



Independent Commission
on UK Public Health
Emergency Powers



Report
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THE COMMISSION

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- **Professor Jeff King**, Professor of Law at UCL and Director of Research at the Bingham Centre for the Rule of Law
- **Professor Fiona de Londras**, Professor of Global Legal Studies at Birmingham Law School
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- **Reema Patel**, Research Director and Head of Deliberative Engagement at Ipsos
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- **Dr Hannah White OBE**, Director and Chief Executive of the Institute for Government

*Lord Patel joined the Commission when it launched in 2022, but for personal reasons was not able to continue his engagement beyond February 2023. We are very grateful to Lord Patel for his valuable contribution and support, particularly during the early months of the Commission's work.

The Bingham Centre for the Rule of Law is the Secretariat for the Commission, and has assisted the Commission with research, drafting and project management. Within the Bingham Centre, Katie Lines has led on conducting research, advising commissioners and drafting the final report, with support and supervision from Lucy Moxham. Research assistance has been provided by Qabas Al-Musawi and Ananya Jain, and administrative assistance by Rachael Beaumont.

ABOUT THE BINGHAM CENTRE FOR THE RULE OF LAW

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EXECUTIVE SUMMARY

The Independent Commission on UK Public Health Emergency Powers reviewed emergency public health laws and parliamentary procedures in the four UK nations. We considered how far these laws and procedures could be enhanced so as to better protect the rule of law and promote accountability, transparency and parliamentary control of executive action. We also undertook comparative research; reviewing public health emergency powers in ten foreign jurisdictions chosen because of their similarities to the UK's parliamentary system and the efficacy of their legal responses to Covid-19. Throughout our inquiry we kept foremost in our minds the need for governments to act quickly in an emergency to secure timely and effective public health outcomes.

After explaining the genesis and work of the Commission in **Chapter One**, **Chapter Two** considers the laws that empower the UK and devolved governments to respond to public health emergencies. We find that the principal legal basis for any response to a public health emergency should be framework [primary legislation](#) which has been designed and enacted outside an emergency period. This legislation should: empower governments to respond to a variety of potential public health threats including by [statutory instrument](#); provide for appropriate democratic oversight and accountability of emergency law-making; and help maintain other principles of the rule of law and good governance. We recognise that a pre-designed framework may need to be supplemented during an emergency by additional primary legislation to address unforeseen or unpredictable contingencies.

After reviewing existing framework legislation in the UK, we consider, but reject, suggestions that an entirely new public health Act might be introduced, and that the Civil Contingencies Act 2004 would generally be a suitable legislative tool for responding to public health emergencies. We conclude that the powers available to ministers in England and Wales in Part 2A of the Public Health (Control of Disease) Act 1984, and equivalent powers available to Scottish ministers in Parts 5A and 7 of the recently amended Public Health etc. (Scotland) Act 2008, provide a useful starting point as framework legislation designed to empower governments to respond to a variety of public health threats. These provisions could be adopted as a model for Northern Ireland's anticipated new public health Bill, which would ensure a largely consistent legal framework applies across the UK. Nonetheless, we have significant concerns around the extent to which the Public Health (Control of Disease) Act 1984 and the Public Health etc. (Scotland) Act 2008 provide for appropriate parliamentary scrutiny and oversight of government law-making, and safeguard human rights and equality considerations in an emergency.

We propose amendments to address these concerns in **Chapter Three**. During Covid-19, significant impediments to parliamentary scrutiny flowed from, or were exacerbated by, the reliance of governments in all four UK nations on the [made affirmative procedure](#) for parliamentary scrutiny of coronavirus regulations. The made affirmative procedure can be used in cases of urgency and enables [regulations](#) to be made and come into force before the legislature has sight of them, which limits opportunities for parliamentary scrutiny of government law-making and reduces the political salience of oversight when it eventually occurs. We consider that using an "urgency" test to determine the appropriate scrutiny of statutory instruments made in response to a public health threat is sensible. However, there are insufficient safeguards in the Public Health (Control of Disease) Act 1984 and the Public Health etc. (Scotland) Act 2008 to restrict use of the made affirmative procedure to truly urgent situations, especially as there is no clear mechanism to bring to an end the emergency period during which resort to an urgent law-making procedure is appropriate. We consider that this needs attention: ministers should be able to use the urgent made affirmative procedure only when a declaration of an urgent health situation is in effect.

We consider that changes should also be made to the procedure for making a made affirmative instrument in response to a public health emergency. We make recommendations to ensure that the decision as to whether circumstances justify the use of the procedure is not purely a matter of a minister's subjective judgement. We also suggest further changes to enhance the information the government is required to provide the legislature on the impact of made affirmative instruments, to improve the promptness of parliamentary scrutiny, and to subject made affirmative instruments to a two-month sunset.

Emergency public health interventions may still need to be imposed outside of an acute crisis period which necessitates urgent law-making, but could be made at a slower pace with greater parliamentary oversight and accountability through the use of the [draft affirmative procedure](#) for parliamentary scrutiny - whereby active parliamentary approval of a statutory instrument is required in advance of it being made and coming into force. We consider the merits of introducing an expedited draft affirmative procedure for public health emergencies. We also suggest limiting the duration of draft affirmative public health instruments to six months and enhancing the information the government is required to provide the legislature on the impact of these instruments.

We also review the [made negative parliamentary scrutiny procedure](#), under which a statutory instrument does not require active approval by the legislature: it comes into force and remains law unless the legislature rejects it within a specified period. This is the weakest form of parliamentary scrutiny. One key difference between Part 2A of the Public Health (Control of Disease) Act 1984 and the comparable provisions in Parts 5A and 7 of the Public Health etc. (Scotland) Act 2008 is in the availability of the made negative procedure. Under the Public Health (Control of Disease) Act 1984, the made negative procedure is the default parliamentary scrutiny procedure for international travel regulations and can be used for some domestic health protection regulations. In contrast, the Public Health etc. (Scotland) Act 2008 does not permit the negative procedure to be used for either type of regulations.

We do not see the logic behind this difference in approach within different parts of the UK, nor in the negative procedure being the default parliamentary scrutiny procedure for international travel regulations in England and Wales, no matter how intrusive they may be. We discuss three alternative options: bringing all nations in line with Scotland by removing the negative procedure as an option; restricting use of the negative procedure to public health instruments which do not have a significant effect on a person's rights; or introducing a parliamentary sifting committee to review proposed negative instruments and consider whether specified criteria governing their use have been met.

We end Chapter Three by considering human rights and equalities. We received evidence about instances in all four nations where human rights and equality considerations appear not to have been properly taken into account by decision-makers during the Covid-19 pandemic. We consider how best to increase the likelihood that governments will properly consider equalities and human rights at each stage of an emergency response. We focus on improving government consultation and engagement with affected groups and independent rights institutions, and also discuss whether advice provided by the Scientific Advisory Group on Emergencies ("SAGE") could be supplemented by advice on equalities and human rights issues from a group of independent experts.

Chapter Four focuses on primary legislation enacted during a public health emergency in order to respond to the health threat. During the Covid-19 pandemic, [emergency-responsive](#) statutes were enacted by both the UK and Scottish governments, in the form of the Coronavirus Act 2020, the Coronavirus (Scotland) Act 2020, and the Coronavirus (Scotland) (No.2) Act 2020. On the basis of that experience, we note the likelihood that parliamentary scrutiny will be limited, especially when legislation is extremely fast-tracked, and discuss ways in which parliamentary oversight of emergency-responsive primary legislation might be enhanced. These include improved use of [sunset clauses](#); an enhanced requirement for ministers to report to the legislature regularly on the emergency measures; stakeholder consultation and engagement on measures planned in advance of an emergency; and publication of any draft emergency-responsive Bill designed in anticipation of a future public health threat.

Chapter Five explores how parliamentary procedures can best be adapted so that legislatures can provide appropriate oversight of an emergency response. We focus on three topics: (1) making parliamentary committees more effective by appointing a specialist committee to oversee the response to a public health emergency; (2) ensuring that adaptations to parliamentary procedure are made in consultation with members of the legislature from across political parties, and are not abandoned too swiftly following the end of an emergency period; and (3) improving parliamentary involvement in government contingency planning, including inter-parliamentary dialogue and cooperation.

Chapter Six assesses the impact of a public health emergency on legal certainty. Legal certainty is a key aspect of the rule of law. In order for people to understand what the law requires them to do, legal rules must be sufficiently clear, stable and accessible, and should enable people to foresee with reasonable confidence when they might be sanctioned for not following the law. We focus on three main areas of legal uncertainty that arose during the Covid-19 pandemic: (1) uncertainty caused by the manner of making and frequently amending large numbers of public health regulations; (2) uncertainty caused by the way legal requirements and public health advice were communicated by government, often without clearly distinguishing between the two; and (3) uncertainty resulting from differences between the responses to Covid-19 in the four UK nations. We suggest ways of ameliorating these problems.

Chapter Seven considers the creation and enforcement of criminal offences during a public health emergency. We begin by reviewing whether public health restrictions should be underpinned by criminal sanctions as a matter of principle. We then consider enforcement mechanisms used during the Covid-19 pandemic. We are particularly concerned, from the perspective of the rule of law, about the way in which [fixed penalty notices](#) (“FPNs”) worked as a tool for enforcing coronavirus restrictions, including the complexity of offences for which FPNs were issued, the high monetary penalty for some offences, and the absence of a formal appeal mechanism. We are also concerned about the proportionality of enforcement of restrictions on people’s protest rights. We make recommendations for improving these matters in future public health emergencies.

LIST OF RECOMMENDATIONS

Emergency public health legislation in the United Kingdom

(1): The UK and devolved governments should maintain a standing legal framework for responding to public health emergencies that is adopted outside of any emergency period, and which empowers ministers to respond to a variety of potential public health threats. Governments should also be prepared to supplement this legal framework with additional emergency-responsive primary legislation once an emergency occurs. ([Paragraph 20](#))

(2): Part 2A of the Public Health (Control of Disease) Act 1984, and Parts 5A and 7 of the Public Health etc. (Scotland) Act 2008, provide a useful starting point as framework legislation which grants emergency regulation-making powers to government. The framework in these Acts could be adopted as a model for Northern Ireland’s anticipated new public health Bill. ([Paragraph 60](#))

Proposed amendments to the general framework in Part 2A of the Public Health (Control of Disease) Act 1984 and Parts 5A and 7 of the Public Health etc. (Scotland) Act 2008

(3): A provision enabling ministers to declare “an urgent health situation” should be introduced to Part 2A of the Public Health (Control of Disease) Act 1984 and Parts 5A and 7 of the Public Health etc. (Scotland) Act 2008. The use of the urgent made affirmative procedure to make public health regulations without prior parliamentary scrutiny should be restricted to situations when the declaration of an urgent health situation is in effect ([Paragraphs 107, 111 and 115](#)). The declaration procedure should be as follows:

(a) The condition for making a declaration should be that, after consulting the Chief Medical Officer in their jurisdiction, the minister considers that an infectious disease or contaminant constitutes, or may constitute, a danger to human health, and it is necessary to make regulations on an urgent basis in order to protect against that danger. The declaration must be revoked if those conditions are no longer satisfied. ([Paragraph 116](#))

(b) The declaration should be laid in draft before the relevant legislature before being made, and be subject to a debate and confirmation vote. If the minister considers that it is not practicable for the declaration to be approved by the legislature in advance, retrospective approval should be required within 14 days. ([Paragraph 117](#))

(c) The legislature should be recalled if a public health declaration is made during a period of parliamentary prorogation or adjournment, and the declaration would otherwise be approved more than 21 days after it was made. If circumstances make recall impracticable then the Speaker/Presiding Officer should have discretion to instruct the recall to take place virtually rather than in person, or in extremis for the recall requirement to be set aside, following consultation with the leaders of all the political parties represented in the Chamber. ([Paragraph 118](#))

(d) Any advice provided by the Chief Medical Officer should be made available to the legislature. ([Paragraph 120](#))

(e) The declaration should be subject to a two-month sunset period that can only be renewed following a parliamentary debate and vote on a motion to extend the declaration. ([Paragraph 121](#))

(f) Before any parliamentary debate and vote on an approval or extension motion, the minister should be required to lay a report outlining the justification for the declaration, having regard to (i) the public health advice received, (ii) the nature of the risks being faced, (iii) plans being drawn up to deal with the emergency, and (iv) the need to show respect for human rights, the principle of proportionality, and the special interests of vulnerable persons. ([Paragraph 125](#))

(4): The urgent made affirmative parliamentary scrutiny procedure in section 45R of the Public Health (Control of Disease) Act 1984 and section 122(6)-(13) Public Health etc. (Scotland) Act 2008 should be amended as follows:

(a) The minister should be required to take into account relevant advice provided by the Chief Medical Officer when determining whether regulations need to be made urgently, and to lay a written statement before the legislature explaining why it is considered that the regulations need to be made urgently with reference, if applicable, to this advice. ([Paragraphs 127-129](#))

(b) The maximum time between the making of made affirmative regulations and their affirmative scrutiny in the legislature should be reduced from 28 to 14 days. The four UK legislatures should review their procedures to provide for the implementation of this recommendation, making the necessary changes to Standing Orders. ([Paragraph 137](#))

(c) The legislature should be recalled to debate regulations that are laid using the made affirmative procedure during a period of parliamentary prorogation or adjournment, if such regulations would otherwise be approved more than 21 days after they were made. If circumstances make recall impracticable then the Speaker/Presiding Officer should have discretion to instruct the recall to take place virtually rather than in person, or in extremis for the recall requirement to be set aside, following consultation with the leaders of all the political parties represented in the Chamber. ([Paragraph 140](#))

(d) Any regulations made using the made affirmative procedure should expire after two months. ([Paragraph 143](#))

(e) As a matter of best practice, governments should set out the anticipated impact of regulations made using the made affirmative procedure before any parliamentary approval debate takes place. Where this is not possible, if any provision within the made affirmative regulations is to be continued in substantially the same form beyond the original two month sunset period, then an impact evaluation should be provided to the legislature in advance of the subsequent approval debate. ([Paragraph 151](#))

(5): The draft affirmative parliamentary scrutiny procedure in section 45Q(2) and (4) of the Public Health (Control of Disease) Act 1984 and section 122(5) of the Public Health etc. (Scotland) Act 2008 – whereby active parliamentary approval of a statutory instrument is required in advance of it being made and coming into force – should be amended as follows, in respect of regulations made under section 45C(1) of the Public Health (Control of Disease) Act 1984 and sections 86A(1) and 94(1) of the Public Health etc. (Scotland) Act 2008:

(a) The four legislatures should be consulted on the minimum amount of time needed to ensure proper scrutiny of draft affirmative regulations, with a view to an expedited draft affirmative scrutiny procedure being developed for public health emergencies, without making scrutiny weaker than it would be under the made affirmative procedure. ([Paragraph 153](#))

(b) [Impact assessments](#) should be laid before the legislature in advance of the approval debate for draft affirmative regulations. ([Paragraph 154](#))

(c) Draft affirmative regulations should expire after six months. ([Paragraph 154](#))

(d) If any provision within the draft affirmative regulations is to be continued in substantially the same form beyond six months, an impact evaluation should be provided to the legislature in advance of the subsequent approval debate. ([Paragraph 154](#))

(6): Under section 45Q(1)-(3) of the Public Health (Control of Disease) Act 1984, the made negative parliamentary scrutiny procedure – whereby a statutory instrument does not require active approval by the legislature – applies to international travel regulations and can also be used for some domestic health protection regulations. In contrast, the Public Health etc. (Scotland) Act 2008 does not permit the negative procedure to be used for either type of regulations. We suggest three ways of addressing this anomaly, none of which we feel able to recommend fully: bringing all nations in line with Scotland by removing the negative procedure as an option; restricting the use of the negative procedure to public health regulations which do not have a significant effect on a person’s rights; or introducing a parliamentary sifting committee to review proposed negative public health regulations and consider whether the criteria governing their use have been met. ([Paragraphs 159-166](#))

(7): If the negative procedure continues to be available for international travel regulations and some domestic health protection regulations under Part 2A of the Public Health (Control of Disease) Act 1984, then an impact assessment should be laid before the legislature alongside such negative regulations, and the regulations should expire after six months. If any provision within the made negative regulations is to be continued in substantially the same form beyond those six months, an impact evaluation should be provided to the legislature. ([Paragraph 167](#))

(8): The proposals of the Hansard Society’s [review](#) of the delegated legislation system at Westminster, as to whether the UK Parliament should be empowered to amend statutory instruments, should be given careful consideration when they are published. ([Paragraph 171](#))

(9): Planning for future public health emergencies should identify points when certain groups should be consulted in a proactive, participatory manner to help embed human rights and equality considerations in policy-making. In the event of a public health emergency, the task of ensuring that certain groups are consulted as part of the legislative drafting process should be assigned to a particular member of the team in charge of developing policy and drafting the legislation. ([Paragraph 181](#))

(10): Ministers should have a statutory duty to have regard to any relevant advice produced by National Human Rights Institutions in their jurisdiction when making or continuing a declaration of an urgent health situation and when laying or continuing public health regulations. This duty might also usefully be extended to other independent rights institutions that represent groups likely to be affected by public health interventions, such as the Children’s Commissioners. ([Paragraphs 182-183](#))

(11): When responding to a public health emergency, governments should convene or recognise a group whose function is to provide independent expert advice on human rights and equality issues arising from potential or existing public health interventions. Such advice should be considered alongside the scientific advice provided by the Scientific Advisory Group for Emergencies and analogous bodies in the devolved governments. ([Paragraph 184](#))

Emergency-responsive primary legislation

(12): Emergency-responsive primary legislation should be subject to a sunset period of no longer than 9-12 months. That duration should not be extendable by statutory instrument. If it is necessary for provisions within the emergency-responsive Act to continue beyond this period, new primary legislation should be used to introduce a new Bill, carrying over such provisions as are still appropriate but providing opportunities to amend them and introduce new provisions. ([Paragraph 215](#))

(13): Legislatures should be provided with two-monthly reports on the functioning of emergency-responsive primary legislation, with reference to evaluative criteria such as the continued need for and impact of the emergency measures. ([Paragraphs 225-226](#))

(14): If a draft Bill is designed in anticipation of a public health emergency with a view to its being revised and enacted as responsive legislation, then it should be drafted only after the widest practicable stakeholder consultation and engagement. The draft Bill should then be published and subject to pre-legislative scrutiny, and kept under periodic review (at least once per Parliament). ([Paragraph 229](#))

Parliamentary procedures

(15): In future public health emergencies, the UK and Scottish Parliaments should establish a specialist emergency committee similar to the Covid-19 Committee established by the Scottish Parliament ([Paragraph 243](#)). It seems probable that such a committee would also have value in the Northern Ireland Assembly and Welsh Parliament, but we have not received sufficient evidence on this point to be able to recommend it with confidence ([Paragraph 244](#)). The specialist committee should:

(a) Review government policy, while the technical scrutiny of statutory instruments should continue to be carried out by the existing designated committees in this area. ([Paragraph 245](#))

(b) Be chaired by a member of the largest opposition party, and its membership include senior parliamentarians, including some nominated by other relevant select committees. ([Paragraph 246](#))

(c) Consider the practices of the Scottish Parliament's Covid-19 Committee as a model. ([Paragraph 247](#))

(d) Have expert advisors to help it understand the science surrounding the public health threat. ([Paragraph 251](#))

(16): If a public health emergency necessitates the introduction of special arrangements in legislatures, such as virtual proceedings or hybrid working, decisions about those provisions should be made in consultation with Members from across all political parties, via the relevant procedure committee of each legislature, with the aim of achieving cross-party support. Special parliamentary provisions developed during emergencies, such as the introduction of hybrid ways of working, should not be abandoned too swiftly following the end of the emergency period, without first considering whether they may have lasting value in facilitating greater participation by all Members. ([Paragraph 256](#))

(17): In addition to their own contingency planning for public health emergencies, the legislatures should be involved in government planning exercises (e.g. any successors to Exercise Cygnus). We would encourage contingency planning to involve inter-parliamentary dialogue and cooperation. We also recommend that all four legislatures consider how inter-parliamentary dialogue and cooperation could be pursued to beneficial effect once a public health emergency occurs. ([Paragraphs 257 to 260](#))

Legal certainty

(18): Emergency public health laws should be kept as simple as possible. In principle, emergency regulations could be simplified by using standardised sets of restrictions for different levels of public health risk. ([Paragraph 266](#))

(19): Legal certainty would be improved in future public health emergencies if less [secondary legislation](#) was made. Policy makers should be conscious of the potential negative impacts of producing large quantities of regulations that change very frequently, and should have regard to these impacts when deciding whether to change legal measures that are already in place. Last minute policy changes should be avoided as far as possible. ([Paragraphs 269 and 273](#))

(20): The legal teams of the four UK administrations should consider whether the checking process for both the content and legal drafting of emergency regulations would benefit from review with the aim of finding a more effective and efficient method when dealing with legislation at speed. ([Paragraph 274](#))

(21): If a public health emergency lasts longer than six months, then legislation should be thoroughly consolidated at least in the sixth month and every three months thereafter. By this we mean that the various laws implementing public health interventions should be reviewed and, if necessary, combined and redrafted in a manner that prioritises clarity and coherence. ([Paragraph 278](#))

(22): The titles of emergency public health regulations should make clear their content in at least broad-brush terms. All legislation relevant to the emergency should use the designated keyword, for example “coronavirus” or “foot and mouth disease”, consistently in every title. Governments should also identify in advance how emergency public health regulations can be sensibly titled on a regional, local or tiered basis. All drafting lawyers should have access to that information to ensure a uniform approach. ([Paragraph 280](#))

(23): When emergency public health regulations are introduced which amend an earlier set of regulations, a document should be produced which shows the original set of regulations and highlights in a reader-friendly fashion the changes made by the amending regulations, similar to a “track changes” version of a Microsoft Word document. ([Paragraph 283](#))

(24): While it may not be possible to produce high quality explanatory memoranda at the start of an emergency, governments should ensure this type of supporting material is produced as soon as possible. ([Paragraph 285](#))

(25): Unless there is a particularly acute and urgent public health reason for proceeding without any delay, regulations should be published at least two days before they come into force. In addition, where laws come into force at the same time, or within three days, of their being published, then this should be taken into account in any enforcement action considered. ([Paragraphs 288 to 289](#))

(26): Government guidance and other public messaging should clearly explain the rationale behind public health restrictions to make it easier for people to understand the actions they are being asked to take. ([Paragraph 290](#))

(27): Governments should provide one central dashboard, updated daily, that sets out in a searchable format (including by geographical area) all the guidance, public health advice and legislation that is currently in force and its date of sunseting. Any legislation that has been subject to amendments should appear on this dashboard in consolidated form. An App containing this information should be available for mobile devices. ([Paragraph 292](#))

(28): Governments should explore building a traffic light, or alert level, system of communication into their contingency planning for future public health emergencies. ([Paragraph 293](#))

(29): Governments should consider as an integral part of policy planning which public health interventions should be given a legal basis, which should only take the form of public health advice, and how that distinction can best be communicated. ([Paragraph 301](#))

(30): We endorse the following five suggestions made by the House of Lords Constitution Committee during the Covid-19 pandemic:

(a) Guidance should clearly distinguish information about the law from public health advice. It should not suggest that instructions are based on law when they are not. We note that guidance produced in other contexts (e.g. the Highway Code) clearly distinguishes between parts that are mandatory and those that are not, and could be used as a model.

