporaneous documents or, where appropriate, by the absence of contemporaneous documents.

260. In ordinary, less pressured circumstances than those prevailing at the DHSC in March and April 2020 one would expect to see a chain of documents including a written submission to the Secretary of State and either a written response on his behalf or a minute of a meeting containing his decision. It is unsurprising that this usual degree of formality was not always observed. But, as recorded above, the Defendants have disclosed what they say are all the relevant recorded communications (including Whats App and text messages) arising from proportionate searches of communications to or from the Secretary of State or the Minister for Social Care during the relevant period. Where there is no record at all of an important issue being raised with the Secretary of State nor of his response we cannot simply assume that everything relevant was taken into consideration. We have to do the best we can with the available material.

Reliance on expert advice

261. As we have noted, the Government was obtaining advice not only from the Chief Medical Officer and Chief Scientific Officer and other individuals, but also from specialist expert committees, SAGE, NERVTAG, SPI-M and the UKSCG. Where it is clear that the Secretary of State made a difficult judgment after taking their advice, we shall follow the same course as the Court of Appeal in *Dolan.* The court said at [89] – [90]:-

> "89. We also bear in mind that this is an area in which the Secretary of State had to make difficult judgements about medical and scientific issues and did so after taking advice from relevant experts. Although this case does not arise under European Union law, we consider that an analogy can be drawn with what was said by Lord Bingham of Cornhill CJ in *R v Secretary of State for Health, ex parte Eastside Cheese Co* [1999] 3 CMLR 123, at para. 47: "on public health issues which require the evaluation of complex scientific evidence, the national court may and should be slow to interfere with a decision which a responsible decision-maker has reached after consultation with its expert advisers"."
>
> 90. We find it impossible to accept that a court could possibly intervene in this context by way of judicial review on the ground of irrationality. There were powerfully expressed conflicting views about many of the measures taken by the Government and how various balances should be struck. This was quintessentially a matter of political judgement for the Government, which is accountable to Parliament, and is not suited to determination by the courts."

The PSED

262. Section 149(1) of the Equality Act 2010 contains the public sector equality duty:

> "A public authority must, in the exercise of its functions, have due regard to the need to –
>
> (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
>
> (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
>
> (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it."

263. The relevant principles which govern the public sector equality duty were not in dispute. They are summarised in the judgment of the Court of Appeal (Sir Terence Etherton MR, Dame Victoria Sharp P and Singh LJ) in *R (Bridges) v Chief Constable of South Wales Police* [2020] EWCA Civ 1058; [2020] 1 WLR 5037, at paragraphs [174]-[175]:

> "174. [T]hose principles were set out by *McCombe LJ in R (Bracking) v Secretary of State for Work and Pensions (Equality and Human Rights Commission intervening)* [2014] Eq LR 60, para 26. It is unnecessary to set out that passage in full here. It is well known and has frequently been cited with approval since, including in *Hotak v Southwark London Borough Council* [2016] AC 811, para 73 (Lord Neuberger PSC).
>
> 175. In that summary McCombe LJ referred to earlier important decisions, including those of the Divisional Court in *R (Brown) v Secretary of State for Work and Pensions (Equality and Human Rights Commission intervening)* [2009] PTSR 1506, in which the judgment was given by Aikens LJ; and *R (Hurley) v Secretary of State for Business, Innovation and Skills* [2012] HRLR 13, in which the judgment was given by Elias LJ. For present purposes we would emphasise the following principles, which were set out in McCombe LJ's summary in *Bracking* and are supported by the earlier authorities:
>
> (1) The PSED must be fulfilled before and at the time when a particular policy is being considered.
>
> (2) The duty must be exercised in substance, with rigour, and with an open mind. It is not a question of ticking boxes.
>
> (3) The duty is non-delegable.
>
> (4) The duty is a continuing one.