(b) Where guidance provides information about the law, this should be accurate and complete. Where the law is too complex to be set out in full, guidance should make clear that the account is partial.

(c) All relevant legal instruments should be identified wherever legal requirements are referred to in guidance, accompanied by up-to-date hyperlinks to the underlying regulations on the relevant government website.

(d) Guidance should make clear when opinions are being offered about the interpretation of the law, including a clear statement of the source and status of such opinions.

(e) A consistent approach to use of the terms “advice”, “guidance”, “recommendation”, “rules” and “restrictions” should be adopted in all government publications and public statements, in each case making clear whether the term is referring to obligations required by law, or to public health advice. ([Paragraph 302](#))

(31): If governments issue guidance that is relevant to the interpretation of emergency public health legislation, or how it should be applied by enforcement bodies, such guidance should ideally have an express statutory basis and in any event be laid before the legislature when made and amended. Definitions that affect the scope or application of the law should always be in the legislation itself. ([Paragraph 303](#))

(32): Where time allows, professional bodies representing frontline workers, such as the police and public health officials, should develop implementation guidance in collaboration with lawyers. If it is not possible for collaboration to happen in advance of implementation guidance being produced, then small and nimble working groups should be set up to review the guidance, with representatives from the relevant professional bodies. ([Paragraph 304](#))

(33): Collaboration and consistency between the four nations should be encouraged, unless different approaches are necessitated on the grounds of public health. There should be mechanisms for facilitating collaboration not just between ministers from the four nations, but also civil servants and senior public health professionals. ([Paragraph 307](#))

Enforcement

(34): In deciding whether emergency public health measures should be underpinned by criminal law, a careful judgement should be made taking into account the threat level, what the public are being asked to do, and what the public sentiment is around compliance and enforcement. The necessity of enforcement and the means by which it is done should continue to be monitored over the course of the emergency response. ([Paragraph 312](#))

(35): Governments should consider whether a formal warning system could be a first-stage alternative to the use of Fixed Penalty Notices (“FPNs”) as an enforcement tool for emergency public health restrictions. ([Paragraph 337](#))

(36): The feasibility of Environmental Health Officers playing a greater role in enforcement of emergency public health restrictions should be explored further by central government and local authorities. ([Paragraph 339](#))

(37): Government contingency planning should involve working with public health officials and the representational bodies of police forces to develop training on the enforcement of public health restrictions. The production of codes of practice for different public health emergencies could form part of this work. ([Paragraph 341](#))

(38): To aid police decision-making during an emergency, governments should ensure that police forces are clearly informed of the wider objectives underpinning public health restrictions, and are given sufficient data to help them assess public health risks in their local area via the well-established multi agency response systems. The principles governing the acceptable sharing of data in a public health emergency need to be clearly outlined and rehearsed during emergency planning exercises. (Paragraphs [342](#) and [344](#))

(39): Where at all possible, governments in future public health emergencies should consult on draft restrictions with the professional bodies representing police forces. ([Paragraph 347](#))

(40): FPNs are ordinarily only appropriate enforcement tools where the level of penalty is low, and they should not be used to impose penalties that exceed a few hundred pounds. If, exceptionally, clear evidence shows that breaches of certain restrictions should attract a higher level penalty in order to manage the public health risk, then those higher level FPNs should be rare, proportionate to the level of risk, and authorised by a senior officer. ([Paragraph 350](#))

(41): Contingency planning for future health emergencies should facilitate a formal mechanism whereby individuals who believe they have been wrongly issued with an FPN for breaching public health restrictions can make representations to the issuing police force. The FPN should be reviewed by a more senior officer who was not involved in issuing it and who has access to legal advice. ([Paragraph 352](#))

(42): In future public health emergencies, carefully considered national guidelines should be produced on the control of protests and certain other sensitive areas that involve human rights and equalities considerations, such as any restriction of online disinformation, and responses to domestic violence and racially sensitive areas of policing. ([Paragraph 358](#))

(43): Governments and policing bodies should explore whether high-level training on fundamental human rights principles might help police officers to understand better the human rights landscape when faced with a novel situation like a public health emergency. As part of contingency planning for future public health emergencies, governments and policing bodies should also consider establishing at the start of an emergency an independent advisor or advisory group on human rights and policing. ([Paragraphs 359-360](#))

(44): Any criminal offence or enforcement power created by legislation in response to a public health threat should explicitly specify that (as a minimum) the rights protected by the European Convention on Human Rights would provide a defence against enforcement or conviction. ([Paragraph 361](#))



CHAPTER ONE:

Introduction to the Commission

1. The Covid-19 pandemic presented the most significant and challenging public health emergency the United Kingdom (“UK”) has faced in generations. As the scale of the emergency became clear, governments in all four nations sought to rely on legislation that would grant them powers to impose wide-scale public health interventions in order to slow the spread of the virus and mitigate the consequences of infection. Some of the legislation used was novel – enacted for the first time in response to Covid-19 – but much of the response relied upon pre-existing laws that had been drafted years prior in anticipation of a future public health emergency.¹
2. Now that the emergency period has drawn to a close, with the World Health Organisation (“WHO”) declaring an end to the public health emergency of international concern for Covid-19 in May 2023, it is important to reflect upon the pandemic to help us better prepare for future public health emergencies. The UK and Scottish Covid-19 Inquiries, chaired respectively by Baroness Hallett and Lord Brailsford, are undertaking extensive reviews of the UK and Scottish responses to the pandemic and the lasting impacts of that period. The Independent Commission on UK Public Health Emergency Powers was launched on 13th October 2022. It is an independent body that operates separately from the UK and Scottish Covid-19 Inquiries, with the goal of informing both these Inquiries and government planning for future public health emergencies.
3. Since our launch, we have reviewed emergency public health laws and parliamentary procedures in the four UK nations. We have considered how far these laws and procedures could be enhanced so as to better protect the rule of law and promote accountability, transparency and parliamentary control of executive action. Our work has been future-facing: we have sought to learn from the UK and international legal responses to the Covid-19 pandemic in order to make recommendations that would improve the constitutional dimensions of the UK’s response to a future health emergency. As we have discussed these issues, we have kept foremost in our minds the need for governments to act quickly in an emergency to secure timely and effective public health outcomes.
4. Our Terms of Reference set out the following aims, scope and method for our work:

1. Aims

The Commission will:

- Review the legislative powers available for use in a public health emergency, and associated procedural safeguards;
- Consider how emergency legislation was made, used, disseminated and enforced during the Covid-19 pandemic;
- Assess how far current legal frameworks and parliamentary procedures protect the rule of law and human rights, and promote accountability, transparency and parliamentary control of executive action;
- Explore these issues in the context of securing timely and effective public health outcomes; and
- Make recommendations for changes in law, policy, practice and procedure in time to inform the UK and Scottish Covid-19 Public Inquiries.

¹ Primarily Part 2A of the Public Health (Control of Disease) Act 1984, which has force in England and Wales, and Part 7 of the Public Health etc. (Scotland) Act 2008. In Northern Ireland and Scotland, the response also relied upon regulation-making powers nearly identical to those in Part 2A of the Public Health (Control of Disease) Act 1984, which were imported into public health law in Northern Ireland and Scotland via Schedules 18 and 19 of the Coronavirus Act 2020.

2. Scope

2.1 The issues examined by the Commission will include:

- The legislative framework that enables the government to adopt emergency powers during a public health crisis;
- The primary and secondary legislation that was used and created in response to the Covid-19 pandemic, including the clarity and accessibility of that legislation, and the process of parliamentary scrutiny of that legislation;
- The consideration of safeguards to ensure that the formulation, exercise and enforcement of emergency public health powers is consistent with human rights law;
- The interplay between reserved and devolved powers for dealing with public health emergencies;
- How government decision-making during the pandemic was communicated to Parliament, including the transparency of the evidence and advice relied upon by the government;
- The extent to which government messaging distinguished between binding law and non-binding public health advice;
- The extent to which the concerns and interests of different groups, in particular marginalised and disadvantaged groups, were taken into account in the formulation and review of emergency powers; and
- The formulation, review and exercise of emergency public health powers during the pandemic in selected jurisdictions outside the UK.

3. Method

3.1 The Commission will:

- Consider relevant, publicly available information, including for example published research and parliamentary committee reports;
- Invite stakeholders to give written and/or oral evidence; and
- Publish its findings, conclusions and recommendations in a final report.

5. These Terms of Reference were drafted following discussions with the UK and Scottish Covid-19 Inquiry teams, to ensure that our review complemented and did not duplicate their work. We have worked to a tight time frame to ensure that our final report can be published in good time to feed into both Inquiries' deliberations. We have therefore had to be selective in the topics we have reviewed. This means that we have excluded from our scope some topics that we consider to be important, such as the role of the courts and judicial review in public health emergencies. We have also had to limit the extent to which we have explored other topics that are included within our inquiry, and in some cases we have suggested options to be considered further by bodies with more resources and time.
6. We approached our review by dividing the Commission into three smaller working groups. The first working group considered public health emergency powers in jurisdictions outside the UK, mostly focussing on ten countries: Australia, Belgium, Canada, France, Germany, Ireland, Israel, Italy, New Zealand, and Norway. These countries were chosen because of their similarities to the UK parliamentary system, the efficacy of their legal response from a rule of law perspective, and qualitative assessments of relevance to the scope of our review.

7. The second working group focussed on public health emergency legislation in the UK, looking at both framework legislation designed to address a range of public health threats and laws that were enacted specifically in response to the Covid-19 pandemic. This work included considering how far human rights and equalities are safeguarded and reviewing the criminal enforcement of emergency public health laws. The third working group reviewed parliamentary procedures in the UK, Scottish and Welsh Parliaments and the Northern Ireland Assembly. It considered how far these legislatures were able to provide appropriate scrutiny and oversight of law-making during the Covid-19 pandemic, and looked at adaptations of parliamentary procedures to facilitate continued operation during a public health emergency.
8. In February 2022, we sent a call for evidence to over 200 stakeholders across the UK, including parliamentarians, government officials, public health practitioners, professional bodies, and academics. We received 34 responses which we have reviewed and referenced in this report where relevant. We decided not to issue a public call for evidence due to the specialised scope of our inquiry, the tight time frame within which we have operated, the limited capacity of the small Bingham Centre research team, and the fact that the UK and Scottish Covid-19 Inquiries are offering the opportunity for members of the public to share their experiences and stories.
9. Our first oral evidence sessions were held in February 2022, when we heard from 14 individuals with expertise in the ten foreign jurisdictions upon which our international comparative work is based. We then heard from 19 witnesses in the UK with experience and expertise in domestic law-making, governments, parliaments, public health, policing and human rights. We also received a small number of additional written responses from individuals who were unable to give oral evidence, or who sent us additional material following oral evidence sessions.
10. In seeking written and oral evidence, we kept in mind the need to achieve geographical and political balance. We therefore approached a wide range of individuals and groups in all four nations, encompassing a variety of political views and affiliations. We considered it important for our inquiry to take a UK-wide focus. However, for some topics we received less evidence concerning Northern Ireland, Scotland and Wales than we did in relation to the UK government and Parliament. Therefore, at some points in the report the consideration of the devolved jurisdictions is based primarily on desk-based research and the expertise of our commissioners. We have made it clear when this is the case.
11. As we began to reach preliminary findings, we had useful discussions with senior officials working on public health matters within the UK Department of Health; the Northern Ireland Department of Health; the Welsh government; and the Scottish Directorates for Population Health and Health and Social Care. We also received helpful comments on our draft recommendations from individuals across the UK's governments, legislatures, and public health bodies, including former and current ministers. We have listed at the end of this report all those individuals who provided us with comments or evidence that has been cited in this report. We are very grateful to all who gave us their evidence, comments and advice.
12. Finally, several of our commissioners have already published their own work within areas covered by the Independent Commission's mandate. Some of this work is referenced within this report, and we have made it clear when that is the case.

CHAPTER TWO:

Emergency Public Health Legislation in the United Kingdom

Introduction

13. In this and the following two Chapters we consider the laws that empower the UK and devolved governments to respond to public health emergencies. To help frame our review, we have kept in mind a set of four guiding principles to which we believe all such legislation should adhere. We have drawn these principles from evidence we received and our discussions as a Commission. They are that legislation designed to respond to a public health emergency should:
- a) Enable the UK and devolved governments to take urgent action to respond to a public health threat, including taking precautionary measures.
 - b) Ensure an appropriate role for the UK and devolved legislatures in providing oversight and accountability over emergency law-making and claims of urgency.
 - c) Ensure the maintenance of the rule of law and principles of good governance including transparency, participation, proportionality and accountability; and foresee the strains that will be put on those processes in an emergency.
 - d) Respect the constitutional law, conventions and principles relating to the role of devolved governance under the UK constitutional framework.

Emergency public health powers and devolution

Under the UK's system of devolved government, powers that are not specifically reserved to the UK Parliament and government in Westminster are devolved or delegated to the legislatures and governments in Northern Ireland, Scotland and Wales.² Under this model, the UK government and Parliament make decisions on reserved matters³ which have effect throughout the whole of the UK, while the devolved jurisdictions have competence over devolved matters. If the UK Parliament wishes to legislate on a matter within devolved competence, there is an established constitutional convention that it will not normally do so without seeking the consent of the relevant devolved legislature (the "Sewel Convention").

The powers that may be used in a public health emergency cover both reserved and devolved matters. "Emergency powers" are a reserved matter, as is air transport and immigration.⁴ Policing and justice are reserved under the Welsh legislation, but are devolved matters in Northern Ireland and Scotland. Core public services such as health and education are mostly devolved to the relevant institutions in Northern Ireland, Scotland and Wales. Some devolved policy areas relevant to public health emergencies, such as health, may overlap with reserved policy areas, such as UK border control. Without sufficient inter-governmental cooperation, this could lead to the policy content of laws made by the devolved jurisdictions differing from or not sitting well with laws designed to address the same issues made by the UK Parliament and government.

14. A number of laws empower the UK and/or the devolved governments to respond to a variety of potential public health emergencies. They include, for example, the Public Health (Control of Disease) Act 1984 and the Public Health etc. (Scotland) Act 2008. Throughout this report

² England does not have a devolved Parliament, and the UK Parliament at Westminster is ultimately responsible for making policy decisions for England

³ And excepted matters in the case of Northern Ireland

⁴ For full lists of reserved matters see Scotland Act 1998, Schedule 5; Northern Ireland Act 1998, Schedules 2 & 3 and Government of Wales Act 2006, Schedule 7A

we refer to this type of [primary legislation](#) as “framework legislation”. When responding to the Covid-19 pandemic, the UK administrations relied upon some existing framework legislation, but also enacted new primary legislation during the emergency to address the specific threat posed by coronavirus – for example, the Coronavirus Act 2020 and the Coronavirus (Scotland) Act 2020. We refer to this latter type of primary legislation as “emergency-responsive legislation”.

15. We began our inquiry by considering whether, from a rule of law and good governance perspective, the UK took the right approach in using a combination of pre-existing framework legislation and emergency-responsive primary legislation to address the public health threat posed by Covid-19. We reviewed the approach taken in other countries and discussed this point with public health professionals and legislative drafters. We start this Chapter by outlining the evidence we received, before concluding that the principal legal basis for any response to a public health emergency should be framework legislation which has been designed and enacted outside of an emergency period, and which can be supplemented by emergency-responsive primary legislation if necessary.

Pre-existing framework legislation, emergency-responsive primary legislation, or a mixture of both?

16. There are some clear benefits of using pre-existing framework legislation as the principal basis of any response to a public health emergency, rather than new primary legislation introduced during the emergency. Designing legislation in advance of an emergency allows sufficient time for policy development, public consultation and engagement with relevant groups and members of the public. It also enables the publication of a draft Bill that can be subject to pre-legislative scrutiny by parliamentary committees, and a final Bill to be laid before the legislature and subject to the normal parliamentary scrutiny and amendment process before being enacted. The resulting framework legislation can then be used to develop contingency plans, produce draft regulations and accompanying guidance, and to train those who will be at the forefront of the response to the emergency. All these mechanisms increase the likelihood that emergency legislation complies with our four guiding principles, and that the emergency response is as well planned as possible.
17. However, we recognise that it is difficult to foresee which specific interventions a future public health emergency might require. This problem was exemplified during Covid-19. When we reviewed the international context, we found that pre-existing framework legislation in some countries had been designed in light of the “last” public health emergency and was not best suited for the exigencies of Covid-19. For example, we heard evidence from Professors Hans Petter Graver⁵ and Eirik Holmøyvik⁶ that one of the key pieces of legislation used to tackle Covid-19 in Norway – the Infection Control Act 1994 – had been designed in response to the HIV and AIDS epidemic. As a result, its drafters had not envisaged the Act being used to impose the type of national measures that were used during Covid-19, such as restrictions on movement. We were informed that the Act therefore did not contain sufficient safeguards to ensure that decisions to impose national measures were taken at the appropriate level of government, as required by the Norwegian constitution.⁷

⁵ Professor of Law at the University of Oslo

⁶ Professor of International, Constitutional and Human Rights Law at the University of Bergen

⁷ For more information on the Norwegian response to the Covid-19 pandemic, see Eirik Holmøyvik, Benedikte Moltumyr Høgberg, and Christoffer Conrad Eriksen, ‘Norway: Legal Response to Covid-19’ in Jeff King and Octavio Ferraz (eds.), *The Oxford Compendium of National Legal Responses to Covid-19* (OUP 2021), accessible at <<https://oxcon.ouplaw.com/display/10.1093/law-occ19/law-occ19-e3>> accessed 1 February 2024. The Oxford Compendium was co-edited by one of our commissioners, Professor Jeff King

18. We also saw uncertainty in the UK at the start of the pandemic as to whether the framework legislation used to implement most nationwide restrictions in response to Covid-19 in England and Wales – the Public Health (Control of Disease) Act 1984⁸ – did in fact empower ministers to impose restrictions upon the population as a whole. There was sufficient uncertainty for numerous commentators, including one of our commissioners, to suggest that the Parliament which approved the relevant sections of the Public Health (Control of Disease) Act 1984 had not foreseen nor intended its use to impose national restrictions of the type relied upon during Covid-19.⁹ This debate was eventually settled legally when the Court of Appeal confirmed that the Act could be used to impose national restrictions, such as lockdowns, in *R (Dolan) v Secretary of State for Health and Social Care*.¹⁰
19. Therefore, in our early discussions we queried whether framework legislation could be adequately drafted to predict what powers might be needed to mount an effective public health response to an unknown future threat. We sought advice on this point from legislative drafters and public health professionals, all of whom expressed a preference for a legal framework to be designed in advance of a public health emergency, but which could be supplemented by emergency-responsive legislation if necessary. Sir Jonathan Jones, who was head of the UK Government Legal Department from 2014 until September 2020, and who spoke with us in a personal capacity, considered that many of the interventions that might be needed in a public health emergency are reasonably standard and predictable. This view was shared by senior public health professionals who provided us with oral evidence or comments on our draft recommendations. Professor Sir David Nabarro,¹¹ Dr Brian McCloskey,¹² Dr Fu-Meng Khaw¹³ and a public health consultant from the UK Health Security Agency all felt that it should be possible to pre-identify in general terms the spectrum of non-pharmaceutical interventions that may be required in a public health emergency. Professor Nabarro and Dr McCloskey informed us that there is a standard menu of interventions that public health practitioners regularly draw upon.¹⁴ Dr McCloskey also highlighted the public health benefits that flow from legislation being designed in advance of an emergency. For example, members of the public can be informed of the measures that may be taken in particular circumstances and be given opportunities to discuss their relevance and application in practice, which can help engender trust and compliance. However, Dr McCloskey also cautioned that it will never be possible completely to predict and predefine what might be needed in any specific emergency, and that interventions will likely need to be adapted in response to the particular public health risk at hand. For example, we may know that closing schools is a potential non-pharmaceutical intervention, but whether it will be used depends on the age at which children are affected by a specific public health threat. We note that all ten countries we reviewed felt it necessary to supplement or amend pre-existing framework legislation to address the Covid-19 pandemic.

⁸ As noted in n1, the Public Health (Control of Disease) Act 1984 was also the basis of near identical powers incorporated into public health law in Scotland and Northern Ireland, via Schedules 18 and 19 of the Coronavirus Act 2020

⁹ Our commissioner Tom Hickman KC argued that, in part because of this uncertainty, new primary legislation should have been enacted to set out a bespoke basis for the social distancing laws required to meet the coronavirus pandemic. See: Tom Hickman KC, 'Responding to the Covid-19 Crisis: The Case for Primary Legislation', (*Blackstone Chambers Blog*, 30 November 2020) <<https://coronavirus.blackstonechambers.com/responding-covid-19-crisis-case-primary-legislation/>> accessed 1 February 2024. Other commentators instead suggested that a different piece of pre-existing legislation – the Civil Contingencies Act 2004 – would have been the most suitable basis for the restrictions imposed during the Covid-19 pandemic. See, for example: Lord Sumption, 'Government by decree: Covid-19 and the Constitution' (*Cambridge Freshfields Annual Law Lecture 2020*, 27 October 2020) <https://resources.law.cam.ac.uk/privatelaw/Freshfields_Lecture_2020_Government_by_Decree.pdf> accessed 1 February 2024

¹⁰ [2020] EWCA Civ 1605. The Supreme Court affirmed this decision by refusing permission to appeal in *R (on the application of Dolan and others) (Appellants) v Secretary of State for Health and Social Care and another* UKSC 2020/0207

¹¹ Co-Director and Chair of Global Health at Imperial College London's Institute of Global Health Innovation and Special Envoy on Covid-19 for the World Health Organization. See written evidence from Professor Sir David Nabarro ([Appendix 10](#))

¹² Senior consulting fellow in the Global Health Programme at Chatham House and formerly Director of Global Health for Public Health England

¹³ National Director of Health Protection and Screening Services and Executive Medical Director at Public Health Wales

¹⁴ Written evidence from Professor Sir David Nabarro ([Appendix 10](#))

20. In light of this evidence, we consider that the principal legal basis for any response to a public health emergency should be framework primary legislation which has been designed and enacted outside of an emergency period, and which empowers governments to respond to a variety of potential public health threats. Designing and enacting legislation before a public health emergency occurs – rather than during an emergency period – helps maintain principles of the rule of law and good governance. Such framework legislation should contain a general menu of non-pharmaceutical interventions, and grant governments the power to implement and adapt these interventions in response to an emergency via [statutory instrument](#) (or “statutory rule” in Northern Ireland). However, we recognise that any legal framework designed in advance of a public health emergency may also need to be supplemented during the emergency period by additional, emergency-responsive primary legislation in order to address unforeseen or unpredictable aspects of the specific emergency at hand.