> (5) If the relevant material is not available, there will be a duty to acquire it and this will frequently mean that some further consultation with appropriate groups is required.
>
> (6) Provided the court is satisfied that there has been a rigorous consideration of the duty, so that there is a proper appreciation of the potential impact of the decision on equality objectives and the desirability of promoting them, then it is for the decision-maker to decide how much weight should be given to the various factors informing the decision."

264. In the highly pressured circumstances of March and April 2020 we do not think that the Government can reasonably be criticised for failure to comply with the usual procedural step of carrying out an equalities impact assessment of its policies relating to care homes addressing the need to eliminate discrimination against the elderly or the need to advance equality of opportunity between the elderly and the rest of the population. In any event, on the facts of this case, the PSED adds nothing to the duties of the Defendants at common law. Anyone devising a policy affecting care homes must, if they are to act rationally, bear in mind that a majority of residents of care homes are not only elderly but also have other health issues which make them particularly vulnerable to infections. That would be the case even if s 149 of the 2010 Act had never been enacted.

Public law

265. Before turning to the particular policies and decisions under challenge we would make some general observations of relevance to all the public law complaints. In so doing, we echo some of the points made above in considering the case under the ECHR, but context is equally important here.

266. We remind ourselves that we are here considering whether the decisions made and the policies promulgated were unlawful by the standards of public law. In addressing that issue we have to consider the facts as they were presented at the time to the decision-makers. As Sir James correctly puts it, *"hindsight is not permissible."* We must ask ourselves whether the decisions taken fell outside the range of reasonable decisions properly open to the Government in the light of the knowledge then available and the circumstances then existing.

267. In answering that question we recognise that the Government was having to make judgements in respect of a novel disease against a background of uncertain and rapidly developing scientific knowledge. It was doing so in circumstances of enormous pressure where the matters at stake were of the utmost gravity. Furthermore, in the early months of the pandemic the options available to the Government were constrained by practical limitations as well as scientific uncertainty. The obvious example is the worldwide shortage of PPE in the early months of the pandemic and the worldwide competition for what little PPE there was.

The decisions under challenge

268. The first document criticised by Mr Coppel in his submissions to us was 'Guidance for social or community care and residential settings on COVID-19' issued by the

Third Defendant on 25 February 2020, which remained in force until 13 March 2020. As noted at [5] above, this was not one of the policies directly under attack in the Claimants' Amended Statement of Facts and Grounds ("SFG"). In any event, however, it is our view that there is no merit in the point.

269. The Claimants criticise statements in the 25 February document to the effect that there was currently no community transmission of COVID-19 and that it was therefore *"very unlikely that anyone receiving care in a care home or the community will become infected."* Mr Coppel points to the fact that within a few days, specifically on 2 March 2020, SPI-M-O noted that it was highly likely that there was sustained transmission of the disease in the UK, and on 5 March 2020 SAGE noted that there was evidence to suggest sustained community transmission in the UK, yet the guidance remained in force until 13 March.

270. We do not accept that there was any unlawfulness in the contents of the 25 February document at the time it was issued. As is demonstrated in the "narrative" section above, the outbreak of the virus in the UK was then at a very early stage indeed. At the time the document was prepared, there was some evidence in the literature that people could become infected before developing symptoms but there was little evidence of transmission from asymptomatic cases. Furthermore, it was not until 28 February that the UK reported its first COVID-19 case with no link to travel abroad. We do not consider that the Defendants acted irrationally or failed to take relevant considerations into account in drawing up this policy given the state of scientific knowledge at that stage.

271. During the three weeks from 25 February to 17 March, the scientific picture was rapidly changing. The SPI-M-O consensus statement on 2 March concluded that it was highly likely that there was sustained transmission in the UK; at the eighth NERVTAG meeting on 6 March Professor Ferguson was pointing to evidence that infectiousness could be detected just before as well as just after the onset of symptoms. On 8 March 2020 three academic papers were published as summarised above. They all pointed to the real possibility of pre-symptomatic transmission of the virus. On 12 March the ECDC published the paper described at [69] above confirming the fact that asymptomatic people could be infectious.