Recommendation 1: The UK and devolved governments should maintain a standing legal framework for responding to public health emergencies that is adopted outside of any emergency period, and which empowers ministers to respond to a variety of potential public health threats. Governments should also be prepared to supplement this legal framework with additional emergency-responsive primary legislation once an emergency occurs.

Framework legislation in the UK

21. There already exists a standing legal framework which empowers the governments of the four nations to respond to a wide variety of public health emergencies. It includes:
- The Civil Contingencies Act 2004.
 - The Public Health (Control of Disease) Act 1984.
 - The Public Health etc. (Scotland) Act 2008.
 - To a more limited extent, the Public Health Act (Northern Ireland) 1967.
22. Each of these Acts has a different geographic scope. The Civil Contingencies Act 2004 was enacted by the UK Parliament and empowers the UK government to make emergency regulations in respect of the whole of the United Kingdom, or any of its constituent parts. The other three Acts are more limited. The Public Health (Control of Disease) Act 1984 was passed by the UK Parliament and empowers the UK government and Welsh ministers to impose public health measures in England and Wales. The Public Health etc. (Scotland) Act 2008 and the Public Health Act (Northern Ireland) 1967 were enacted, respectively, by the Scottish and Northern Ireland legislatures, and empower the Scottish government and the Northern Ireland Department of Health to make public health regulations in relation to Scotland and Northern Ireland.
23. We summarise the relevant parts of each of these Acts below, before concluding that the Public Health (Control of Disease) Act 1984 and Public Health etc. (Scotland) Act 2008 provide the best template for use in a future public health emergency, subject to our proposed amendments.

The Public Health (Control of Disease) Act 1984

24. Part 2A of the Public Health (Control of Disease) Act 1984 (“the England and Wales Public Health Act”) contains a suite of health protection measures which apply in England and Wales. Sections 45B and 45C empower the UK government and Welsh ministers to make regulations to address public health risks to England and Wales respectively. These measures date from 2008, when the England and Wales Public Health Act was updated and modernised following the “SARS” outbreak so as to implement the International Health Regulations 2005 and their “all hazards” approach to dealing with public health threats.¹⁵
25. The regulation-making powers in the England and Wales Public Health Act were the template for the Covid-19 response across the whole of the UK. Most of the major restrictions imposed in England and Wales came from regulations made under sections 45B and 45C of the England and Wales Public Health Act. In Scotland, the Public Health etc. (Scotland) Act 2008 already contained equivalent regulation-making powers in relation to international travel.¹⁶ At the start of the pandemic, further powers were adapted from the England and Wales Public Health Act and imported temporarily into public health law in Northern Ireland and Scotland under schedules 18 and 19 of the UK Parliament’s Coronavirus Act 2020, meaning that the administrations in both these nations had access to the full suite of regulation-making powers that were available to UK and Welsh ministers under the England and Wales Public Health Act.¹⁷ This was necessary because the pre-existing public health laws in Northern Ireland and Scotland were considered insufficient to mount a full response to Covid-19.
26. The England and Wales Public Health Act does not strictly contain an emergency regime, in that the ability of UK or Welsh ministers to make regulations is not contingent on there being an emergency. In fact, before the Covid-19 pandemic occurred, the relevant regulation-making powers in Part 2A of the England and Wales Public Health Act were last used in 2010 when the UK and Welsh governments made regulations to enable public health officials to better respond to health risks as part of their customary activities. For example, one set of the 2010 regulations requires medical practitioners to notify local authorities when patients present with, or appear to have died from, certain diseases, infections or contamination.¹⁸ Another empowers local authorities to disinfect or decontaminate things and premises, manage dead bodies that may be infected or contaminated, and temporarily require a child to be kept away from school.¹⁹
27. Two broad categories of regulations can be made under Part 2A of the England and Wales Public Health Act: (1) regulations governing international travel, which are made under section 45B of the Act and (2) regulations relating to domestic health protection, which are made under section 45C. The possible content and levels of parliamentary control for these two categories differ.

¹⁵ UK Department of Health, *Review of Parts II, V and VI of the Public Health (Control of Disease) Act 1984 A Consultation* (March 2007), pages 7-10

¹⁶ [Section 94](#) Public Health etc. (Scotland) Act 2008, which is equivalent to section [45B](#) England and Wales Public Health Act

¹⁷ Although the powers available to the administrations in Northern Ireland and Scotland did not take an “all hazards” approach – they were expressly limited to addressing SARS-CoV-2 and Covid-19: see [section 1\(2\)](#), [schedule 18](#) and [paragraph 1](#) of schedule 19 Coronavirus Act 2020.

¹⁸ [Health Protection \(Notification\) Regulations 2010/659](#) and [Health Protection \(Notification\) \(Wales\) Regulations 2010/1546](#)

¹⁹ [Health Protection \(Local Authority Powers\) Regulations 2010/657](#) and [Health Protection \(Local Authority Powers\) \(Wales\) Regulations 2010/1545](#)

International travel regulations

28. Regulations relating to international travel can be made to address public health risks arising from international travel (i.e. from “vessels, aircraft, trains or other conveyances” arriving at, or leaving, any place), and to give effect to international agreements relating to the spread of infection or contamination.²⁰ A non-exhaustive list of provisions can be included in such regulations, including:
- a) The medical examination, detention, isolation or quarantine of people (although the regulations cannot require a person to undergo medical treatment);
 - b) The detention of conveyances; and
 - c) The inspection, analysis, retention, isolation, quarantine or destruction of things.²¹
29. There are no additional conditions that need to be met before international travel regulations can be made, and they will generally be subject to the made negative parliamentary scrutiny procedure.²² This is the weakest form of parliamentary oversight, and means that the regulations will be laid before the UK or Welsh Parliament only after they have been made, and will automatically remain law unless the Welsh Parliament or either House of the UK Parliament rejects them within 40 days (an extremely rare occurrence).²³ Many regulations relating to international travel were made using this procedure during the Covid-19 pandemic. Data compiled by the Hansard Society show that between 27th January 2020 and 3rd March 2022 the UK government made 90 international travel regulations using the made negative procedure.²⁴ These included the regulations which implemented a scheme of hotel quarantine for travellers returning from certain countries.²⁵

Parliamentary scrutiny procedures for secondary legislation

In this report we refer to the following procedures for making secondary legislation.

Affirmative procedure

Statutory instruments made under the affirmative procedure require active debate and approval by the relevant legislature (i.e. both Houses of the UK Parliament, the Scottish or Welsh Parliament, or the Northern Ireland Assembly).

Draft affirmative procedure

Under the draft affirmative procedure, a statutory instrument must be laid in draft before the legislature and cannot be made into law until it is debated and approved by that legislature.

²⁰ [Section 45B\(1\)](#) England and Wales Public Health Act

²¹ [Section 45B\(2\)](#) and [45E](#) England and Wales Public Health Act

²² [Section 45Q\(1\)](#) England and Wales Public Health Act

²³ Recesses of over four days do not count towards the 40 days

²⁴ Data provided by Dr Ruth Fox, Director of the Hansard Society and one of our commissioners, using information compiled as part of the Hansard Society’s Coronavirus Statutory Instruments Dashboard <<https://www.hansardsociety.org.uk/publications/data/coronavirus-statutory-instruments-dashboard>> accessed 1 February 2024

²⁵ [Health Protection \(Coronavirus, International Travel\) \(England\) \(Amendment\) \(No. 7\) Regulations 2021 \(SI 2021/150\)](#)

Made affirmative procedure (in Northern Ireland the “confirmatory procedure”)

In cases of urgency an affirmative statutory instrument can be made into law by a minister and come into force without parliamentary approval, but will expire within a specified period (usually 28 or 40 days) unless it is debated and approved by the legislature.

Negative procedure

Statutory instruments made under the negative procedure do not require active approval by the legislature.

Made negative procedure

Under the made negative procedure, a statutory instrument comes into force and remains law unless the legislature rejects it within a specified period. If the legislature does not reject the instrument within that period, it is deemed to have consented.

Domestic health protection regulations

30. Domestic health protection regulations are subject to more stringent controls on their content than international travel regulations. They can be made to prevent, protect against, control, or provide a public health response to the incidence or spread of infection or contamination in England and Wales.²⁶ However, a proportionality test must be satisfied before they can impose - or enable the imposition - of restrictions or requirements on or in relation to persons, things or premises. These types of measures can only be imposed if the relevant minister, or person empowered by the regulations, considers that the restriction or requirement is proportionate to what is sought to be achieved.²⁷
31. Domestic health protection regulations are also subject to further safeguards which differ depending on whether the regulations **directly impose** or **enable the imposition of** restrictions or requirements (i.e. by virtue of a decision taken under the regulations by the minister, the local authority, or another person). Regulations which impose restrictions or requirements **directly** cannot contain certain measures. They cannot:
- a) Require a person to submit to medical examination or undergo medical treatment;
 - b) Be removed to a hospital or other suitable establishment;
 - c) Be detained in a hospital or other suitable establishment; or
 - d) Be kept in isolation or quarantine.²⁸
32. Except for requiring a person to undergo medical treatment, these measures can be included in domestic health protection regulations which **enable the imposition of** restrictions or requirements, but they are part of a list of “special restrictions or requirements” which can only be introduced in response to a serious and imminent threat to public health.²⁹ Other “special restrictions or requirements” include the need for a person to be disinfected or decontaminated, to abstain from working or trading, or to be subject to restrictions on their movement.

²⁶ [Section 45C\(1\)](#) England and Wales Public Health Act

²⁷ [Section 45D\(1\)-\(2\)](#) England and Wales Public Health Act

²⁸ [Sections 45D\(3\)](#) and [45E](#) England and Wales Public Health Act

²⁹ [Sections 45C\(6\)](#) and [45\(D\)\(4\)](#) England and Wales Public Health Act

Parliamentary control of domestic health protection regulations

33. Different levels of parliamentary control apply to domestic health protection regulations depending on their content and the urgency of the situation. Regulations must usually be laid before the UK or Welsh Parliament in draft and cannot become law until approved by the legislature (the [draft affirmative scrutiny procedure](#)).³⁰ However, there are two important exceptions to this general rule.
34. The first exception applies in cases of urgency. Regulations need not be subject to the draft affirmative procedure if the minister declares that he or she is of the opinion that, by reason of urgency, it is necessary to make regulations without a draft being laid before and approved by the legislature.³¹ In this case, the regulations can be subject to the [made affirmative scrutiny procedure](#), which means they will become law immediately but will lapse after 28 calendar days unless they receive retrospective approval by the UK or Welsh Parliament.³² The 28 day countdown is paused if the legislature is prorogued, dissolved, adjourned or goes into recess for more than four days, so in practice the time period for approval can be quite lengthy if regulations are made shortly before recess.³³
35. This exception was relied upon so extensively during the Covid-19 pandemic that it became the default procedure for making domestic public health regulations. Data compiled by the Hansard Society in relation to the UK Parliament shows that UK ministers made 100 domestic public health regulations under the England and Wales Public Health Act using the made affirmative procedure between 27th January 2020 and 3rd March 2022. Only one set of domestic public health regulations was made under the Act using the draft affirmative procedure during the same time period.³⁴
36. The second exception is when the minister is of the opinion that the regulations do not contain any measure in relation to persons, things or premises which is either (1) a special restriction or requirement; or (2) otherwise has, or would have, a significant effect on a person's rights.³⁵ If this exception applies, then regulations can be subject to the [made negative parliamentary scrutiny procedure](#). This means that they will be laid before the UK or Welsh Parliament only after they have been made, and will automatically remain law unless Parliament rejects them within 40 days.³⁶ Data compiled by the Hansard Society shows that this exception was relied upon by UK ministers to make four domestic health regulations under the England and Wales Public Health Act between 27th January 2020 and 3rd March 2022.³⁷

³⁰ [Section 45\(Q\)\(2\)\(a\) and \(4\)](#) England and Wales Public Health Act

³¹ [Section 45R\(1\)-\(3\)](#) England and Wales Public Health Act

³² [Section 45R\(4\)](#) England and Wales Public Health Act

³³ [Section 45R\(6\)](#) England and Wales Public Health Act

³⁴ Data provided by the Hansard Society (whose Director, Dr Ruth Fox, is one of our commissioners) using information compiled as part of the Hansard Society's Coronavirus Statutory Instruments Dashboard <<https://www.hansardsociety.org.uk/publications/data/coronavirus-statutory-instruments-dashboard>> accessed 1 February 2024

³⁵ [Section 45Q\(3\)](#) England and Wales Public Health Act

³⁶ Recesses of over four days do not count towards the 40 days

³⁷ Data provided by the Hansard Society (whose Director, Dr Ruth Fox, is one of our commissioners) using information compiled as part of the Hansard Society's Coronavirus Statutory Instruments Dashboard <<https://www.hansardsociety.org.uk/publications/data/coronavirus-statutory-instruments-dashboard>> accessed 1 February 2024

Public Health etc. (Scotland) Act 2008

37. The Public Health etc. (Scotland) Act 2008 (the “Scotland Public Health Act”) is an Act of the Scottish Parliament that, among other things, grants powers to the Scottish ministers. The regulation-making powers in the Scotland Public Health Act follow the same outline structure, and have broadly the same content, as those in the England and Wales Public Health Act. As discussed above at paragraph 25, the Scotland Public Health Act has always contained regulation-making powers in relation to international travel that are equivalent to those in the England and Wales Public Health Act.³⁸ In addition, at the start of the Covid-19 pandemic, the Scottish ministers were granted temporary powers to make domestic public health regulations that were almost identical to those granted to UK and Welsh ministers in the England and Wales Public Health Act.³⁹ These temporary powers are now available to Scottish Ministers on a permanent basis, after the Scottish Parliament amended the Scotland Public Health Act in 2022.⁴⁰ However, some important modifications were made to the England and Wales Public Health Act powers when they were permanently adopted into public health law in Scotland. The key differences for the purposes of this report are that the Scotland Public Health Act contains enhanced parliamentary scrutiny mechanisms and additional safeguards on government law-making, to which we now turn.

Public health declaration

38. The amended Scotland Public Health Act restricts the circumstances in which domestic public health protection regulations can be made by introducing a public health declaration procedure. In general, domestic health protection regulations can only be made when a public health declaration has effect.⁴¹ The only exception is for regulations which are not “responding to a particular infection or contamination”, i.e. those which establish standing preparedness arrangements.

39. Scottish ministers can make a public health declaration when they consider that an infectious disease or contaminant constitutes, or may constitute, a danger to human health, and the making of domestic public health regulations may be a way of protecting against that danger.⁴² Before making a public health declaration, the Scottish ministers must consult the Chief Medical Officer for Scotland or another person designated by the ministers.⁴³

40. A public health declaration will come into effect after it has been approved by the Scottish Parliament, although there is also a backstop for post-implementation approval (or rejection) if the Scottish ministers consider that it is not practicable for the declaration to be approved in advance, for example because Parliament is dissolved.⁴⁴ In this case, the ministers must make a statement explaining why it is not practicable to secure advance approval of the declaration, after which the public health declaration will have effect immediately but must be approved by the Scottish Parliament within 28 days if it is to remain in force.⁴⁵ The statement explaining why it is not practicable to secure advance approval must also be laid before the Scottish Parliament.⁴⁶

³⁸ [Section 94](#) Public Health etc. (Scotland) Act 2008, which is equivalent to [section 45B](#) England and Wales Public Health Act

³⁹ Although the powers available to the Scottish Ministers did not take an “all hazards” approach – they were expressly limited to addressing SARS-CoV-2 and Covid-19: see [section 1\(2\)](#) and [paragraph 1](#) of schedule 19 Coronavirus Act 2020

⁴⁰ The amendments to the Scotland Public Health Act were made via the Coronavirus (Recovery and Reform) (Scotland) Act 2022, and they take an “all hazards” approach

⁴¹ [Section 86B\(1\)](#) Scotland Public Health Act. The declaration procedure does not apply to regulations concerning international travel (i.e. those which address health risks arising from vehicles arriving or leaving Scotland), which are made under a different section of the Scotland Public Health Act – [section 94](#)

⁴² [Section 86B\(2\)](#) Scotland Public Health Act

⁴³ [Section 86B\(3\)](#) Scotland Public Health Act

⁴⁴ [Section 86B\(6\)](#) and [86C](#) Scotland Public Health Act

⁴⁵ [Section 86C\(4\)](#) Scotland Public Health Act. Recesses of over four days or any time during with the Scottish Parliament is dissolved do not count towards the 28 days – [Section 86C\(6\)](#) Scotland Public Health Act

⁴⁶ [Section 86C\(3\)](#) Scotland Public Health Act

41. The Scottish ministers must publish the declaration, its approval by Parliament, and the time at which it comes into effect, in such manner as they consider appropriate.⁴⁷ Ministers must revoke the declaration if they no longer consider that the infectious disease or contaminant constitutes or may constitute a danger to human health, and that the making of regulations may be a way of protecting against that danger.⁴⁸ A notice of the revocation must be laid before the Scottish Parliament and published in such manner as the Scottish ministers consider appropriate.⁴⁹ The revocation of a declaration does not affect anything done before the declaration ceased to have effect.⁵⁰

Mandatory review period

42. The 2022 amendments to the Scotland Public Health Act also introduced a mandatory review period for domestic public health regulations which impose restrictions or requirements on, or in relation to, persons, things or premises. Scottish ministers must review these types of regulations every 21 days, except where the regulations only contain measures of a “general nature or contingent provision”.⁵¹ In contrast, the England and Wales Public Health Act contains no mandatory review period for regulations made by UK or Welsh ministers. In England and Wales, a review is only required where regulations enable a decision to be made to detain someone in a hospital or other suitable establishment, or to keep a person in isolation or quarantine, in which cases the continuation of the detention, isolation or quarantine must be reviewed every 28 days or less.⁵²

43. When the mandatory review requirement was introduced to the Scotland Public Health Act in 2022, the Scottish Parliament’s Covid-19 Recovery Committee recommended that it should be enhanced by requiring Scottish ministers to notify the Scottish Parliament of the outcome of their reviews, including the options considered and the evidence underpinning any decisions taken.⁵³ The Committee also felt that, more generally, the use of public health protection regulations should be accompanied by a process for reporting to Parliament on how relevant provisions had been used.⁵⁴ These recommendations were not incorporated into the Scotland Public Health Act. In rejecting them, the Scottish government explained that it considered that review requirements would best be set out in the relevant regulations rather than in the parent Act, so that they can be appropriately tailored by ministers.⁵⁵

⁴⁷ [Section 86B\(5\) and \(8\)](#) Scotland Public Health Act

⁴⁸ [Section 86B\(9\)](#) Scotland Public Health Act

⁴⁹ [Section 86B\(9\)](#) Scotland Public Health Act

⁵⁰ [Section 86B\(11\)\(a\)](#) Scotland Public Health Act

⁵¹ [Section 86I\(1\)-\(2\)](#) Scotland Public Health Act

⁵² [Section 45F\(7\)-\(8\)](#) England and Wales Public Health Act. Section 45F(7) also creates an additional discretionary review provision: Where regulations enable a “special restriction or requirement” to be imposed, and that restriction or requirement is capable of remaining in force for more than a specified period, then the regulations must empower a specified person to require a review of the continuation of the restriction or requirement at specified intervals. These provisions also exist in the Scotland Public Health Act, in addition to the broader mandatory review period, although the 28 day review period for decisions to detain or quarantine someone is reduced to 21 days in the Scottish legislation – [section 86I\(3\)-\(5\)](#) Scotland Public Health Act

⁵³ The Scottish Parliament Covid-19 Recovery Committee, *Stage 1 Report on the Coronavirus (Recovery and Reform) (Scotland) Bill* (2022, SP 161), paragraph 65

⁵⁴ *Ibid*, paragraph 64

⁵⁵ Scottish Government Response to Scrutiny Committee Reports on the Coronavirus (Recovery and Reform) (Scotland) Bill at Stage (9 May 2022), Annex A available at <<https://www.parliament.scot/chamber-and-committees/committees/current-and-previous-committees/session-6-covid19-recovery-committee/correspondence/2022/scottish-government-response-coronavirus-recovery-and-reform-scotland-bill-at-stage-1>> accessed 1 February 2024

Urgent made affirmative procedure

44. The amended Scotland Public Health Act also contains additional safeguards on the use of the made affirmative procedure to make domestic health protection regulations in cases of urgency. If a Scottish minister believes it is necessary to make domestic health protection regulations using the made affirmative procedure because of the urgency of the situation – without a draft of the regulations first being laid before and approved by Parliament – then the minister must “explain why they consider that the regulations need to be made urgently”.⁵⁶ The regulations must also contain a [sunset clause](#) specifying a day on which they will expire.⁵⁷ While neither of these requirements are imposed on UK or Welsh ministers under the England and Wales Public Health Act, the sunset clause provision in the Scotland Public Health Act nevertheless does not stipulate a maximum period for the duration of the made affirmative regulations, unlike many public health frameworks in comparable jurisdictions. The provision also does not apply to international travel regulations.
45. Two committees in the Scottish Parliament suggested that additional safeguards be imposed on the use of the made affirmative procedure under the Scotland Public Health Act. These suggestions were not taken forward by the Scottish government. The Delegated Powers and Law Reform Committee recommended that ministers should be required to provide an assessment of the impact of any made affirmative regulations.⁵⁸ In rejecting this recommendation, the Scottish government asserted that “current scrutiny frameworks (per Standing Orders, existing statutory requirements or via government procedures and internal guidance) are fit for purpose and that there is no need for such an amendment”.⁵⁹
46. In addition, the Scottish Parliament’s Covid-19 Recovery Committee highlighted the fact that “Scottish ministers currently have the power to determine whether a situation is urgent”, and recommended that more detail should be set out on the face of the Scotland Public Health Act to note the types of scenarios in which Scottish ministers may consider that legislation is required to be made urgently.⁶⁰ This recommendation was not adopted by the Scottish government, which argued that there may be “disadvantages in being overly prescriptive on the face of the [Act] which might leave Scotland ill-equipped to respond to new public health threats”.⁶¹

Negative parliamentary scrutiny procedure

47. Finally, the Scotland Public Health Act differs from the England and Wales Public Health Act in the availability of the made negative parliamentary scrutiny procedure. Under the England and Wales Public Health Act, the made negative procedure is the default scrutiny procedure for international travel regulations and some domestic health regulations (see paragraphs 29 and 36 above). In contrast, the Scotland Public Health Act does not permit the made negative procedure to be used for either type of regulations. Instead, only the draft affirmative and, in cases of urgency, made affirmative procedure are available.⁶²

⁵⁶ [Section 122\(12\)\(a\)](#) Scotland Public Health Act

⁵⁷ [Section 122\(12\)\(b\)](#) Scotland Public Health Act

⁵⁸ Scottish Parliament Delegated Powers and Law Reform Committee, *Coronavirus (Recovery and Reform) (Scotland) Bill: Stage 1* (2022, SP 147), paragraph 23

⁵⁹ Scottish Government Response to Scrutiny Committee Reports (n 55), Annex E

⁶⁰ The Scottish Parliament Covid-19 Recovery Committee, Stage 1 Report (n 53), paragraph 51

⁶¹ Scottish Government Response to Scrutiny Committee Reports (n 55), Annex A

⁶² [Section 122\(5\)-\(7\)](#) Scotland Public Health Act

48. The only exception is for regulations which have to be made urgently and “revoke (in whole or in part) emergency regulations and do (i) nothing else; or (ii) nothing else except make provision incidental or supplementary to the revocation”. In this case, the made affirmative procedure applies but is modified, so that these regulations must be laid before the Scottish Parliament but will **not** expire after 28 days if they are not approved by Parliament.⁶³ This is essentially the made negative procedure.

Public Health Act (Northern Ireland) 1967

49. The Public Health Act (Northern Ireland) 1967 (the “Northern Ireland Public Health Act”) empowers the Northern Ireland Department of Health to make regulations for preventing and controlling certain diseases. These regulation-making powers were considered insufficient to address the threat posed by Covid-19, so at the start of the pandemic the Department was granted additional regulation-making powers under schedule 18 of the Coronavirus Act 2020. This schedule temporarily imported into the Northern Ireland Public Health Act near identical regulation-making powers to those granted to UK and Welsh ministers in the England and Wales Public Health Act, except that the Northern Ireland powers were expressly limited to addressing SARS-CoV-2, the virus that causes Covid-19, and did not take an “all hazards” approach. These temporary amendments were initially due to expire on 25th March 2022, but – notwithstanding the absence of a functioning Northern Ireland executive from February 2022 to early 2024 – the expiry date for the amendments was extended a number of times before the provisions eventually expired on 24th March 2024.

50. The main purpose of the Northern Ireland Public Health Act is the notification and prevention of disease. The Northern Ireland Department of Health is empowered to make regulations which have effect in Northern Ireland, and which are made:

- a) With a view to the treatment of persons affected with any epidemic, endemic or infectious disease;
- b) For preventing the spread of such diseases; and
- c) For preventing danger to public health from the arrival and, in some cases, departure of vessels and aircraft.⁶⁴

51. Regulations may provide for, among other things:

- a) Questions to be answered by masters, pilots and travellers about cases of disease on board;
- b) The detention of vessels or aircraft and persons on board them; and
- c) Signals to be displayed by vessels or aircraft which are carrying passengers suffering from an epidemic, endemic or infectious disease.⁶⁵

52. The Department of Health is also empowered to make regulations related to the disposal of bodies of persons who have died from certain notifiable diseases.⁶⁶ Regulations made under the Northern Ireland Public Health Act are subject to the negative parliamentary scrutiny procedure.⁶⁷

⁶³ [Section 122\(8\)](#) Scotland Public Health Act

⁶⁴ [Section 2A\(1\)](#) Northern Ireland Public Health Act

⁶⁵ [Section 2A\(3\)](#) Northern Ireland Public Health Act

⁶⁶ [Section 13](#) Northern Ireland Public Health Act

⁶⁷ [Section 23\(2\)](#) Northern Ireland Public Health Act

53. A review of the Northern Ireland Public Health Act was commissioned by the Northern Ireland Department of Health in 2013-2015, following an extensive period of consultation. The review identified a number of issues with the Northern Ireland Public Health Act primarily relating to its need for modernisation. For example, the Department of Health noted that the Act does not properly incorporate human rights protections, and is not consistent with the WHO International Health Regulations 2005 as it does not take an “all hazards” approach to public health risks.⁶⁸ The review recommended that an entirely new public health Bill should be introduced in Northern Ireland, which could re-enact provisions from the existing Northern Ireland Public Health Act as necessary.⁶⁹ This recommendation has not yet been implemented, but work has recently resumed on scoping the policy for inclusion in a new health protection legislative framework for Northern Ireland. Senior officials within the Northern Ireland Department of Health informed us that, before the collapse of the Northern Ireland Executive in 2022, Department of Health ministerial approval was given for civil servants to conduct a scoping exercise for a new Northern Ireland public health Bill. That exercise remains underway as this report goes to press.

Civil Contingencies Act 2004

54. The Civil Contingencies Act 2004 (“the Civil Contingencies Act”) was designed to deliver a single framework for civil protection across the UK. It was the result of a review of emergency planning arrangements which began in early 2001 following a number of UK-wide incidents (e.g. disruption to fuel supplies and large-scale flooding). The scope of the Civil Contingencies Act was also influenced by the 2001 foot and mouth outbreaks and the 9/11 terrorist attacks, the latter having led to a “reassessment of what should be encompassed within potential civil protection legislation”.⁷⁰ The Civil Contingencies Act is therefore a broad piece of legislation that is designed to address a wide variety of threats, from war and terrorist attacks to serious public health threats.⁷¹

55. Part 2 of the Civil Contingencies Act empowers the UK government to make regulations in response to an emergency. These emergency regulation-making powers have never been used, including during the Covid-19 pandemic. The UK government is empowered to make regulations in relation to the whole of the UK. While the relevant ministers or legislatures in Northern Ireland, Scotland, and Wales must be consulted before emergency regulations are made in relation to those nations, this requirement may be dis-applied if the UK government thinks it necessary by reason of urgency. In any event, a failure to consult will not affect the validity of emergency regulations.⁷²

⁶⁸ Department of Health, Social Services and Public Safety, *Review of the Public Health Act (NI) 1967 Final Report* (March 2016), pages 34-36

⁶⁹ *Ibid.*, page 36

⁷⁰ UK Parliament Joint Committee on the *Draft Civil Contingencies Bill*, *Draft Civil Contingencies Bill* (2002-3, HC 1074 HL 184), paragraph 2; Cabinet Office, *Draft Civil Contingencies Bill Consultation Document – June 2003* (June 2003), page 9

⁷¹ The Civil Contingencies Act defines an “emergency” in a number of ways, one of which is “an event or situation which threatens serious damage to human welfare”, including loss of human life, human illness or injury, or disruption of services relating to health ([Section 19](#) Civil Contingencies Act). The Act can therefore be used to respond to public health emergencies: its explanatory notes confirm that an epidemic could satisfy the definition of an emergency if it reaches the required level of seriousness (Explanatory Notes to the Civil Contingencies Act 2004, [paragraph 39](#))

⁷² [Section 29](#) Civil Contingencies Act

Conditions for use of emergency regulations

56. Before emergency regulations can be made, a minister must be satisfied that three conditions have been met: (1) an emergency must have occurred, be occurring, or be about to occur; (2) it must be necessary to make provision for the purpose of preventing, controlling or mitigating an aspect or effect of the emergency; and (3) the need for such provision must be urgent.⁷³ In relation to the second of these conditions – the test of necessity – there is an additional condition that must be met where the proposed emergency regulations are the same as, or could be made under, existing legislation. In these circumstances, the necessity test will only be met if:
- a) The existing legislation cannot be used without the risk of serious delay;
 - b) It is not possible without the risk of serious delay to ascertain whether the existing legislation can be used; or
 - c) The existing legislation might be insufficiently effective.⁷⁴
57. Once the minister is satisfied that the three conditions for making emergency regulations are met, they are granted a broad power to make “any provision” which they are satisfied is proportionate and appropriate for the “purpose of preventing, controlling or mitigating an aspect or effect of the emergency”.⁷⁵ With a few exceptions, regulations may make provision of any kind that could be made by an Act of Parliament or the Royal Prerogative. This includes dis-applying or modifying any Act of Parliament, excluding only Part 2 of the Civil Contingencies Act itself and the Human Rights Act 1998.⁷⁶

Parliamentary scrutiny requirements

58. The breadth of the powers granted to the UK government in the Civil Contingencies Act is balanced by stringent parliamentary scrutiny requirements. While emergency regulations can be made and come into force before the UK Parliament has had sight of them, they must be laid before Parliament as soon as is reasonably practicable and will lapse after seven days unless approved by both Houses (this is a form of the made affirmative scrutiny procedure).⁷⁷ Parliament may amend the regulations or bring them to an end, if both Houses pass a motion to this effect.⁷⁸ Even after regulations have been approved by the UK Parliament, they will automatically lapse after 30 days, and will need to be re-made if the government wishes them to continue in force.⁷⁹ If Parliament is prorogued or adjourned for more than five days when emergency regulations are made, then both Houses will be recalled.⁸⁰
59. Emergency regulations must be made by Order in Council – which requires a meeting of the Privy Council and formal approval by the Monarch in addition to that of Parliament – unless it would not be possible, without serious delay, to arrange for an Order in Council.⁸¹

⁷³ [Section 21](#) Civil Contingencies Act

⁷⁴ [Sections 21\(5\)-\(6\)](#) Civil Contingencies Act

⁷⁵ [Section 22\(1\)](#) and [23\(1\)](#) Civil Contingencies Act

⁷⁶ [Sections 22\(3\)](#) and [23\(5\)](#) Civil Contingencies Act. The explanatory notes also state that “Parliamentary Counsel have advised that the effect of the normal principles of the construction of delegated powers is that substantive amendments could not be made by emergency regulations to provisions of an enactment which are of constitutional significance” (Explanatory notes to the Civil Contingencies Act 2004, [paragraph 53](#))

⁷⁷ [Section 27\(1\)](#) Civil Contingencies Act

⁷⁸ [Section 27\(2\)-\(3\)](#) Civil Contingencies Act

⁷⁹ [Section 26](#) Civil Contingencies Act

⁸⁰ [Section 28](#) Civil Contingencies Act

⁸¹ [Section 20\(1\)-\(2\)](#) Civil Contingencies Act

The suitability of the UK's existing public health framework legislation for responding to future health emergencies

60. Taking into account the evidence we have heard and read, including from other jurisdictions we considered, it is our view that Part 2A of the England and Wales Public Health Act and the equivalent powers in the recently amended Scotland Public Health Act provide a useful starting point as framework legislation for public health emergencies. The framework in Part 2A could also be adopted as a model for Northern Ireland's anticipated new public health Bill, which would ensure a largely consistent legal framework applies across the UK in future health emergencies.
61. Although we received much evidence criticising certain aspects of the England and Wales Public Health Act, and many suggestions for amendments, no witnesses argued for the abandonment of the Act and the introduction of entirely new public health legislation. Rather, the public health professionals with whom we discussed this point felt that the framework within Part 2A of the England and Wales Public Health Act generally granted government and public health officials sufficient powers to tackle public health emergencies. Similarly, witnesses who were asked this question and who had served in government during the Covid-19 pandemic, whether as ministers or civil servants, considered that the framework had largely provided them with sufficient powers.
62. We nevertheless have significant concerns around the extent to which the Act provides for appropriate parliamentary scrutiny and oversight of government law-making in an emergency. Some of those concerns have been partially ameliorated in the recently amended Scotland Public Health Act (as discussed above at paragraphs 37-48). However, in our view, further improvements could be made. In the next chapter, we outline a series of recommendations for legislative change which could form part of an amended England and Wales Public Health Act, Scotland Public Health Act, and Northern Ireland's anticipated new public health law.
63. The rest of this chapter discusses the Civil Contingencies Act. During the Covid-19 pandemic, a number of parliamentary committees and other commentators argued that it would have been preferable for the Civil Contingencies Act to have been used to implement public health interventions, rather than the England and Wales Public Health Act and the equivalent powers extended to Scotland and Northern Ireland. However, we do not consider that the Civil Contingencies Act would be a suitable legislative tool for responding to most public health emergencies for the reasons set out below.

Recommendation 2: Part 2A of the Public Health (Control of Disease) Act 1984, and Parts 5A and 7 of the Public Health etc. (Scotland) Act 2008, provide a useful starting point as framework legislation which grants emergency regulation-making powers to government. The framework in these Acts could be adopted as a model for Northern Ireland's anticipated new public health Bill.

Arguments for the use of the Civil Contingencies Act

64. The commentators who advocated the use of the Civil Contingencies Act during the Covid-19 pandemic did so largely because it mandates stronger parliamentary oversight over government law-making than the framework in Part 2A of the England and Wales Public Health Act and the equivalent powers that were extended to Scotland and Northern Ireland.⁸² As noted above at paragraph 58, oversight measures in the Civil Contingencies Act include, for example, the ability for the UK Parliament to amend emergency regulations, the need for regulations to be scrutinised and approved by Parliament within seven days of being laid, and the requirement for regulations to be renewed every 30 days. The House of Lords Constitution Committee noted that the Civil Contingencies Act “shows that [the UK] Parliament can have, and expects to have, a central role in legal changes during periods of national crisis”.⁸³
65. These points were repeated in oral evidence we received from Michael Clancy⁸⁴ and Daniel Greenberg CB,⁸⁵ who argued that the UK government should use the Civil Contingencies Act in future public health emergencies. Mr Greenberg, who drafted the Civil Contingencies Act, considered that the failure to use the Civil Contingencies Act during Covid-19 was an attempt to avoid parliamentary scrutiny. We note that this suggestion was rejected by Lord Bethell, who was Parliamentary Under-Secretary of State at the Department of Health and Social Care during the first 18 months of the Covid-19 pandemic. In oral evidence, Lord Bethell told us that UK ministers had recognised the importance of keeping the UK Parliament “on-side” and had therefore found appealing the high levels of parliamentary engagement required by the Civil Contingencies Act. However, he explained that the Department of Health received firm legal advice that the Civil Contingencies Act could not be used to respond to the pandemic because it is designed for a “black swan emergency” that is an “unexpected event”. Covid-19 was not such an event because the government had been aware from the start of January 2020 that the virus may reach the UK, and the Department of Health had therefore been working on its response for 2.5 months before the first lockdown was imposed in mid-March.

Could the Civil Contingencies Act be used in future public health emergencies?

66. In some ways, it is now redundant to argue that the UK government should use the Civil Contingencies Act in future public health emergencies, as the test of “necessity” in section 21(3) of the Act will likely exclude its use. As outlined above at paragraph 56, this test only allows the Civil Contingencies Act to be used if the person making emergency regulations is satisfied that the regulations are “necessary” for the purpose of preventing, controlling, or mitigating an aspect or effect of the emergency.⁸⁶ Where proposed emergency regulations are the same as, or could be made under, existing legislation, the test of “necessity” prevents the regulations being made under the Civil Contingencies Act unless:

⁸² UK Parliament Joint Committee on Human Rights, *The government's response to COVID-19: human rights implications* (2019-21, HC262 HL125), paragraph 222 (One of our commissioners, Adam Wagner, was Specialist Advisor to the Joint Committee on Human Rights' inquiry into the human rights implications of the government's response to coronavirus); House of Commons Public Administration and Constitutional Affairs Committee, *Parliamentary Scrutiny of the government's handling of Covid-19* (2019-21, HC 377), paragraph 34; House of Lords Constitution Committee, *COVID-19 and the use and scrutiny of emergency powers* (2021-22, HL15), paragraphs 40-41; and Rebecca Moosavian, Clive Walker and Andrew Blick, 'Coronavirus legislative responses in the UK: regression to panic and disdain of constitutionalism' (2021) 72 *Northern Ireland Legal Quarterly Covid-19 Supplement*, pages 1-36

⁸³ Constitution Committee, *COVID-19 and the use and scrutiny of emergency powers* (n 82), paragraph 41

⁸⁴ Director of Law Reform at the Law Society of Scotland

⁸⁵ Parliamentary Commissioner for Standards in the House of Commons and formerly Counsel for Domestic Legislation in the House of Commons (2016-2022).

⁸⁶ [Section 21\(3\)](#) Civil Contingencies Act

- a) The existing legislation cannot be used without the risk of serious delay;
- b) It is not possible without the risk of serious delay to ascertain whether the existing legislation can be used; or
- c) The existing legislation might be insufficiently effective.⁸⁷

67. As a result, the Civil Contingencies Act can only be used to make emergency regulations where there is no other existing legislation that can be used to deal with the emergency.

68. It is hard to envisage many future public health emergencies that could not be dealt with using the powers available to governments under Part 2A of the England and Wales Public Health Act or the equivalent powers in the Scotland Public Health Act, given the breadth of these powers as interpreted by the courts. During the pandemic, the High Court and Court of Appeal in England and Wales confirmed that the regulation-making powers in Part 2A of the England and Wales Public Health Act could be used to introduce wide-ranging and national public health interventions such as imposing nationwide lockdowns, requiring parts of the population to isolate, and authorising the removal of people to their homes.⁸⁸ It therefore seems likely that the test of “necessity” in section 21 of the Civil Contingencies Act will exclude its use in most future public health emergencies, especially if Northern Ireland introduces a new public health Bill modelled on the England and Wales Public Health Act, because governments will be able to rely on existing powers in the England and Wales, Scotland, or new Northern Ireland Public Health Act.

69. In 2021, the House of Lords Constitution Committee recommended that the test of “necessity” in the Civil Contingencies Act be reconsidered because it presented a legal and practical barrier to use of that Act during an emergency.⁸⁹ However, we hesitate to endorse this recommendation insofar as it applies to public health measures. The Civil Contingencies Act grants extraordinarily broad powers and its use is tightly restricted as a result, with the necessity test forming a key part of that design. The explanatory notes to the Civil Contingencies Act confirm that the “necessity” test reflects “the presumption that emergency regulations will not be made where existing legislation (or provision which can be made under existing legislation) is adequate to deal with the emergency.”⁹⁰

70. The UK government also appears to have no appetite for amending the Civil Contingencies Act to remove the test of necessity. A post-implementation review published by the Cabinet Office in March 2022 concluded that no changes should be made to the Act’s emergency regulation-making powers.⁹¹ The review found that these powers continued to be “fit for purpose as an option of last resort”, and that the “triple lock” conditions – including the test of necessity – provide “robust and necessary safeguards that should not be amended”.⁹² Moreover, 77% of respondents to the review’s public consultation were also against changing the “triple lock” protections in the Act.⁹³ Respondents to the consultation included representatives of 33 out of the 38 Local Resilience Forums in England, councils, emergency services (including the National Police Chiefs Council and National Fire Chiefs Council), charities, academia and business (including utilities and transport).⁹⁴

⁸⁷ [Sections 21\(5\)-\(6\)](#) Civil Contingencies Act

⁸⁸ *R. (on the application of Dolan) v Secretary of State for Health and Social Care* [2020] EWCA Civ 1605; *R. (on the application of Francis) v Secretary of State for Health and Social Care* [2020] EWHC 3287 (Admin)

⁸⁹ Constitution Committee, *COVID-19 and the use and scrutiny of emergency powers* (n 82), paragraphs 38 and 215

⁹⁰ Explanatory Notes to the Civil Contingencies Act 2004, [paragraph 46](#)

⁹¹ Cabinet Office, *Civil Contingencies Act Post-Implementation Review 2022* (29 March 2022), paragraph 90

⁹² *Ibid.*, paragraph 88

⁹³ *Ibid.*, paragraph 81

⁹⁴ *Ibid.*, paragraph 36

Should the Civil Contingencies Act be used in future public health emergencies?

71. Even if the test of necessity were removed or amended, we are not persuaded that the Civil Contingencies Act would be a suitable legislative tool for addressing most public health emergencies. There are three main reasons why we have reached this conclusion.
72. First, the type of parliamentary oversight required by the Civil Contingencies Act is not well suited to the realities of a major or prolonged public health emergency. The Civil Contingencies Act requires the UK Parliament to approve emergency regulations within seven days, and regulations will automatically lapse after 30 days and need to be re-made if the government wishes to continue exercising the powers they contain. A number of witnesses felt that these requirements would present too many practical problems for the management of any except the most short-lived public health emergencies, and may in fact inhibit parliamentary scrutiny. Sir Bernard Jenkin MP, Chair of the House of Commons Liaison Committee, and Professor Adam Tomkins, who served as an MSP on the Scottish Parliament's Covid-19 Committee, both noted that permitting Parliament just seven days to review regulations shortens the opportunity for proper scrutiny, and is more likely to result in legislation being rubber stamped. In addition, Lord Bethell informed us that day-to-day management of the Covid-19 pandemic would have been impossible if large swathes of regulations had lapsed and needed to be renewed every 30 days. A similar point was made by Lord Anderson, a Crossbench Member of the House of Lords, who noted in oral evidence that if coronavirus regulations had contained a sunset clause of 30 days they would have clogged Parliament up with a huge number of regulations that needed to be remade even though they were plainly sensible. Lord Blencathra, who chaired the House of Lords Delegated Powers and Regulatory Reform Committee during the Covid-19 pandemic, also emphasised that the scrutiny provisions in the Civil Contingencies Act were not suitable for a prolonged public health emergency.
73. Second, it is our view that there is an inherent benefit to using public health law, rather than civil contingencies law, to tackle a public health emergency. This point was made by the UK Cabinet Office in its 2022 post-implementation review of the Civil Contingencies Act. The review expressed the UK government's preference to rely on "sector-specific emergency legislation rather than the generic powers in the Civil Contingencies Act" because sectoral legislation is "known to those using or subject to the legislation, enabling effective implementation" and has undergone "the oversight and scrutiny to ensure [it is] proportionate to the circumstances that present themselves".⁹⁵
74. The same opinion was impressed upon us by public health professionals, both those on our Commission and others who provided us with evidence or comments on our draft recommendations. Their view was that public health officials are accustomed to using public health legislation, including the England and Wales Public Health Act, to respond to smaller public health threats, and are therefore very familiar with its provisions. Dr Brian McCloskey expanded on this point in oral evidence, emphasising that public health law is used almost every day for outbreak control, and that the restrictions imposed in an emergency are an escalation of interventions with which public health professionals are already familiar. He expressed concern that using one legislative approach (i.e. civil contingencies law) to respond to an emergency, and a different approach (i.e. public health law) for lower-level outbreaks, might make it harder to have coordinated and sensible decision-making across the whole range of public health interventions that will occur before, during and after a public health emergency. We note that Daniel Greenberg CB disagreed. He considered that the Civil Contingencies Act should

⁹⁵ Cabinet Office, *Civil Contingencies Act* (n 91), paragraph 82

in general be used over sectoral legislation in an emergency, because it is a modern piece of legislation designed to balance scrutiny, human rights, and an effective response to emergency. However, we are not persuaded that this is the right approach for the reasons given above.