272. Sir James warns us against reading too much into these academic papers. He makes the fair point that much of this evidence was based on scientific modelling and that there was little of what he calls *"real world evidence"* in any of them. He says that the presence of the virus in a patient's throat does not necessarily indicate a likelihood of transmission. He underlines the important distinction between asymptomatic *infection* and asymptomatic *transmission*. He submits that Ministers were receiving advice on the science from suitably qualified experts and were entitled to rely on it.

273. We consider, however, that this is too simplistic a view of the issue. It is undoubtedly right that there was no scientific *proof* in mid March 2020 that asymptomatic transmission was occurring, but it was well recognised by the experts that such transmission was *possible*. That was the burden of the academic and expert opinion to which we have referred.

274. The fact that many of the academic commentors were relying on modelling does not undermine the point. Modelling is a valid scientific tool and in circumstances where

there was, and could be, little "real world" evidence it produced useful evidence. Indeed, it was on the basis of modelling that the Government was concluding that without drastic action the capacity of NHS hospitals to care for those suffering the most severe effects of COVID would be exceeded.

275. Sir James is, of course, right when he submits that the nature of the scientific evidence pointing towards the possibility that the virus was being transmitted by those not exhibiting symptoms goes to the weight Ministers should have attached to the evidence. But the fact that evidence is not conclusive does not mean that it carries no weight. Ministers were obliged to weigh up not just the likelihood that non-symptomatic transmission was occurring, but also the very serious consequences if it did so. Non-symptomatic transmission would mean that one elderly patient moved from hospital to a care home could infect other residents before manifesting symptoms or even without ever manifesting symptoms. In this context it is important to recall the emphasis laid by the Defendants on the fact that they were intending to adopt the precautionary principle, in essence preparing on the basis that the worst could happen, throughout their response to COVID-19.

276. It is apparent that the changing evidential picture was recognised within Government. Lord Bethell's remark in the House of Lords on 9 March that asymptomatic and untested people could be infectious was an early sign of that recognition. Sir Patrick Vallance's remarks on the *Today* programme on 13 March - *"it looks quite likely that there is some degree of asymptomatic transmission"* - confirmed the position. Professor Doyle's evidence to the Health and Social Care Select Committee on 26 March underlined its significance.

277. Sir James sought to explain these public observations by those at the heart of Government by suggesting that all that was being done was *"acknowledging the building evidence"* and that the purpose of these remarks was *"to encourage people to reduce their social contact."* In other words, it is suggested that all that was said was that asymptomatic transmission was a possibility and all that was intended was that the public would respond by reducing their social contact.

278. In our judgment, however, the growing appreciation that asymptomatic transmission was a real possibility ought to have prompted a change in Government policy concerning care homes earlier than it did. We turn next to consider what that change should have been.

279. On 13 March PHE published the March PHE Policy. The first ground of complaint relates to the advice about visitors to care homes. The document stated that no one feeling unwell should be allowed to visit but did not address the possible risk to residents arising from transmission from asymptomatic visitors, staff, or new residents, whether arriving from hospital or from the community. We do not consider that this document can properly be criticised on the basis that all visiting should have been prohibited. It was not until 23 March, the day on which the Prime Minister announced the lockdown, that the UKSCG advised that visiting should be prohibited save in emergencies. That aspect of lockdown was one of its most controversial features, with important issues on both sides of the argument. We regard it as unrealistic for the Claimants to say that on 13 March a ban on all visiting was the only rational course for the Defendants to have pursued.

280. Four days later the Government published the first element of the March Discharge Policy. That policy comprised an instruction issued by NHSE on 17 March, "Next Steps on NHS Response to COVID-19" and a further document dated 19 March 2020, "COVID-19 hospital discharge service requirements". These are criticised by the Claimants on several grounds: failure to consider the safety of care home residents; failure to make transfer of patients from hospital into care homes conditional on an assessment of the ability of each care home to provide safe care; and failure to provide for the testing of each patient before discharge to a care home.