75. Third and finally, the Civil Contingencies Act empowers the UK government to make emergency regulations for the entire United Kingdom. The devolved governments in Northern Ireland, Scotland and Wales do not have corresponding powers to make regulations themselves. While the devolved governments must be consulted by UK ministers before emergency regulations are made in relation to their respective nations, this requirement is not binding, and is in no way a substitute for the governments and legislatures of the devolved nations making and scrutinising public health regulations themselves.
76. This point was emphasised in written correspondence we received from Eluned Morgan MS, Minister for Health and Social Services in the Welsh government. Ms Morgan expressed the Welsh government's view that, as a matter of democratic and constitutional principle, the responsibility for public health matters in Wales rests with the Welsh Parliament and government and, on a practical basis, the Welsh government is best placed to respond to a public health emergency because it is already responsible for the day-to-day operation of the health service and a wide range of other public services. Ms Morgan found it "vital" that the Welsh government could use "systems and infrastructure to respond to the pandemic that did not exist on a cross-UK basis", and highlighted the engagement that took place during the Covid-19 pandemic between the Welsh government and wider society, including NHS Wales, schools and higher education institutes, public bodies, businesses, unions, local government, the third sector and the people of Wales. Ms Morgan concluded that "it was quite right and proper that powers during the [Covid-19] pandemic could be exercised differently for England, Scotland, Wales and Northern Ireland – and indeed it is very difficult to envisage how any other approach could possibly have worked". She set out the Welsh government's view that powers exercised by ministers should "be those that are best designed to address the particular problem in hand, and best reflect the constitutional and practical context – which importantly, includes consideration of how Scotland, Wales and Northern Ireland are governed differently", meaning that the Civil Contingencies Act "should continue to be reserved only for the gravest and most urgent emergencies, where it is proper to override (on a temporary basis) other constitutional and practical considerations". We agree with these views.
77. However, some who gave us evidence thought that the Civil Contingencies Act could be used in a way which respected the devolution arrangements under the UK constitution. Michael Clancy, Director of Law Reform at the Law Society of Scotland, took the view that emergency public health powers could be exercised by the UK government under the Civil Contingencies Act in a way which properly accommodated and respected the devolved governments' policies. Mr Clancy noted that regulations under the Civil Contingencies Act could confer on the devolved governments the authority for ministers to give directions or orders, or even make further secondary legislation.⁹⁶ He also referred us to the Concordat between Scottish ministers and the UK government, which agrees a framework for co-operation on the application of the Civil Contingencies Act in Scotland. We understand that a similar Concordat exists in relation to Wales. Mr Clancy recommended that respect for devolution could be strengthened by putting the Concordats on a statutory footing, and creating an obligation for there to be regular ministerial meetings between the four nations. We note, however, that conferring power on devolved governments under the Civil Contingencies Act to make orders would seem to require monthly renewal, and adjustments to the Concordats of the constitution and intergovernmental relations are both complex and contested areas of constitutional reform.⁹⁷

⁹⁶ Using [section 22\(3\)\(a\)](#) Civil Contingencies Act

⁹⁷ House of Lords Constitution Committee, *The Union and devolution* (2015-16, HL 149)

78. Others we spoke to indicated that, as a matter of principle, public health emergencies should be centrally managed. Although supportive of our overall findings, Matt Hancock MP, who was the UK Secretary of State for Health and Social Care during the first 15 months of the pandemic, emphasised “the irrationality of having three separate regimes across [Great Britain], given that the virus does not respect borders”. He took the view that “simply accepting that ‘health’ is devolved will leave us with a seriously suboptimal system. Response to communicable diseases is materially different to provision of NHS services and the arguments for its devolution do not stack up in the same way”. This chimes with evidence we received from Lord Bethell, who was Parliamentary Under Secretary of State at the Department of Health and Social Care between 9th March 2020 and 17th September 2021. Lord Bethell took the view that differences between the devolved nations did not work well during the Covid-19 pandemic, and that the coronavirus response should have been run as one country. He stated that the failure to mount a UK-wide response cost a lot of lives, and particularly emphasised the importance of the flow of data in an emergency, which he thought was compromised during the Covid-19 pandemic by the four nations running different data systems. Lord Bethell also noted that public messaging is important to maintaining public confidence, and having different nations running alternative – and sometimes contradictory – health measures caused problems.
79. While not advocating a UK-wide approach, a Northern Ireland official working in Health Protection also drew our attention to the complexities of dealing with an emergency public health response where reserved and devolved matters come close to overlapping. They told us that the Northern Ireland executive and Department of Health had to work very closely with the UK government to deal with international travel during the pandemic, explaining that the management of borders was a reserved issue, but that as soon as someone stepped over the Northern Ireland border then this became a health protection matter which fell under devolved powers. During the Covid-19 pandemic, Northern Ireland coronavirus legislation had to place powers on UK Home Office officials at the Northern Ireland border to ensure there was a consistent policy response.
80. We are very much alive to all the difficulties and concerns expressed above, and do not want to minimise them, particularly concerns around potential excess loss of life. From a rule of law perspective, we have our own concerns around legal uncertainty caused by divergences between the four nations, which we discuss in Chapter Six. However, the devolution of responsibility for health policy and provision is firmly embedded in the UK’s constitutional framework. The UK now comprises four different health systems with pronounced differences in administration and funding. We cannot recommend the use of a legal framework – i.e. the Civil Contingencies Act – that prevents the devolved governments from making their own public health regulations. We do not consider that the safeguards in the Civil Contingencies Act highlighted by Mr Clancy are sufficient to counterbalance the significance of a choice to withhold from the devolved administrations the power to decide for themselves to make public health regulations. Instead, we consider that different approaches between the four nations ought to be managed by close intergovernmental cooperation, and there should be an agreed formal basis for cooperation that is embedded in preparedness planning.

Intergovernmental cooperation in other countries

We understand that intergovernmental cooperation is one of the key themes being considered by the UK Covid-19 Inquiry, and so we have not considered it in detail as part of our review. However, our examination of intergovernmental cooperation in other countries indicates that intergovernmental institutions, bodies and structures should be developed in times of calm that can then allow for a coordinated approach between local and central powers in times of emergency.

We considered how countries with a federal structure facilitated cooperation between different governments. We heard that in Australia a national cabinet had initial success in coordinating action, but political divisions led to a breakdown in cooperation.⁹⁸ Similarly, in Germany, informal meetings between the heads of state-level governments and the Chancellor began taking place in March 2020 and helped limit initial policy divergence between federal states, but this system collapsed in March 2021 after some states decided to take a different approach. In response, in April 2021 a federal “emergency brake” was introduced into the federal Infection Protection Act 2000, which functioned until June 2021. This provided that, if the number of coronavirus infections exceeded a certain level in a state, then particular measures would take effect without the need for further state-level regulations. This provision was controversial and was challenged in the Federal Constitutional Court of Germany, but was ultimately upheld.⁹⁹

The country we reviewed that had the greatest success in intergovernmental cooperation was Belgium, where there was a strongly unified response to Covid-19. We heard that the federal government took the lead with broad consensus among Communities and Regions, and that it is highly unusual in Belgium for there to be such a spirit of collaboration. The central government took powers that would ordinarily fall under local competencies, e.g. measures to close schools and museums, and the measures that were coordinated by the central government provided a floor not a ceiling, with Communities and Regions having the ability to impose stricter restrictions. We heard that there were a number of possible explanations for the close collaboration in Belgium, including (1) the vertical integration of political parties across the country; (2) the high density of the Belgian population; (3) the limited size of the Belgian territory and the significant number of interregional travels which limited the practical possibility for policy divergences; (4) the uniformity of social rights and protections across the country; and (5) the possibility for legal challenge if authorities acted outside their jurisdiction, which necessitated collaboration.¹⁰⁰

⁹⁸ Evidence provided by Dr Marco Rizzi (Associate Professor in health law and policy at the UWA Law School)

⁹⁹ Evidence provided by Professor Anna Katharina Mangold (Professor for European Law at the Europa-Universität Flensburg) and Professor Anna-Bettina Kaiser (Professor of Public Law and the Foundations of Law at Humboldt University Berlin). See also: Roman Hensel, *The Federal Constitutional Court’s Final Decisions on the ‘Federal Emergency Brake’* (*Lex-Atlas Covid-19*, 21 December 2021) <<https://lexatlas-c19.org/final-decisions-on-the-federal-emergency-brake/>> accessed 9 March 2024

¹⁰⁰ Evidence provided by Professor Emmanuel Slautsky (Professor of Public and Comparative Law at the Université libre de Bruxelles) and Professor Johanne Poirier (Peter MacKell Chair in Federalism at McGill University)

CHAPTER THREE:

**Proposed
Amendments to the
General Framework
in the Public Health
(Control of Disease)
Act 1984 and the
Public Health etc.
(Scotland) Act 2008**

Introduction

81. In this chapter we outline our proposed amendments to the legislative framework which empowers ministers to make public health regulations under Part 2A of the England and Wales Public Health Act and Parts 5A and 7 of the Scotland Public Health Act, and which formed the template for the temporary coronavirus amendments to the Northern Ireland Public Health Act, which have now expired.¹⁰¹ We use “Public Health Act framework” as a shorthand term to refer to this general legislative framework; but make clear where there is a significant difference between measures in the England and Wales Public Health Act, Scotland Public Health Act and the temporary coronavirus amendments to the Northern Ireland Public Health Act.
82. At the outset, it is important to note that the temporary amendments to the Northern Ireland Public Health Act were expressly limited to addressing SARS-CoV-2, the virus that causes Covid-19.¹⁰² Our recommendations are premised on Northern Ireland’s anticipated new public health law instead taking an “all hazards” approach, in line with the Public Health Act framework as it applies in England, Wales and Scotland. We also recognise that any emergency public health legislation adopted in Northern Ireland will have additional complexities: plans for public health responses in Northern Ireland need to grapple with the island of Ireland being a single epidemiological unit, and have to answer the tricky question of how a public health emergency can best be managed if the Northern Ireland Assembly and executive are not functioning due to a collapse of devolved government. Unfortunately, we have not had the capacity to consider those issues in this report, but we hope that our recommendations will provide a useful general framework that can be further adapted.
83. Our focus in this Chapter is on amendments to enhance parliamentary oversight of government law-making during a public health emergency. At the end of the Chapter, we also consider an amendment which we hope will better embed human rights and equalities considerations into government decision-making during public health emergencies. In the light of the evidence we have received from public health professionals, we also think that the Public Health Act framework should be reviewed from a public health and governance perspective to ensure that it provides governments with a sufficient ‘menu of options’ to launch an effective response to future emergencies. This task falls outside our areas of expertise as a Commission, but we hope it will be taken forward by policy makers in consultation with public health professionals and the wider public.
84. Some of those who gave us evidence were pessimistic as to how far a future government, faced with a public health emergency, would willingly submit to a pre-existing legislative framework that enhances parliamentary oversight of government law-making by limiting ministerial powers. In oral evidence, Lord Blencathra stated that it is naïve to think we can invent a blueprint that governments will follow in the future, and there is nothing that can be put in place now to stop governments behaving poorly in future public health emergencies. He was of the view that, when the next emergency occurs, the government will say that the situation is different and new emergency powers are needed, and will set aside pre-existing legislation. We acknowledge this concern, but note that the vast majority of the UK and Welsh governments’ legal response to Covid-19 was carried out through powers conferred under existing legislation, and the powers

¹⁰¹ Namely, sections [45A-F](#) and [45P-R](#) England and Wales Public Health Act, sections [86A-I](#), [94](#) and [112](#) Public Health Scotland Act, and the now repealed [Part 1A](#) Northern Ireland Public Health Act

¹⁰² [Schedule 18](#) Coronavirus Act 2020

extended to Northern Ireland and Scotland to deal with the pandemic were copied from that template. The majority of the foreign nations we reviewed also relied on a combination of pre-existing and emergency-responsive legislation.

85. We have tried to address the concerns expressed by Lord Blencathra by keeping in the forefront of our minds the need for ministers to act as swiftly as possible in an emergency. We intend that our recommendations should not obstruct in any way a timely and effective public health response. In addition, we hope that a future government will recognise the great benefits provided by legislative scrutiny of emergency law-making. As well as helping to ensure the maintenance of the rule of law and principles of good governance, parliamentary oversight can aid the effectiveness of a public health response. The House of Lords Constitution Committee made this point in their report on Covid-19 and the use and scrutiny of emergency powers, stating that:

“[w]hen scrutiny is limited through the fast-tracking of legislation, or the extensive use of secondary legislation, essential checks on executive power are lost, and the quality of the law could suffer. Governments should not fear meaningful legislative scrutiny. While the Government is responsible for initiating most legislation, Parliament’s responsibility for the legislative process promotes better laws, governance and, most importantly, better policy.”¹⁰³

86. Lord Bethall, who experienced emergency governance as Parliamentary Under-Secretary of State at the Department of Health and Social Care during the first 18 months of the Covid-19 pandemic, also outlined in oral evidence the importance of parliamentary scrutiny in a public health emergency from the perspective of government. He noted that, as the “national pulpit”, the UK’s Parliament sets the tone in the whole country through the media and it is therefore important for the UK government to communicate effectively in Parliament. He also praised the merits of thoughtful parliamentary scrutiny, noting how the law enacted in response to Covid-19 was clearer, with fewer errors, inconsistencies and contradictions when it had been subjected to proper legislative scrutiny. He emphasised that no one has a monopoly on wisdom, and the involvement of parliamentarians from all parties in scrutinising government decision-making helps make better policy. Finally, from a practical point of view, he stressed that it is important to keep legislatures on side in an emergency, as governments do not want to begin losing the support of parliamentarians as that could slow down their ability to “get things done”.
87. Research conducted during the Covid-19 pandemic by the Bingham Centre for the Rule of Law and the Ada Lovelace Institute, which involved one of our commissioners, also shows that members of the public expect ministers to comply with the rule of law and principles of good governance in a public health emergency. The study found that citizens accept that policymakers face unusual pressures and may need to resort to unprecedented mechanisms, but nonetheless expect the frameworks of the rule of law and democracy – such as accountability, proportionality, equality and human rights – to remain in place, and for public health interventions to be transparently and clearly justified.¹⁰⁴
88. We now turn to our analysis and recommendations for amendment of the Public Health Act framework.

¹⁰³ Constitution Committee, *COVID-19 and the use and scrutiny of emergency powers* (n 82)

¹⁰⁴ Reema Patel, Aidan Peppin and Nardine Alnemr, *The rule of trust: Findings from citizens’ juries on the good governance of data in pandemics* (Ada Lovelace Institute, July 2022), pages 10-30

A central problem with the current Public Health Act framework: insufficient parliamentary scrutiny of regulations, including insufficient oversight of the urgent procedure

89. When seeking written and oral evidence, we asked how far Covid-responsive secondary legislation had been subject to adequate levels of parliamentary scrutiny. Witness across all four nations found that parliamentary scrutiny had been deficient. They gave varied reasons for this view. However, a common theme was governments' overreliance on the urgent [made affirmative procedure](#), which was used habitually and to impose the most severe restrictions, namely national and local 'lockdown' measures such as the stay at home regulations and other restrictions on people's movement, limits on gatherings, and the closure of businesses.
90. As discussed above at paragraph 34, the Public Health Act framework permits a minister to use the made affirmative procedure when he or she considers that domestic public health measures need to be imposed urgently. This enables regulations that would ordinarily need to be laid before the legislature in draft to instead be made into law by a minister and come into force without prior parliamentary debate and approval. By the time parliamentarians come to consider a made affirmative instrument, the type of scrutiny applied to it is likely to be less robust and carry less political salience than the scrutiny applied to an instrument that has not yet come into law, because the made affirmative instrument is often "already in force, being implemented, and being complied with".¹⁰⁵
91. Before the Covid-19 pandemic, use of made affirmative instruments was generally rare. Data from the Scottish Parliament shows that only nine made affirmative instruments were made between 2011 and the end of 2019,¹⁰⁶ while only two were laid before the UK Parliament in 2017 and four in 2018.¹⁰⁷ The use of made affirmative instruments accelerated during the Brexit process, with 30 made affirmative Brexit instruments laid before October 2019.¹⁰⁸ During Covid-19, the use of the made affirmative procedure increased even more rapidly. In the UK Parliament, 100 made affirmative regulations were introduced under the England and Wales Public Health Act between 27th January 2020 and 3rd March 2022.¹⁰⁹ In Northern Ireland and Scotland, 86 and 67 made affirmative regulations were made respectively using equivalent powers extended to those nations under the Coronavirus Act 2020.¹¹⁰ In Scotland, a further 62 made affirmative international travel regulations were made under the Scotland Public Health Act.¹¹¹
92. The made affirmative procedure exists to facilitate fast government law-making in times of urgency, and it is therefore right and necessary that the procedure should be available for use during a public health emergency. Our starting point as a Commission has always been that

¹⁰⁵ Fiona de Londras, Pablo Grez Hidalgo and Daniella Lock, 'Rights and parliamentary oversight in the pandemic: reflections from the Scottish Parliament' [2022] Public Law, page 599. Professor de Londras is one of our commissioners.

¹⁰⁶ Scottish Parliament Delegated Powers and Law Reform Committee, *Inquiry into the use of the made affirmative procedure during the coronavirus pandemic* (2022, SP 110), paragraphs 23-24.

¹⁰⁷ Written evidence from the Secondary Legislation Scrutiny Committee ([Appendix 14](#))

¹⁰⁸ Alexandra Sinclair and Joe Tomlinson, *Plus ça change? Brexit and the flaws of the delegated legislation system* (Public Law Project, October 2020)

¹⁰⁹ Hansard Society, 'Coronavirus Statutory Instruments Dashboard, 2020-2022' (June 2022), <<https://www.hansardsociety.org.uk/publications/data/coronavirus-statutory-instruments-dashboard>> accessed on 20 December 2023

¹¹⁰ Written evidence from the Northern Ireland Assembly ([Appendix 11](#)) and data provided by the Scottish Parliament's Delegated Powers and Law Reform Committee

¹¹¹ Data provided by the Scottish Parliament's Delegated Powers and Law Reform Committee. In England, Northern Ireland and Wales international travel regulations are subject to the negative procedure.

any primary legislation designed to address public health emergencies must enable urgent law-making – a position that received support from all those who provided us with written evidence on this point. However, the experience of the Covid-19 pandemic suggests that the Public Health Act framework does not currently contain sufficient safeguards to restrict the use of the made affirmative procedure to truly urgent situations. The House of Commons Public Administration and Constitutional Affairs Committee reached this conclusion in September 2020, when it published a report which found that “the use of the urgent procedure [by the UK government] has not always been justified, particularly when the government has announced that measures will be introduced some weeks in advance.”¹¹² The House of Lords Secondary Legislation Scrutiny Committee made a similar point in its written evidence to us, informing us that, when scrutinising made affirmative instruments related to Covid-19, the Committee was “often unconvinced that the policy being implemented justified the use of the urgency provisions”.¹¹³

93. These comments echo those made by parliamentarians during the pandemic. On 10 June 2020, Justin Madders, a Labour MP, strongly critiqued the fact that the House of Commons was debating made affirmative ‘lockdown’ regulations retrospectively, stating that:

“[o]f course we accept that the initial regulations had to be hurriedly introduced, in response to the rising number of infections. However, as I stated when we debated those initial regulations back on 4 May—some six weeks after they had been introduced—given that Parliament was up and running again by that time, there should have been sufficient time to ensure that future changes were debated and had democratic consent before they were introduced.”¹¹⁴

94. Three months later, the Speaker of the House of Commons, Sir Lindsay Hoyle, made a rare intervention to criticise a perceived overuse of the made affirmative procedure by government, expressing his view that:

“The way in which the Government have exercised their powers to make secondary legislation during this crisis has been totally unsatisfactory. All too often, important statutory instruments have been published a matter of hours before they come into force, and some explanations of why important measures have come into effect before they can be laid before this House have been unconvincing; this shows a total disregard for the House.”¹¹⁵

95. One example of an English statutory instrument which arguably did not need to be made using the urgent made affirmative procedure is that which required face coverings to be worn in certain public places.¹¹⁶ On 4th June 2020, the UK government announced that regulations would be made to make face coverings mandatory from 15th June. However, the regulations were not laid before Parliament until 14th June, using the made affirmative procedure, before they came into force from midnight on 15th June.
96. In his oral evidence, Sir Jonathan Jones, who was head of the UK Government Legal Department from 2014 until September 2020, and who spoke with us in a personal capacity, noted that one might say the UK government relied excessively upon the made affirmative procedure because it had a positive aversion to scrutiny. However, he also emphasised the immense time pressure

¹¹² Public Administration and Constitutional Affairs Committee, *Parliamentary Scrutiny* (n 82), page 8

¹¹³ Written evidence from the Secondary Legislation Scrutiny Committee ([Appendix 14](#)) Others shared this view, including Sir Jonathan Jones and Dr Ronan Cormacain

¹¹⁴ [DLC Deb](#) 10 June 2020, col 6

¹¹⁵ [HC Deb](#) 30 September 2020, vol 681 col 331

¹¹⁶ The Health Protection (Coronavirus, Wearing of Face Coverings on Public Transport) (England) Regulations 2020 (SI 2020/592)

the government was under. He explained that time for scrutiny and debate had simply not been factored into the process, and that as time was tight it became easier to do things in a rush. Lord Bethell also informed us that decisions were made at a very late stage and often extremely reluctantly, so that even when there was evidence and the central case was pointing in one direction, Downing Street was very reluctant to make an early decision.

97. Excessive reliance on the made affirmative procedure was not unique to Westminster, although we received less evidence on this issue from other jurisdictions. The Committee on the Administration of Justice, a non-governmental human rights organisation in Northern Ireland, drew our attention to the “continued use” of the urgent procedure in Northern Ireland during Covid-19. The Committee highlighted one occasion where made affirmative regulations were used to extend criminal offences on the evening of a Black Lives Matter Protest in June 2020 and referred to an academic article by one of its staff members, which argued that “it is at best questionable whether [the extension of criminal offences] was necessary ‘by reason of urgency’”.¹¹⁷ The Northern Ireland Assembly’s Committee for Health also queried whether the emergency procedure was being inappropriately used for non-urgent measures in June 2020, when made affirmative regulations were used to increase the number of individuals permitted to attend gatherings from 10 to 30 people. In response, a representative from the Northern Ireland Department of Health informed the Committee that the Department’s approach was that “legislative changes are made just as soon as is practicable after the executive have taken a decision”.¹¹⁸ This seems to suggest that the Northern Ireland Department of Health was using the made affirmative procedure habitually, without necessarily considering whether each measure being introduced was sufficiently urgent to justify the use of the procedure.
98. We are also aware of at least one instance where the Scottish Parliament’s Delegated Powers and Law Reform Committee found that the Scottish government had used the made affirmative procedure inappropriately. On 5th October 2021, made affirmative regulations were used to implement a vaccine certification scheme in Scotland. The vaccine certification policy had a long gestation: it had been announced on 3rd August 2021 and an outline ‘Strategy/Plan’ was published by the Scottish government on 9th September 2021. Nonetheless, a draft of the regulations introducing the scheme was not provided to MSPs until 29th September 2021, after which the regulations were made into law and laid before the Scottish Parliament the following day. One member of the Delegated Powers and Law Reform Committee stated that the Scottish government had been “wrong” to use the made affirmative procedure when the First Minister had “announced weeks ago that she and the Scottish government wanted to bring in a vaccination passport scheme,” while another suggested that “[the regulations] are being put through the made affirmative procedure not because of urgency but because of political expediency.”¹¹⁹ After reviewing this incident, researchers from the University of Birmingham’s Covid-19 Review Observatory, including one of our commissioners, concluded that the made affirmative procedure in the Public Health Act framework had the potential “to be used as a mode of scrutiny-avoidance (or at least minimisation) rather than being limited to situations of bona fide urgency”.¹²⁰

¹¹⁷ Written evidence from the Committee on the Administration of Justice ([Appendix 1](#)). The article referred to in the evidence is Daniel Holder, ‘From special powers to legislating the lockdown: the Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020’ (2020) 71(4) NILQ, pages 537-555

¹¹⁸ The Northern Ireland Assembly Committee for Health, *Meeting on Health Protection Regulations: Amendment (No. 9) and Amendment (No. 10)* (9 July 2020) available at <<https://aims.niassembly.gov.uk/officialreport/minutesofevidencereport.aspx?AgendaId=23001&evidID=11998>> accessed 1 February 2024

¹¹⁹ The Scottish Parliament Delegated Powers and Law Reform Committee, *7th Meeting 2021, Session 6* (5th October 2021) accessible at <<https://www.parliament.scot/chamber-and-committees/official-report/search-what-was-said-in-parliament/DPLR-05-10-2021?meeting=13351&iob=121128>> accessed 1 February 2024

¹²⁰ Fiona de Londras, Pablo Grez Hidalgo and Daniella Lock, ‘Rights and parliamentary oversight’ (n 105) page 591

99. The above discussion illustrates the serious potential for the made affirmative procedure to be abused, showing that the Public Health Act framework does not currently contain sufficient safeguards to ensure that use of the procedure is restricted to truly urgent situations. This issue is compounded by a further problem raised by witnesses in oral evidence sessions: that the current Public Health Act framework contains no clear mechanisms to bring to an end the emergency period during which resort to the urgent law-making procedure is appropriate. One of the lessons we have learned from Covid-19 is that a public health emergency can last for a long time, but urgent law-making may not be necessary for the entirety of that time. A public health emergency may contain both acute crisis periods, during which resort to urgent law-making is necessary, and periods during which interventions are still needed but there is more time for parliamentary oversight of executive action. We therefore propose amendments to the Public Health Act framework that we hope will:

- a) Enable the UK and devolved governments to take urgent action to respond to a public health threat, including taking precautionary measures;
- b) Restrict the use of urgent law-making to truly urgent situations;
- c) Contain a mechanism which recognises the end of a period of crisis necessitating urgent law-making;
- d) Ensure an appropriate role for the UK and devolved legislatures in providing oversight and accountability over emergency law-making and claims of urgency;
- e) Enable emergency public health interventions to be imposed outside of an urgent crisis period, with greater oversight and accountability by the UK and devolved legislatures; and
- f) Maintain the rule of law and principles of good governance including transparency, proportionality, participation and accountability.

How significantly should the Public Health Act framework be changed?

100. We considered some relatively radical changes to the Public Health Act framework in order to meet the above aims. In particular, we were struck by legislative reform that was introduced in Israel at the start of 2022. Professor Aeyal Gross from Tel Aviv University's Faculty of Law informed us that Israel amended its coronavirus legislation ('The Coronavirus Law') in 2022 to recognise two types of situation – an “emergency” and a “special health situation”. During an “emergency” the government has access to greater powers with lower levels of parliamentary oversight. For example, lockdowns can only be implemented during an emergency, and emergency regulations can be scrutinised by the Israeli Parliament (the Knesset) a few days after enactment, whereas during a special health situation they must be scrutinised a few days prior to enactment. The distinction between an “emergency” and a “special health situation” is based on an assessment of the level of risk. “Emergency” powers are available when there is a significant rise in disease transmission and a real risk for significant damage to public health. The “special health situation” applies before an increase in disease transmission occurs: when there is a real risk of Covid-19 spreading and causing significant infections.

101. Professor Gross was critical of some aspects of detail within this legislation, in particular the breadth of the powers available to the Israeli government during a “special health situation” and the limited length of time that Knesset committees have to scrutinise regulations.¹²¹ However, we found the overall framework interesting, and spent some time considering whether it could provide a model for UK legislation. Some witnesses were in favour of this approach. Dr Brian McCloskey supported a public health law that in some way had escalating stages built in with break-points and safeguards beyond which the government cannot go

¹²¹ Aeyal Gross and Nir Kosti, 'The Paradox of Israel's Coronavirus Law' (*Verfassungsblog*, 8th January 2021) <<https://verfassungsblog.de/the-paradox-of-israels-coronavirus-law/>> accessed 1 February 2024

without more parliamentary scrutiny. For example, section one might contain powers that are always available, section two powers that are only available if an emergency is declared, and section 3 powers that could only be triggered by a vote in Parliament and must be reviewed on a regular basis. Dr McCloskey, Sir Jonathan Jones and Daniel Greenberg CB felt that this type of tiered legislation would be useful in clearly bringing an emergency period to an end, as it could contain criteria for when certain powers would no longer be available to government. Professor Sir David Nabarro also thought a tiered approach would be practical, advising that the “WHO approach is all about encouraging decision-makers to establish policies and then change the stringency of responses based on assessments of the nature and level of risk for different population groups (as well as the need for urgency)”¹²²

102. However, when we discussed the detail of how a tiered structure could be implemented into the Public Health Act framework, we became less convinced of its merits. Unlike Israel’s Coronavirus Law, the England and Wales Public Health Act and Scotland Public Health Act take an “all hazards” approach and are designed to enable governments to respond to a wide variety of potential health risks.¹²³ These risks may arise from any type of infection or contamination, including radiation. We found it difficult to conceive of criteria for determining levels of “public health risk” that could be applied to any potential infection or contamination without being overly broad and simplistic.
103. In addition, we found it hard to identify which criteria should determine whether particular public health interventions were allocated to “higher” or “lower” tiers. The most obvious criterion was the impact that an intervention would have on people’s rights. However, almost all interventions in a public health emergency will impact people’s rights, and we consider that any measure that interferes with an individual’s rights – even if it affects only a small number of people – should be subject to the most thorough parliamentary scrutiny that is practicable.
104. Finally, we were conscious that all the public health professionals to whom we spoke advised that the Public Health Act framework is generally sound from a public health perspective. A tiered structure would be a radical departure from the current framework. It would also introduce a level of complexity that we concluded was not necessary to achieve our aims of securing greater parliamentary scrutiny and respect for the rule of law. We therefore concluded that it would be preferable to amend the Public Health Act framework in ways other than through the introduction of a statutory system of multiple layers or tiers.
105. As a result, we recommend that some elements of the existing structure for making emergency public health regulations should be maintained: the [draft affirmative procedure](#) should be the default parliamentary procedure for domestic public health regulations, and the made affirmative procedure should continue to be available for regulations that need to be made urgently. Our key proposed amendments, which we outline in the rest of this chapter, focus on improving the use of the made affirmative procedure in public health emergencies from the perspective of the rule of law and democratic accountability. Our organising principle has been to recommend amendments that will restrict the procedure’s use to truly urgent situations and impose significantly more robust accountability requirements over its exercise than those found in the current frameworks, while continuing to allow governments to act as swiftly as possible in an emergency. Our intention is for governments to use the draft affirmative procedure to make public health regulations when that is at all possible, so that the UK legislatures have a chance to scrutinise, debate and approve public health regulations before they become law.

¹²² Written evidence from Professor Sir David Nabarro ([Appendix 10](#))

¹²³ The temporary coronavirus amendments to the Northern Ireland Public Health Act did not take an all hazards approach, they were expressly limited to addressing SARS-CoV-2, the virus that causes Covid-19: see [schedule 18](#) Coronavirus Act 2020.

106. Within the structure that we propose to achieve this objective, we suggest some further amendments to address some more piecemeal problems with the Public Health Act framework that arose in evidence we received and our discussions as a Commission. These problems include the four UK legislatures not being provided with sufficient impact assessments; and international travel regulations made under the England and Wales Public Health Act, and the temporary coronavirus amendments to the Northern Ireland Public Health Act, being subject to the [negative parliamentary procedure](#) despite them often being gravely intrusive.

The introduction of a “declaration of an urgent health situation”

107. Our first proposed amendment is that ministers should only be able to use the urgent made affirmative procedure to make regulations in response to a public health threat when a declaration of an urgent health situation is in effect. The declaration would therefore unlock the use of the made affirmative procedure in public health emergencies, and act as a start and end point to an acute period of crisis which necessitates urgent law-making.

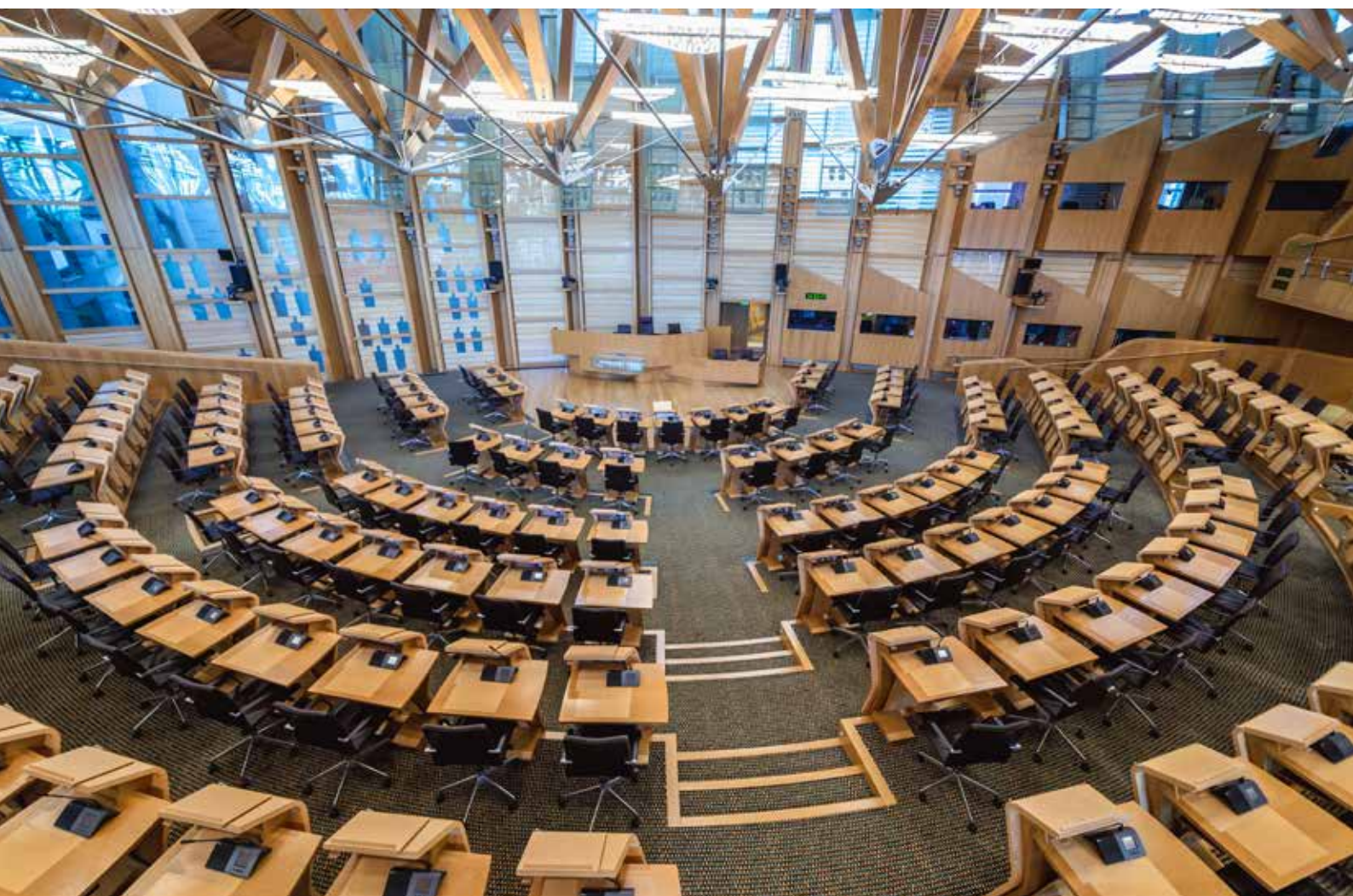
108. A clear majority of foreign jurisdictions that we reviewed – eight out of ten – used some form of declaration procedure to grant the executive powers for urgent law-making. We heard that in some countries (e.g. France) this procedure gave excessive power to the executive, but in other countries (e.g. New Zealand) emergency declarations enhanced the accountability of government to the legislature. Closer to home, in 2022 the “public health declaration” procedure we discussed in paragraphs 38-41 was introduced into the Scotland Public Health Act.

109. We therefore sought evidence as to whether a declaration procedure should also be introduced in the England and Wales Public Health Act, and Northern Ireland’s anticipated new public health Bill, (and, if necessary, modified in Scotland) so as to facilitate better parliamentary oversight of urgent law-making in public health emergencies. The evidence we received was mixed. Some were in favour of introducing a declaration procedure. David Melding, a former Member of the Senedd who sat on the Welsh Parliament Constitutional and Legislative Affairs Committee during the early stages of the Covid-19 pandemic, considered that the use of a declaration to unlock emergency public health powers would probably have been wise during the pandemic, and would have allowed the Welsh Parliament to focus more on the initial big decisions that the Welsh government was making. Baroness Thornton, who was Labour’s Shadow Spokesperson for Health in the House of Lords from 2018 to 2022, also thought that a declaration procedure would be useful in signalling a clear starting point to a crisis. She, however, felt that a declaration procedure would only work if certain things flow from it, i.e. how you handle the next stage and who is involved in that process. Lord Bethell made a similar point, suggesting that a declaration should be used to formally mark the start of an emergency period and shift the shape of government. He explained that the Department of Health acquired a wide range of responsibilities during the pandemic but was desperately short of people to implement and manage those responsibilities, and so a declaration procedure should trigger a process to facilitate the restructuring of government departments to enable them better to respond to a public health emergency. We see the logic in this suggestion, but consider that the re-shaping of Whitehall is a matter for government and policy planning, rather than a legislative framework.¹²⁴

¹²⁴ Although we note that some reallocation of financial resources may be needed within government. If this is a significant sum, then it will require approval from Parliament, and could be provided for in an emergency-responsive statute.

110. Other witnesses were firmly opposed to the introduction of an emergency declaration procedure. Lord Blencathra was not convinced that a declaration procedure would lead to enhanced scrutiny, as a future government could easily pass new primary legislation amending or removing the need for a declaration. Lord Anderson, Sir Bernard Jenkin and Professor Adam Tomkins were opposed to emergency declarations in general. Their reasons included that governments tend to keep declarations in force for longer than is desirable; that a declaration of emergency will provide governments with cover for the use of the urgent procedure when it is not justified; and that in practice parliamentarians will not challenge governments' assertions of emergency. Sir Bernard also observed that an emergency declaration procedure which enabled the government to make law without parliamentary approval would be foreign to the UK's legal framework.
111. We recognise the force of these objections. We had a number of discussions where we considered the evidence we received on this topic, explored the arguments against introducing a declaration, and reviewed the declaration procedure in the amended Scotland Public Health Act. These discussions led us to conclude that it is possible to draft a declaration procedure that would ameliorate the concerns expressed by Lord Anderson, Sir Bernard Jenkin and Professor Adam Tomkins. Ultimately, we felt that introducing a declaration procedure into the public health Acts of all four nations would be an effective way to help restrict the use of urgent law-making to truly urgent situations, and should form part of our recommended amendments. We have used the declaration procedure in the Scotland Public Health Act as a starting point but propose that some amendments be made to it.

Image: The Scottish Parliament Chamber



RECAP OF THE SCOTLAND PUBLIC HEALTH ACT DECLARATION PROCEDURE

The 2022 amendments to the Scotland Public Health Act restricted the circumstances in which domestic public health protection regulations can be made by introducing a public health declaration procedure. In general, domestic health protection regulations can only be made when a public health declaration has effect.¹²⁵ The only exception is for regulations which are not “responding to a particular infection or contamination”, i.e. those which establish standing preparedness arrangements.

Scottish ministers can make a public health declaration when they consider that an infectious disease or contaminant constitutes, or may constitute, a danger to human health, and the making of domestic public health regulations may be a way of protecting against that danger.¹²⁶ Before making a public health declaration, the Scottish ministers must consult the Chief Medical Officer for Scotland or another person designated by the ministers.¹²⁷

A public health declaration will come into effect after it has been approved by the Scottish Parliament, although there is also a backstop for post-implementation approval (or rejection) if the Scottish ministers consider that it is not practicable for the declaration to be approved in advance, for example because Parliament is dissolved.¹²⁸ In this case, the ministers must make a statement explaining why it is not practicable to secure advance approval of the declaration, after which the public health declaration will have effect immediately but must be approved by the Scottish Parliament within 28 days if it is to remain in force.¹²⁹ The statement explaining why it is not practicable to secure advance approval must also be laid before the Scottish Parliament.¹³⁰

The Scottish ministers must publish the declaration, its approval by Parliament, and the time at which it comes into effect, in such manner as they consider appropriate.¹³¹ Ministers must revoke the declaration if they no longer consider that the infectious disease or contaminant constitutes or may constitute a danger to human health, and that the making of regulations may be a way of protecting against that danger.¹³² A notice of the revocation must be laid before the Scottish Parliament and published in such manner as the Scottish ministers consider appropriate.¹³³ The revocation of a declaration does not affect anything done before the declaration ceased to have effect.¹³⁴

¹²⁵ [Section 86B\(1\)](#) Scotland Public Health Act. The declaration procedure does not apply to regulations concerning international travel (i.e. those which address health risks arising from vehicles arriving or leaving Scotland), which are made under a different section of the Scotland Public Health Act – [section 94](#)

¹²⁶ [Section 86B\(2\)](#) Scotland Public Health Act

¹²⁷ [Section 86B\(3\)](#) Scotland Public Health Act

¹²⁸ [Section 86B\(6\)](#) and [86C](#) Scotland Public Health Act

¹²⁹ [Section 86C\(4\)](#) Scotland Public Health Act. Recesses of over four days or any time during with the Scottish Parliament is dissolved do not count towards the 28 days - [Section 86C\(6\)](#) Scotland Public Health Act

¹³⁰ [Section 86C\(3\)](#) Scotland Public Health Act

¹³¹ [Section 86B\(5\) and \(8\)](#) Scotland Public Health Act

¹³² [Section 86B\(9\)](#) Scotland Public Health Act

¹³³ [Section 86B\(9\)](#) Scotland Public Health Act

¹³⁴ [Section 86B\(11\)\(a\)](#) Scotland Public Health Act

Proposed amendments to the Scottish declaration procedure

(I) Raising the threshold for the use of a declaration and restricting its unlocking function to made affirmative regulations

112. There are two main issues with the Scottish declaration procedure which limit its ability to address the key problems that we have identified with the Public Health Act framework. The first is that the Scottish declaration procedure has a relatively low threshold that must be met before a declaration can be made: a declaration of a public health situation can be made when “an infectious disease or contaminant constitutes, or may constitute, a danger to human health”, and the making of domestic health protection regulations “may be a way of protecting against that danger”. With a threshold this low, a public health declaration could be made at any time there is a mere risk of danger. This means that the Scottish declaration does not act to specifically delineate a period of acute crisis, during which it may be necessary to resort to urgent law-making.
113. Second, **all** domestic public health regulations are locked behind the Scottish declaration: a minister cannot make any domestic health regulations at all, except for those making standing preparedness arrangements, unless a declaration is in force. Using the declaration procedure to unlock all domestic public health regulations means that there is no enhanced parliamentary oversight of the made affirmative procedure in particular, and is another reason why the Scottish declaration procedure does not delineate a period of crisis.
114. Therefore, the Scottish declaration procedure does not significantly enhance parliamentary scrutiny of the government’s use of the urgent made affirmative procedure, nor limit urgent law-making to truly urgent situations. Instead, it seems to encapsulate some of the concerns expressed by Lord Anderson, Sir Bernard Jenkin and Professor Adam Tomkins: that governments can keep declarations in force for longer than is desirable, and that a declaration can provide the government with cover for the use of the urgent procedure when it is not justified.
115. For these reasons, we favour a different approach. We recommend that the declaration should not be of a public health situation, but rather of an **urgent** health situation. Ministers should only be able to use the urgent made affirmative procedure to make public health regulations¹³⁵ when a declaration of an urgent health situation is in effect. The declaration would therefore unlock the use of the urgent made affirmative procedure in public health emergencies, meaning that the legislature would have greater oversight of the use of this procedure. Other parliamentary scrutiny procedures would remain available without a declaration needing to be in force.
116. We also consider that the bar for triggering the declaration of an urgent health situation should be raised: recourse to a declaration of an urgent health situation should only be available if, after consulting the Chief Medical Officer in their jurisdiction, a minister considers that an infectious disease or contaminant constitutes, or may constitute, a danger to human health, and it is necessary to make regulations on an urgent basis in order to protect against that danger. It will be necessary to make urgent regulations only where it is not possible for such regulations to

¹³⁵ Including international travel regulations under [section 94\(1\)](#) Scotland Public Health Act, which are not covered by the current Scottish declaration procedure

be made using the draft affirmative scrutiny procedure in a timeframe that affords appropriate parliamentary scrutiny. The declaration must be revoked if those conditions are no longer satisfied. The declaration would therefore delineate the start and end point of an acute period of crisis during which resort to the urgent made affirmative procedure is appropriate. It would also function to alert the legislature to the government's intention to have recourse to urgent law-making powers, and give all parliamentarians the opportunity to voice general concerns and make general recommendations about the government's response to the urgent public health emergency. It would also, through media coverage, give the public exposure to a broader variety of views on what constitutes an appropriate response.