281. We regard the sustained attack on the Hospital Discharge Policy as quite unrealistic. As we have noted, the Defendants were extremely and understandably concerned by the prospect of the numbers of seriously ill patients requiring intensive care rising so rapidly that the NHS's intensive care capacity would simply be overwhelmed. In Italy, where the disease had spread some two weeks earlier than in England, hospitals had run out of beds and patients were being left to die at home. It must be remembered that, at this stage of the emergency, vaccines lay far in the future and the experts were unable to predict whether the graph of serious infection would go on rising exponentially for a long period. The NHS was using temporary overflow facilities with open plan wards at venues such as the ExCeL conference centre, known as Nightingale Hospitals, to help with the rapid surge in demand for beds. At this stage there was a shortage of PPE (both in this country and worldwide) and of tests.

282. Subject to a point which we make below, there was nothing unlawful in the policy on discharges from NHS hospitals contained in the documents of 17-19 March 2020. The fact that as matters turned out the NHS was not overwhelmed and its expanded capacity was never breached, a point laboured by Mr Coppel, does not assist his argument on this issue. The Government was advised by experts that there was a real risk of the NHS being overwhelmed and it could not afford to wait to see whether that advice was over-cautious.

283. We also regard as unrealistic the Claimants' suggestion that the transfer of patients from hospital into care homes should have been conditional on an assessment of the ability of each care home to provide safe care. It was properly open to the Government to regard the need to discharge from hospital those who appeared medically fit to be discharged as paramount. That could not sensibly wait for every care home to be assessed.

284. Similarly, the suggestion that the Government should have made provision in March for the testing of each patient before discharge to a care home is hopeless. As the narrative above shows there were only 5,000 tests available each day by 18 March and only 10,000 each day by 27 March. Even were it the case that in fact not all the available tests were used, it cannot sensibly be said that the Defendants acted irrationally in agreeing a prioritisation list, on expert advice, to ensure the limited number of tests were allocated where they were most needed.

285. However, there is a separate question as to how those discharged from hospital to care homes should have been treated and cared for. The fact that discharge was necessary to preserve the capacity of the NHS to provide in-patient care to those seriously affected by COVID did not eliminate the need to consider the best way to manage those discharged.

286. On 2 April 2020, a week after the lockdown had been given legal effect (by the Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 (SI 2020/350)) , the Admissions Guidance was published. As noted above, this included the following about new admissions (emphasis in the original):

> "Some of these patients [admitted from a hospital or from a home setting] may have COVID-19, whether symptomatic or asymptomatic. **All of these patients can be safely cared for in a care home if this guidance is followed.** If an individual has no COVID-19 symptoms, or has tested positive for COVID-19 but is no longer showing symptoms and has completed their isolation period then care should be provided as normal. … Negative tests are not required prior to transfers/admissions into the care home."

287. It is not clear to us how this document came to be issued in the terms we have quoted. We have seen a draft of the document from PHE indicating that people who were confirmed to have COVID should not be admitted to a COVID-free care home and similarly that patients who did *not* appear to be suffering from COVID should not be admitted to a care home where there was already an outbreak. But, although there had been growing awareness of the risk of asymptomatic transmission (as shown for example by Sir Patrick Vallance's interview of 13 March and Professor Doyle's evidence to the Select Committee on 26 March), there is no evidence that the Secretary of State or anyone advising him addressed the issue of the risk to care home residents of asymptomatic transmission.

288. Mr Coppel suggested that all patients discharged from hospital pursuant to the March Discharge Policy should have been kept in a quarantine facility for 14 days before being permitted to enter a care home. The Defendants' response was that this too was unrealistic; the facilities did not exist to provide this service for all those discharged. But in our judgment, this was not a binary question - a choice between on the one hand doing nothing at all, and on the other hand requiring all newly admitted residents to be quarantined. The 19 March document could, for example, have said that where an asymptomatic patient (other than one who has tested negative) is admitted to a care home, he or she should, so far as practicable, be kept apart from other residents for up to 14 days.

289. Since there is no evidence that this question was considered by the Secretary of State, or that he was asked to consider it, it is not an example of a political judgment on a finely balanced issue. Nor is it a point on which any of the expert committees had advised that no guidance was required. Those drafting the March Discharge Policy and the April Admissions Guidance simply failed to take into account the highly relevant consideration of the risk to elderly and vulnerable residents from asymptomatic transmission.

290. Counsel for the Defendants have put forward possible counter arguments. There is no evidence that any of these was considered at the time and in any event they are entirely unconvincing. The first was that many care home residents suffer from dementia and such a patient might experience disorientation if moved to a new environment and isolated from other patients. This is no doubt true, up to a point, but many of the new arrivals were being discharged from hospital where their experience

must have been not only disorientating but terrifying; and there is no evidence that the policy makers at the time took the view that the risk of serious trauma to a new resident who is told that she will have a single room for the first week or two in her new home outweighed the risk to other residents of asymptomatic transmission. Another argument was that such advice might increase the staffing difficulties faced by care home managers, but a recommendation to maintain a policy of isolation only "so far as practicable" would not have created any such difficulties.

291. In our judgment, such a provision could and should have been included by the First and Third Defendants in the March Discharge Policy. Furthermore, if it was not included on 19 March, it could and should have been included in the Admissions Guidance of 2 April.

292. It is notable that on 25 and 28 March, days before the publication of the 2 April Admissions Guidance, the Minister for Social Care (Ms Whately) was raising concerns about this aspect of the guidance. It was not until 15 April in the Action Plan of that date that the Department recommended both testing and isolation for 14 days for new residents admitted to care homes, whether from hospital or from the community. Such isolation was to be either in the care home itself or using "local authority-based arrangements", that is to say quarantine facilities.

293. This was a significant delay at a critical period. We consider that the decision to issue the 2 April Admissions Guidance in that form was irrational in that it failed to take into account the risk of asymptomatic transmission, and failed to make an assessment of the balance of risks.

294. The 15 April Action Plan was also criticised on behalf of the Claimants. One ground was that it did not address the risk of transmission of the disease to residents from staff, including agency and bank staff. This seems to us unrealistic. Staff shortages in the care home sector, exacerbated by the fact that so many staff had caught the disease themselves, were at this stage widespread and notorious. Complaint is also made that the recommendation that care homes "may wish" to isolate new residents was not forceful enough. There was of course no power to compel care homes to isolate anyone, and while "should isolate" might have been preferable wording to "may wish to isolate" we do not regard this as a ground for judicial review.

295. As we indicated at the start, we consider that the 15 May 2020 Support Policy and the 19 June 2020 Admissions Guidance, coming as they do after the deaths of the fathers of both Claimants, cannot be the subject of attack in this already very wide-ranging claim for judicial review.

296. We have set out above the extent to which the public law claim succeeds against the First and Third Defendants. We see no grounds on which the decision-making of the Second Defendant can properly be attacked. Although the Second Defendant were part of the discussion within Government about the need to establish the discharge policies, it was the First and Third Defendants who bore the responsibility of making proper arrangements for those admitted to care homes.

Conclusions

297. The claims under the Human Rights Act 1998 are dismissed.

298. The common law claim succeeds against the Secretary of State and Public Health England in respect of both the March Discharge Policy and April Admissions Guidance documents to this extent: the policy set out in each document was irrational in failing to advise that where an asymptomatic patient (other than one who had tested negative) was admitted to a care home, he or she should, so far as practicable, be kept apart from other residents for 14 days.

299. The claim against NHS England is dismissed.