(II) Reducing the window for retrospective approval by the legislature

117. We recommend retaining the parliamentary approval mechanism in the Scottish declaration procedure. This requires a declaration to be laid in draft before the legislature before being made, and be subject to a debate and confirmation vote, but also allows for retrospective parliamentary approval if the minister considers that it is not practicable for the declaration to be approved in advance. The provision for retrospective approval ensures that a declaration can be made in the most urgent of situations. However, we recommend shortening the time period for retrospective parliamentary approval from 28 days to 14 days, to ensure that the legislature considers the declaration in a timely fashion.

118. We also recommend that the legislature should be recalled if a public health declaration is made during a period of parliamentary prorogation or adjournment, and the declaration would otherwise be approved more than 21 days after it was made. If circumstances make recall impracticable then the Speaker/Presiding Officer should have discretion to instruct the recall to take place virtually rather than in person, or in extremis for the recall requirement to be set aside, following consultation with the leaders of all the political parties represented in the Chamber.

(III) Enhancing the requirement to consult the Chief Medical Officer before making a declaration

119. We consider that the Scottish declaration procedure, whereby the Chief Medical Officer participates in the decision to trigger the declaration, introduces a desirable element of objectivity into the process of urgent law-making: the minister alone cannot subjectively decide whether a situation requires urgent law-making. This element of objectivity is lacking from the England and Wales Public Health Act, and was also absent from the temporary amendments to the Northern Ireland Public Health Act, a matter which was the subject of criticism during the Covid-19 pandemic. For instance, the House of Lords Constitution Committee considered it to be a "problem" that the emergency procedure within the England and Wales Public Health Act uses a notion of "urgency" that is not objective.¹³⁶ We received similar oral evidence on this point from Lord Anderson and written evidence from the Scottish Police Federation.¹³⁷

120. We would, however, propose two modest amendments to the Scottish procedure. First, we consider that any advice provided by the Chief Medical Officer on the decision to issue a declaration should be made available to the legislature, so that parliamentarians can properly

¹³⁶ Constitution Committee, *COVID-19 and the use and scrutiny of emergency powers* (n 82), paragraph 58

¹³⁷ Written evidence from the Scottish Police Federation ([Appendix 13](#))

review the scientific basis underpinning the urgency of the situation. Second, Scottish ministers must currently consult the Chief Medical Officer for Scotland or another person designated by the Scottish ministers before making a declaration. We do not see why another person would need to be consulted in place of the Chief Medical Officer, unless the Chief Medical Officer is incapacitated or otherwise unavailable. We therefore suggest that ministers in all four nations should be required to consult the relevant Chief Medical Officer in their jurisdiction, and may only consult another person designated by the minister if the Chief Medical Officer is unable to provide advice.

(IV) Introducing a sunset clause

121. Under the existing legislation the Scottish Parliament has no oversight of the declaration once it is in force – it is the Scottish ministers who decide if a declaration needs to be revoked. We consider that the legislature should have greater involvement in reviewing the operation of a declaration of an urgent health situation. We therefore recommend introducing a two month sunset clause to the declaration that can only be renewed with approval of the legislature, following a debate and vote on a motion to extend the declaration. This should give parliamentarians a chance to review the strategy of the government’s emergency response to date, and require the minister to justify why urgent law-making continues to be warranted. We consider that this should help ameliorate the concern expressed by Lord Anderson, Sir Bernard Jenkin and Professor Adam Tomkins that governments tend to keep declarations in force for longer than is desirable.
122. When we sought feedback on the proposed sunset clause, Matt Hancock MP expressed some reservations. He noted that, in his experience “repeat votes lead to much greater populist pressure, and difficulties in keeping to a rational agenda - whereas one-off votes are much more reasonable as there isn’t a head of steam built up in the same way”. He stated that “we don’t have repeat votes like this for any other measures I know of.” We note these concerns but consider that it is important for the UK legislatures to be able regularly to review whether it is necessary for urgent law-making to continue. When considering the position in the other jurisdictions that formed part of our inquiry, a two month sunset period emerges as a reasonable time frame for review. Although we recognise that the nature and function of declarations differs according to jurisdiction, in many countries the time period is similar or much shorter. For instance, in New Zealand, an “epidemic notice” can be issued by the Prime Minister, on advice of the Director-General of Health and agreement of the Minister of Health, which grants ministers powers to, for example, activate dormant emergency provisions. The epidemic notice is subject to a three month, renewable sunset period.¹³⁸ In addition, a state of emergency in New Zealand lasts seven days, unless renewed, which can be followed by a 90 day “transition period”.¹³⁹ In France a declaration of a state of health emergency is ordinarily subject to a one-month sunset period that can be extended by Parliament (although during Covid-19 new laws were adopted that allowed the executive to declare a two-month state of emergency, which was then extended).¹⁴⁰

¹³⁸ Dean Knight, ‘New Zealand: Legal Response to Covid-19’ in Jeff King and Octavio Ferraz (eds.), *The Oxford Compendium of National Legal Responses to Covid-19* (OUP 2021), paragraph 16 accessible at <<https://oxcon.ouplaw.com/display/10.1093/law-occ19/law-occ19-e4>> accessed 1 February 2024. The Oxford Compendium was co-edited by one of our commissioners, Professor Jeff King.

¹³⁹ *Ibid.*, paragraph 14

¹⁴⁰ Estelle Chambas and Thomas Perroud, ‘France: Legal Response to Covid-19’ in Jeff King and Octavio Ferraz (eds.), *The Oxford Compendium of National Legal Responses to Covid-19* (OUP 2021), paragraph 12 accessible at <<https://oxcon.ouplaw.com/display/10.1093/law-occ19/law-occ19-e9>> accessed 1 February 2024. The Oxford Compendium was co-edited by one of our commissioners, Professor Jeff King.

123. In addition, relatively regular reviews of the declaration of an urgent health situation provide a moment where the legislatures can debate government strategy as a whole. This is important from both a rule of law and public health perspective. In oral evidence, Dr Brian McCloskey explained that government strategy needs to be subject to regular and rapid reviews to ensure it is based on the right evidence.
124. Our commissioners who followed the parliamentary debates on the coronavirus response considered that the current Public Health Act framework did not provide sufficient opportunity for general debates on government strategy. We heard opposing evidence from Lord Blencathra, who informed us that a declaration procedure was not needed to facilitate these types of debates, because general debates on coronavirus happened regularly during the pandemic. However, the minister responsible for taking the coronavirus regulations through the House of Lords, Lord Bethell, felt differently. He stated that there were very few moments when UK parliamentarians had the opportunity to review government strategy, which meant that the UK government was not adequately held to account for its overall strategy. Instead, Lord Bethell felt that parliamentary scrutiny was focussed on individual statutory instruments and some general thematic debates. We have therefore concluded that there is a real need for more opportunities to debate overall government strategy in future public health emergencies. Debates on regular renewal motions for an urgent health declaration would provide such an opportunity.

(V) Introducing a reporting requirement

125. In order to assist parliamentary scrutiny of the declaration, the minister should be required to lay a report in advance of any parliamentary debate and vote on an approval motion, or an extension motion. This report should outline the justification for the declaration, having regard to (a) public health advice received by the Chief Medical Officer, (b) the nature of the risks being faced, (c) plans being drawn up to deal with the emergency, and (d) the need to show respect for human rights, the principle of proportionality, and the special interests of vulnerable persons.

Recommendation 3: A provision enabling ministers to declare “an urgent health situation” should be introduced to Part 2A of the Public Health (Control of Disease) Act 1984 and Parts 5A and 7 of the Public Health etc. (Scotland) Act 2008. The use of the urgent made affirmative procedure to make public health regulations without prior parliamentary scrutiny should be restricted to situations when the declaration of an urgent health situation is in effect. The declaration procedure should be as follows:

(a) The condition for making a declaration should be that, after consulting the Chief Medical Officer in their jurisdiction, the minister considers that an infectious disease or contaminant constitutes, or may constitute, a danger to human health, and it is necessary to make regulations on an urgent basis in order to protect against that danger. The declaration must be revoked if those conditions are no longer satisfied.

(b) The declaration should be laid in draft before the relevant legislature before being made, and be subject to a debate and confirmation vote. If the minister considers that it is not practicable for the declaration to be approved by the legislature in advance, retrospective approval should be required within 14 days.

(c) The legislature should be recalled if a public health declaration is made during a period of parliamentary prorogation or adjournment, and the declaration would otherwise be approved more than 21 days after it was made. If circumstances make recall impracticable then the Speaker/Presiding Officer should have discretion to instruct the recall to take place virtually rather than in person, or in extremis for the recall requirement to be set aside, following consultation with the leaders of all the political parties represented in the Chamber.

(d) Any advice provided by the Chief Medical Officer should be made available to the legislature.

(e) The declaration should be subject to a two-month sunset period that can only be renewed following a parliamentary debate and vote on a motion to extend the declaration.

(f) Before any parliamentary debate and vote on an approval or extension motion, the minister should be required to lay a report outlining the justification for the declaration, having regard to (i) the public health advice received, (ii) the nature of the risks being faced, (iii) plans being drawn up to deal with the emergency, and (iv) the need to show respect for human rights, the principle of proportionality, and the special interests of vulnerable persons.

Proposed amendments to the made affirmative procedure

126. In addition to requiring a declaration to be in force before made affirmative regulations can be used, we also propose amendments to the made affirmative procedure itself within the Public Health Act framework.

(I) Increased objectivity and justification in the making of individual made affirmative instruments

127. Currently, a minister can make public health regulations that are subject to the made affirmative procedure if he or she “is of the opinion that, by reason of urgency, it is necessary” to make the regulations “without a draft being... laid and approved” by the legislature.¹⁴¹ This is a subjective test, and we consider that an element of objectivity should be added by requiring the minister to take into account relevant advice provided by the Chief Medical Officer of their jurisdiction when determining whether a regulation needs to be made urgently.

128. Ministers should also be required to justify to the legislature the urgency of each made affirmative instrument. The 2022 amendments to the Scottish Public Health Act implemented this change in relation to domestic public health regulations: the Scottish ministers are now required to “explain why they consider that the regulations need to be made urgently”.¹⁴² We consider this to be a sensible way to enhance parliamentary oversight of the use of the urgent procedure, and should be extended to all public health regulations made using the made affirmative procedure. This reflects recommendations made by the House of Lords Constitution Committee and oral evidence we received from Lord Janvrin, a member of the House of Lords Delegated Powers and Regulatory Reform Committee who spoke to us in a personal capacity.¹⁴³ Requiring ministers to justify the urgency of each made affirmative regulation should also help avoid a declaration of an urgent health situation being used as a blanket authorisation for the habitual use of the urgent procedure.

129. We therefore recommend that, when the made affirmative procedure is used, a minister should be required to lay a written statement before the relevant legislature explaining why it is considered that the regulations need to be made urgently, with reference, if applicable, to any relevant advice provided by the Chief Medical Officer.

(II) Approval of made affirmative instruments by the legislature within 14 days, and recall of the legislature if it is in recess

130. Made affirmative regulations under the Public Health Act framework will lapse after 28 days unless they receive retrospective approval by the legislature. In theory, this seems like a reasonable time during which regulations can be considered, debated and approved (or rejected). However, the fast-moving nature of the Covid-19 pandemic and the scheduling of approval debates meant that made affirmative regulations had often already been amended or superseded by the time parliaments were considering whether to approve them. In oral evidence, Lord Blencathra stated that his main criticism of the Covid-19 response was that regulations would come into force shortly after being made, but would inevitably be debated by the House of Lords a week or two later, by which time another regulation had come into effect.

¹⁴¹ [Section 45R](#) England and Wales Public Health Act. The formulation is slightly different in the Scotland Public Health Act but the meaning is the same: the made affirmative procedure can be used “if the Scottish Ministers consider that the regulations need to be made urgently”, [section 122](#) Scotland Public Health Act

¹⁴² [Section 122\(12\)\(a\)](#) Scotland Public Health Act

¹⁴³ Constitution Committee, *COVID-19 and the use and scrutiny of emergency powers* (n 82), paragraph 64

131. This problem seems to have occurred in all four legislatures. In June 2020, Suzy Davies MS, a Conservative member of the Welsh Parliament’s Legislation, Justice and Constitution Committee, complained that some of the amendments to lockdown restrictions were “taking up to 28 days [to be brought before the Welsh Parliament]” and “most of them are [taking] three weeks, by which time the press narrative’s gone, the public narrative has gone.”¹⁴⁴ In oral evidence, David Melding informed us that Wales often had three-week reviews of the regulations, where the minister would be making a statement about reviewing and replacing made affirmative regulations which had not yet been scrutinised.
132. In Northern Ireland, the Chair of the Assembly’s Committee for Health stated in November 2020 that members of the committee had been discussing “the challenge... of debating [made affirmative] regulations a number of weeks after they have come into effect and, sometimes, after they have been superseded”, noting that the delay in scheduling debates was partly caused by the Northern Ireland government not providing appropriate supporting material to enable the Committee to conduct its scrutiny more quickly.¹⁴⁵ Meanwhile, a review of coronavirus regulations in Scotland undertaken by the Covid-19 Review Observatory (led by one of our commissioners) found one case where the Scottish government made a “chain” of made affirmative statutory instruments, each one of which extended a previous set of lockdown restrictions, and none of which were debated before they were superseded or expired by the next made affirmative instrument.¹⁴⁶
133. We sought evidence on whether this problem could be resolved by shortening the 28-day time period during which scrutiny of made affirmative public health regulations must take place, in order to ensure that they are debated more speedily. Most of those to whom we spoke felt that shortening the time period would enhance scrutiny. Lord Janvrin, Baroness Thornton, Lord Anderson, Lord Blencathra and David Melding considered that the time period could be shortened, although Lord Janvrin noted that this would have been impracticable at the start of the pandemic. Both Lord Janvrin and Baroness Thornton advised that the machinery to scrutinise statutory instruments in the UK Parliament can move very quickly, while Lord Blencathra explained that the Lords did not usually take the full 28 days to scrutinise made affirmative instruments, and suggested that the 28 day period for review should perhaps be shortened to 14 days. Lord Anderson advised a slightly longer period, suggesting that the time period for scrutiny should be 21 days, drawing upon a previous recommendation made by the Constitution Committee.¹⁴⁷ David Melding advised us that the use of a 28 day review period was more understandable in the first six weeks or so of the pandemic, but as the emergency continued the time period for scrutiny could probably have been reduced to 14 days.
134. However, we were cautioned not to reduce the time period too significantly. Sir Bernard Jenkin and Professor Adam Tomkins, who have experience of scrutinising made affirmative coronavirus regulations in the UK and Scottish Parliaments respectively, warned us that shortening the period in which there can be scrutiny and questioning of a statutory instrument shortens the opportunity for proper scrutiny. Both concluded that reducing the approval period to seven or 14 days probably doesn’t enhance scrutiny, as regulations are more likely to be rushed through Parliament and rubber stamped.

¹⁴⁴ Welsh Senned Legislation, Justice and Constitution Committee, *The Health Protection (Coronavirus) Wales Regulations 2020 - Evidence session with the minister for Health and Social Services* (8th June 2020) <<https://record.assembly.wales/Committee/6352>> accessed 1 February 2024

¹⁴⁵ Northern Ireland Assembly [Deb 9 November 2020](#), Vol 132 No 5, page 19

¹⁴⁶ Fiona de Londras, Pablo Grez Hidalgo and Daniella Lock, ‘Rights and parliamentary oversight’ (n 105), page 592

¹⁴⁷ Constitution Committee, *COVID-19 and the use and scrutiny of emergency powers* (n 82), paragraph 83

135. In addition, some queried whether a shortened period for scrutiny would lead to any change. Lord Bethell stated that, in relation to the UK government, it would be solving the wrong issue. He considered that the real issue was that the Department of Health and Social Care's legal department was massively under-resourced, which caused unnecessary delays in parliamentary debates being scheduled because there was a delay in preparing the necessary paperwork around the regulations. A similar point was made by Lord Blencathra, who cautioned that the issue was maybe not a matter of the official timetable but rather the government getting regulations to the Lords as quickly as possible.
136. These points have force, but we consider that shortening the time period for debate is likely to impose increased discipline on governments to ensure that proper resources are allocated to enable regulations to be brought before legislatures in a timely manner. The experience of the Covid-19 pandemic shows that made affirmative regulations can be brought to legislatures quickly when governments have the will to do so. For example, after MPs and Peers firmly expressed their dissatisfaction with the use of the made affirmative procedure in September 2020, the UK government generally kept a promise it made to bring made affirmative regulations to UK Parliament within a few days so that they could be approved before they came into force.¹⁴⁸ A few months later, the Scottish government and Parliament agreed to new measures to enhance scrutiny of made affirmative regulations, by which Scottish ministers would “make a weekly ministerial statement on COVID-19 on Tuesday afternoons; provide a draft copy of proposed regulations on Wednesday afternoon; and make Scottish ministers available to give evidence to the [Parliament's Covid-19] Committee each week on Thursday morning.”¹⁴⁹ Draft regulations were then often made into law on Thursday afternoon or the following day.¹⁵⁰ The Scottish Parliament's Covid-19 Committee found that these enhanced scrutiny agreements worked well.¹⁵¹
137. Taking into account the above discussion, we recommend that the maximum time period between the making of urgent public health regulations and their affirmative scrutiny in the legislature should be reduced to 14 days. The four UK legislatures should review their procedures to provide for the implementation of this recommendation, making the necessary changes to Standing Orders.
138. We also consider that the legislature should generally be recalled if it is in recess during this 14 day period. When calculating the current 28 day period for approval of made affirmative regulations, the Public Health Act framework excludes periods when the legislature is dissolved, prorogued or adjourned for more than four days.¹⁵² During the pandemic, this meant that regulations were sometimes not debated until a very long time after they had been made. For example, following the 2020 summer recess of the Scottish Parliament – which ran from 27th June to 9th August – Scottish statutory instruments made before or during the recess were approved only on 26th August.¹⁵³ In Westminster, the first set of lockdown regulations were laid on 26th March 2020, the day after Parliament had gone into an extended Easter recess, and were not debated in the Commons until 4th May and the Lords until 12th May.¹⁵⁴

¹⁴⁸ Katie Lines, *18 Months of COVID-19 Legislation in England: A Rule of Law Analysis* (Bingham Centre for the Rule of Law, 16 October 2021), paragraphs 74-75

¹⁴⁹ Scottish Parliament COVID-19 Committee, *Legacy Report* (2021, SP 1010), paragraph 17

¹⁵⁰ *Ibid.*

¹⁵¹ *Ibid.*

¹⁵² [Section 45R\(6\)](#) England and Wales Public Health Act 1984; [section 122\(9\)](#) Scotland Public Health Act; and the now repealed [section 25Q](#) Northern Ireland Public Health Act

¹⁵³ Fiona de Londras, Pablo Grez Hidalgo and Daniella Lock, 'Rights and parliamentary oversight' (n 105), paragraph 592

¹⁵⁴ Tom Hickman KC, 'Abracadabra law-making and accountability to Parliament for the coronavirus regulation' in *Parliaments and the Pandemic* (Study of Parliament Group, January 2021), page 45. Tom Hickman is one of our commissioners.

139. We note that the Civil Contingencies Act contains strict recall requirements for the parliamentary approval of emergency regulations: if Parliament stands prorogued or either House stands adjourned for more than 5 days, Parliament shall be summoned by way of proclamation or arrangements shall be made for the House to meet.¹⁵⁵
140. Therefore, we consider that the legislature should be recalled to debate instruments that are laid using the urgent made affirmative procedure during a period of parliamentary prorogation or adjournment, if such instruments would otherwise be approved more than 21 days after they were made. If circumstances make recall impracticable then the Speaker/Presiding Officer should have discretion to instruct the recall to take place virtually rather than in person, or in extremis for the recall requirement to be set aside, following consultation with the leaders of all the political parties represented in the Chamber.

(III) Made affirmative regulations should be subject to a two month sunset period

141. The England and Wales Public Health Act does not require regulations to contain a sunset clause, and neither did the temporary coronavirus amendments to the Northern Ireland Public Health Act. The 2022 amendments to the Scotland Public Health Act introduced a requirement for made affirmative domestic public health regulations to contain a sunset clause specifying a day on which the regulations will expire, but did not prescribe a maximum time period, nor apply the sunset clause to made affirmative international travel regulations.¹⁵⁶
142. We were unanimously advised by the parliamentarians, legislative drafters and politicians with whom we discussed this issue – all of whom had first-hand experience of the legislative response to Covid-19 – that all public health regulations made to address an emergency should have a mandatory sunset period. The House of Lords Constitution Committee made a similar recommendation during the pandemic, advising that:

*“since Parliament cannot amend or revoke regulations made under the [England and Wales Public Health Act] once they have been made (unless it passes primary legislation doing so), it is particularly important that regulations made under the [England and Wales Public Health Act] be limited in duration. Sunset clauses enable Parliament to reassess the regulations made at a later point in time, once it is clearer how they are being used in practice and how suitable they are to the circumstances at hand”.*¹⁵⁷

143. The Constitution Committee recommended that all public health regulations should be subject to a three-month sunset period. We consider that a shorter sunset period is more appropriate for made affirmative instruments, as they are designed only to be used in the most urgent cases, and are not usually subject to parliamentary scrutiny before being made. We consider that a two-month sunset period strikes the right balance between ensuring that made affirmative regulations have a clear end date and can be regularly reviewed, and avoiding overloading the legislature with regulations being frequently remade.

¹⁵⁵ [Section 28](#), Civil Contingencies Act

¹⁵⁶ [Section 122\(12\)\(b\)](#) Scotland Public Health Act

¹⁵⁷ Constitution Committee, *COVID-19 and the use and scrutiny of emergency powers* (n 82), paragraph 67

(IV) Impact evaluations to be produced for any measures that are to be continued in substantially the same form beyond the end of the two-month sunset period.

144. We are conscious that, in order to scrutinise public health regulations, legislatures need to be provided with sufficient information and advice to understand the scientific and other data underpinning the policies being enacted. We heard evidence that members of the UK, Scottish and Welsh Parliaments were in general provided with sufficient evidence and information to understand government policies during the Covid-19 pandemic. For example, Lord Anderson noted that members of both Houses of the UK Parliament were able to have unmediated meetings with the Chief Medical Officer and Chief Scientific Officer, where MPs were asking sensible, searching and profound questions that reflected constituents' concerns. Lord Anderson thought this was an extremely effective way of keeping parliamentarians informed, making them feel they were to some extent on the inside, and thereby probably blunting the force of objections people had to regulations being introduced in such short order. We also heard from David Melding that the Welsh Parliament was provided with information and advice regularly through, for example, meetings with ministers, the police, local health boards, and briefings with the Chief Medical Officer and Chief Scientific Officer. Mr Melding said that he had sometimes been quite critical of the Welsh government's behaviour, but he never sensed that the government were withholding information in their possession that would have been pertinent to scrutiny.
145. However, the evidence we received was less positive when it came to the level of information and evidence that parliamentarians received in relation to individual statutory instruments. In particular, we heard that members of the UK Parliament found it difficult to scrutinise individual regulations because impact assessments were often not provided.

IMPACT ASSESSMENTS

Impact assessments are evaluative assessments of the costs, benefits and risks of a proposed government policy, including the likely direct or indirect impacts that the policy will have on individuals, society and/or businesses. Governments can use targeted impact assessments to consider the impact a policy will have on a particular group. For example, equality impact assessments are used to consider how individuals protected under the Equality Act 2010 will be affected by government decision-making. In some cases, governments are legally required to produce an impact assessment before a policy is introduced. For example, in Wales, a Health Impact Assessment must be carried out for certain policies.

146. In written evidence, the House of Lords Secondary Legislation Scrutiny Committee advised us that its scrutiny of statutory instruments during Covid-19 revealed “defects in the quality of the supporting information provided by the [UK] government to explain its policy and its intended effects”. In some cases, the Committee took the view that information gaps “indicated that major policies were being implemented without having been properly thought through.” A “key area of concern” for the Committee was the failure by UK government departments “to provide impact information alongside pandemic secondary legislation”. This led the Committee to conclude that there were “several significant instruments where it was evident that the policy had been formulated without adequate analysis of the potential impact”.¹⁵⁸

¹⁵⁸ Written evidence from the Secondary Legislation Scrutiny Committee ([Appendix 14](#))

147. This conclusion reflects comments made by Lord Bethell in oral evidence, who stated that, while he was supportive of impact assessments, many of the key potential impacts of Covid-19 were not being assessed by government. Lord Bethell explained that Treasury economic forecasting around the pandemic was never published, and impact assessments were not carried out on furlough or “any of the big measures”. As such, the UK Parliament was asking for impact assessments on individual statutory instruments when there was no impact assessment on the whole Covid-19 strategy.
148. The UK Parliament was not the only legislature whose deliberations were impeded by the absence or poor quality of impact assessments. In October 2020, the Chair of the Northern Ireland Assembly’s Health Committee, Colm Gildernew, expressed the Committee’s “ongoing concerns about the level of information we are getting on statutory rules and our ability to scrutinise the restrictions and regulations”.¹⁵⁹ Mr Gildernew explained that the committee understood the urgency of the situation, but regulations were being made “without consultation, and there is no impact assessment.”¹⁶⁰ In Wales, the Welsh Parliament’s Legislation, Justice and Constitution Committee regularly reported on inadequacies in the Welsh government’s assessment of equality impacts in particular. The committee noted in December 2021 that “in the context of coronavirus regulations, chasing the Welsh government for information about equality impact assessments has become a bit of a theme for this committee and its predecessor committee in the fifth Senedd”.¹⁶¹
149. Impact assessments are vital for enabling parliamentarians to scrutinise public health restrictions in a novel, emergency situation, and are also an integral part of good policy-making. In oral evidence, Stephen Gibson, Chair of the Regulatory Policy Committee,¹⁶² explained that he strongly believed that good policy choices are best made when they are supported by very good information about costs, benefits and wider consequences, and that having this information not only supports choices on whether to go with one policy or not, but also helps government to consider different policy options that could achieve the same objectives. To illustrate his point, Mr Gibson explained that, during the pandemic, the UK government sought to introduce a policy which would have required all health care staff and others involved in the healthcare sector to be vaccinated against Covid-19. However, in his view, the impact of this on the NHS labour force had not been properly considered, and the policy was withdrawn once it became clear that 5% to 6% of the NHS workforce would no longer be able to continue working.¹⁶³
150. We therefore discussed how best to resolve the problem of missing impact assessments. We considered whether governments should be legally required to prepare impact assessments before made affirmative instruments are debated, but had concerns about how practical this might be in a genuine emergency. Such a requirement might lead to rushed, poor quality impact assessments that do not assist scrutiny. We explored alternatively whether there would be value in requiring impact **evaluations** to be prepared if any or all of an instrument subject to

¹⁵⁹ Northern Ireland Assembly Committee for Health, *COVID-19 Disease Response: Mr Robin Swann MLA, minister of Health; Dr Michael McBride, Chief Medical Officer* (1 October 2020) available at <<https://aims.niassembly.gov.uk/officialreport/minutesofevidencereport.aspx?Agendald=23556&evidID=12259>> accessed 1 February 2024

¹⁶⁰ Northern Ireland Assembly Committee for Health, *Health Protection Amendment Regulations 2020: Department of Health; Department of Finance* (5 November 2020) available at <<https://aims.niassembly.gov.uk/officialreport/minutesofevidencereport.aspx?Agendald=23983&evidID=12370>> accessed 1 February 2024

¹⁶¹ Welsh Parliament Legislation, Justice and Constitution Committee (13th December 2021) available at <<https://record.assembly.wales/Committee/12515>> accessed 1 February 2024

¹⁶² The Regulatory Policy Committee is the independent scrutiny body for the UK government. It assesses the quality of evidence and analysis in Regulatory Impact Assessments and Post Implementation Reviews used to inform government policy, and rates them as either ‘fit for purpose’ or ‘not fit for purpose’.

¹⁶³ The government stated that the policy was withdrawn following a public consultation where 90% of responses supported its removal, and because the less severe Omicron variant of Covid-19 had become the dominant variant in the UK: Department of Health and Social Care, *Regulations making COVID-19 vaccination a condition of deployment to end* (1 March 2022) <<https://www.gov.uk/government/news/regulations-making-covid-19-vaccination-a-condition-of-deployment-to-end>>

the made affirmative procedure was to be continued beyond its two-month sunset period. In oral evidence, Stephen Gibson emphasised the benefits of impact evaluations, advising us that “even if it was not possible to complete an impact assessment before measures are introduced, there is still a lot of value in completing a post-implementation assessment to inform future policy decisions”. He noted that timely assessment of some of the early interventions during the Covid-19 pandemic would have better informed later ‘lockdowns’ and other measures, as well as the government’s general understanding of the impacts of different regulatory choices.

151. Taking into account the above evidence, we recommend that, as a matter of best practice, governments should set out the anticipated impact of statutory instruments made using the urgent made affirmative procedure before any parliamentary approval debate takes place. Where this is not possible, if any provision within the statutory instrument is to be continued in substantially the same form beyond the original two month sunset period, then an impact evaluation should be provided to the legislature in advance of the subsequent approval debate. Policy makers should consider how this recommendation can best be integrated with any pre-existing legal requirements, which are likely to differ among the four nations.

Recommendation 4: The urgent made affirmative parliamentary scrutiny procedure in section 45R of the Public Health (Control of Disease) Act 1984 and section 122(6)-(13) Public Health etc. (Scotland) Act 2008 should be amended as follows:

(a) The minister should be required to take into account relevant advice provided by the Chief Medical Officer when determining whether regulations need to be made urgently, and to lay a written statement before the legislature explaining why it is considered that the regulations need to be made urgently with reference, if applicable, to this advice.

(b) The maximum time between the making of made affirmative regulations and their affirmative scrutiny in the legislature should be reduced from 28 to 14 days. The four UK legislatures should review their procedures to provide for the implementation of this recommendation, making the necessary changes to Standing Orders.

(c) The legislature should be recalled to debate regulations that are laid using the made affirmative procedure during a period of parliamentary prorogation or adjournment, if such regulations would otherwise be approved more than 21 days after they were made. If circumstances make recall impracticable then the Speaker/Presiding Officer should have discretion to instruct the recall to take place virtually rather than in person, or in extremis for the recall requirement to be set aside, following consultation with the leaders of all the political parties represented in the Chamber.

(d) Any regulations made using the made affirmative procedure should expire after two months.

(e) As a matter of best practice, governments should set out the anticipated impact of regulations made using the made affirmative procedure before any parliamentary approval debate takes place. Where this is not possible, if any provision within the made affirmative regulations is to be continued in substantially the same form beyond the original two month sunset period, then an impact evaluation should be provided to the legislature in advance of the subsequent approval debate.

Proposed amendments to the draft affirmative procedure under the Public Health Act framework

152. Our above recommendations should restrict use of the made affirmative procedure to periods of acute crisis which necessitate urgent law-making. Emergency public health interventions may still need to be imposed outside of an acute crisis period, but can be made at a slower pace with greater oversight and accountability by the UK and devolved legislatures through the use of the [draft affirmative procedure](#). Under that procedure, parliamentary approval of a statutory instrument is required in advance of it being made and coming into force.
153. We recognise that legislatures are usually afforded a significant amount of time to consider draft affirmative instruments before a debate and approval vote. This is likely to be too long a period for many instruments that need to be made in an emergency, even outside of a crisis period. Therefore, we recommend that the four legislatures are consulted on the minimum amount of time needed to ensure proper scrutiny of draft affirmative instruments, with a view to an expedited draft affirmative procedure being developed for public health emergencies. It is important that the draft affirmative procedure should not be so expedited as to make it a weaker form of scrutiny than the made affirmative. We understand that the Scottish Parliament's Delegated Powers and Law Reform Committee is already working with the Scottish government to develop a protocol for an 'expedited affirmative procedure' which could be used on a case-by-case basis in place of the made affirmative procedure.¹⁶⁴
154. In addition, in light of the importance we attach to impact assessments and sunset clauses in respect of emergency legislation, we propose that impact assessments should be laid before the legislature in advance of the approval debate for draft affirmative public health regulations made under the Public Health Act Framework. Such regulations should also contain a six month sunset clause. If any provision within the draft affirmative regulations is to be continued in substantially the same form beyond those six months then an impact evaluation should be provided to the legislature in advance of the approval debate.

¹⁶⁴ The Scottish Parliament Delegated Powers and Law Reform Committee, *Annual Report 2021-22* (2022, SP 175), paragraph 18

Recommendation 5: The draft affirmative parliamentary scrutiny procedure in section 45Q(2) and (4) of the Public Health (Control of Disease) Act 1984 and section 122(5) of the Public Health etc. (Scotland) Act 2008 – whereby active parliamentary approval of a statutory instrument is required in advance of it being made and coming into force – should be amended as follows, in respect of regulations made under section 45C(1) of the Public Health (Control of Disease) Act 1984 and sections 86A(1) and 94(1) of the Public Health etc. (Scotland) Act 2008:

(a) The four legislatures should be consulted on the minimum amount of time needed to ensure proper scrutiny of draft affirmative regulations, with a view to an expedited draft affirmative scrutiny procedure being developed for public health emergencies, without making scrutiny weaker than it would be under the made affirmative procedure.

(b) Impact assessments should be laid before the legislature in advance of the approval debate for draft affirmative regulations.

(c) Draft affirmative regulations should expire after six months.

(d) If any provision within the draft affirmative regulations is to be continued in substantially the same form beyond six months, an impact evaluation should be provided to the legislature in advance of the subsequent approval debate.

Proposed amendments to the negative procedure under the Public Health Act framework

155. One key difference in the Public Health Act framework as it applies in Scotland is in the availability of the [made negative procedure](#). The Scotland Public Health Act does not permit the made negative procedure to be used for either domestic public health regulations or international travel regulations.¹⁶⁵ Only the draft affirmative and, in cases of urgency, made affirmative scrutiny procedure is available for such regulations.

156. In contrast, as discussed above at paragraph 29, the made negative procedure is the default parliamentary procedure for international travel regulations made under the England and Wales Public Health Act.¹⁶⁶ The made negative procedure can also be used for domestic health protection regulations if the person making the regulations is of the opinion that they do not contain any measures in relation to persons, things or premises which are a “special restriction or requirement”, or otherwise have, or would have, a significant effect on a person’s rights.¹⁶⁷ These provisions were copied from the England and Wales Public Health Act into the temporary amendments to the Northern Ireland Public Health Act.¹⁶⁸

¹⁶⁵ There is one in exception in [section 122\(8\)](#) for regulations which have to be made urgently and “revoke (in whole or in part) emergency regulations and do (i) nothing else; or (ii) nothing else except make provision incidental or supplementary to the revocation”. In this case, the made affirmative procedure applies, but is modified, so that these regulations must be laid before the Scottish Parliament but will not expire after 28 days if they are not approved by Parliament – so in effect this seems to be the made negative procedure.

¹⁶⁶ [Section 45Q](#) England and Wales Public Health Act

¹⁶⁷ [Section 45Q\(4\)](#) England and Wales Public Health Act

¹⁶⁸ The now repealed [section 25P](#) Northern Ireland Public Health Act

RECAP OF “SPECIAL RESTRICTIONS AND REQUIREMENTS”

“Special restrictions or requirements” are a list of particularly severe restrictions. They include requiring a person to submit to medical examination, be detained in a hospital or other suitable establishment, or be kept in isolation or quarantine.¹⁶⁹

157. We do not see the logic behind this difference in approach within different parts of the UK, nor in the made negative procedure being the default scrutiny procedure for international travel regulations in England and Wales, no matter how intrusive they may be. Some of the international travel regulations that were introduced during the Covid-19 pandemic were extremely restrictive.¹⁷⁰ For example, international travel regulations were used to ban travel from certain countries and create a mandatory hotel quarantine scheme.¹⁷¹
158. We discussed three potential options to address our concerns, but found that there were complexities with each of them that meant we are not able fully to endorse any of them without further exploratory work being undertaken.

Option One – removing the negative procedure as an option for both domestic public health regulations and international travel regulations

159. We considered whether England and Wales, and Northern Ireland in its proposed new public health Bill, should follow the Scottish approach and remove the negative procedure as an option for both domestic public health regulations and international travel regulations. Instead, these regulations would need to be made using the draft affirmative procedure or, in cases of urgency, the made affirmative procedure. However, we have some reservations about this approach. First, it may be that the UK government is not able to relinquish the use of the negative procedure for international travel regulations because it holds ultimate responsibility over some important reserved matters relating to international travel. Second, we recognise the increased strain that removing the negative procedure would put on legislatures’ capacity to review regulations, which would need to be carefully considered. For example, we understand that 90 international travel regulations were laid before the UK Parliament under the England and Wales Public Health Act using the negative procedure between 27th January 2020 and 3rd March 2022, all of which would have needed parliamentary time for approval if they had been made using the affirmative procedure.¹⁷² Third, despite our inquiries, we were not made aware of any occasions when the negative procedure was used by the administrations in England, Wales and Northern Ireland in circumstances when it should not have been. Therefore, we did not feel able to recommend the removal of the negative procedure in its entirety for public health regulations in those jurisdictions.

¹⁶⁹ [Section 45\(D\)\(4\)](#) England and Wales Public Health Act

¹⁷⁰ See the discussion by one of our commissioners: Adam Wagner, *Emergency State: How We lost Our Freedoms in the Pandemic and Why it Matters* (Penguin, 2022), page 91

¹⁷¹ [Health Protection \(Coronavirus, International Travel\) \(England\) \(Amendment\) \(No. 7\) Regulations 2021 \(SI 2021/150\)](#)

¹⁷² Data provided by the Hansard Society (whose Director, Dr Ruth Fox, is one of our commissioners) using information compiled as part of the Hansard Society’s Coronavirus Statutory Instruments Dashboard <<https://www.hansardsociety.org.uk/publications/data/coronavirus-statutory-instruments-dashboard>> accessed 1 February 2024

Option Two – introducing a “significant effect on a person’s rights” test as a bar on the use of the negative procedure

160. We also considered whether the “significant effect on a person’s rights” test that forms part of the bar on the use of the made negative procedure for domestic health protection regulations in the England and Wales Public Health Act, and was copied into the temporary coronavirus amendments to the Northern Ireland Public Health Act, should be extended to international travel regulations. This would mean that the negative procedure could not be used to make international travel regulations or domestic health protection regulations which contain any measures that have, or would have, a significant effect on a person’s rights. We recognise that applying a “significant effect on a person’s rights” test to international travel regulations would likely severely restrict the use of the negative procedure – and the impact of this on parliamentary time must be carefully considered – but this is reflective of the serious impact of many international travel restrictions.

161. We sought feedback on this recommendation, and received mixed responses. Matt Hancock MP thought that “the principle of ‘significant effect’ as the bar for a negative procedure is probably sensible”. However, Daniel Greenberg CB stated that he would:

“not be enthusiastic about a statutory limitation on the use of the negative procedure that depended on a concept as open to different views as how significant an effect on a person’s rights might be. By definition, all legislation impinges on people’s rights (although not always on core [rights in the European Convention of Human Rights])... [T]he danger is that a later challenge to the satisfaction of the precondition for negative resolution could undermine the validity of an instrument that would have been made and acted upon; and that degree of uncertainty would be in nobody’s interests.”

162. We share some of Mr Greenberg’s concerns. While a “significant effect on a person’s rights” test was applied to domestic public health regulations in England, Wales and Northern Ireland throughout the pandemic,¹⁷³ and we are not aware of any occasions where this caused difficulties, “significant effect on a person’s rights” is nonetheless a loose definition that is open to multiple interpretations. In addition, the test is subjective – in that it allows the minister responsible for making the regulations to decide whether they would have a “significant effect on a person’s rights” without the need for any objective verification. This latter point was raised by the UK Parliament’s Joint Committee on Human Rights when the test was introduced for domestic public health regulations in 2008. The Committee did not think it was appropriate for a minister “subjectively to determine the process for parliamentary consideration of measures which may engage individual rights on a case by case basis”. The Committee considered that, “where individual rights may be engaged, the relevant provisions should be contained in primary legislation and subject to full parliamentary scrutiny. Failing that, the affirmative resolution procedure should always apply to any categories of regulations which may engage individual rights”.¹⁷⁴

163. We do not think these concerns preclude the extension of the “significant effect on a person’s rights” test to international travel regulations, but they must be borne in mind when considering this option.

¹⁷³ Under [section 45Q\(4\)](#) England and Wales Public Health Act and the now repealed [section 25P\(5\)](#) Northern Ireland Public Health Act

¹⁷⁴ UK Parliament Joint Committee on Human Rights, *Legislative Scrutiny: 1) Health and Social Care Bill and 2) Child Maintenance and Other Payments Bill: Government Response* (2007-8, HL 66 HC 379), paragraph 1.42

Option Three – introducing a parliamentary sifting committee to review proposed negative instruments

164. We discussed whether a parliamentary sifting committee should be responsible for reviewing proposed negative public health regulations. This would mean that a minister would be required to lay before the sifting committee a draft of any proposed negative instrument. The sifting committee would then consider whether the criteria governing the use of negative instruments had been satisfied, and if not, would recommend upgrading the instrument to the draft affirmative procedure. This would increase parliamentary oversight by removing from the minister the decision as to whether the test for the use of the negative procedure had been met.
165. Matt Hancock MP thought this suggestion would be feasible so long as the sifting could be done in a sufficiently timely manner. However, some commissioners felt that introducing a sifting committee would have the practical effect of entirely excluding the use of the negative procedure, due to the amount of time sifting would take. They considered that ministers would simply choose to use the draft or made affirmative procedure, in order to avoid the time and uncertainty caused by laying proposed negative instruments to be sifted. Daniel Greenberg CB also expressed a similar view, stating that:

“For restrictions being imposed by reference to public health, which are always going to be contentious, experience suggests that [members of a sifting committee] would be inclined to recommend more or less everything [should be upgraded to the draft affirmative procedure]. The result is that the government would be likely to adopt an approach of “killing the cat with cream” whereby everything would be put up for affirmative resolution in the first place to avoid the possible interruption of a sifting uplift decision, which would have the effect of significantly diluting the effectiveness of the affirmative resolution process. If there were to be a sifting mechanism, it would have to be against articulated criteria that distinguish between suitability for the two procedures: and if one could articulate those criteria sufficiently clearly, it might be easier simply to require the government (formally or informally) to have regard to them in determining the choice of procedure for a particular instrument.”

166. For these reasons, the majority of commissioners do not consider that a sifting committee is a feasible option in a public health emergency. It would introduce additional complexity and time but is likely in practice to have the same effect as simply removing the ability for governments to use the made negative procedure. However, we note that one of our commissioners is not in agreement with us on this point.

Recommendation 6: Under section 45Q(1)-(3) of the Public Health (Control of Disease) Act 1984, the made negative parliamentary scrutiny procedure – whereby a statutory instrument does not require active approval by the legislature – applies to international travel regulations and can also be used for some domestic health protection regulations. In contrast, the Public Health etc. (Scotland) Act 2008 does not permit the negative procedure to be used for either type of regulations. We suggest three ways of addressing this anomaly, none of which we feel able to recommend fully: bringing all nations in line with Scotland by removing the negative procedure as an option; restricting the use of the negative procedure to public health regulations which do not have a significant effect on a person’s rights; or introducing a parliamentary sifting committee to review proposed negative public health regulations and consider whether the criteria governing their use have been met.

Requiring impact assessment and sunset clauses for negative instruments

167. If the negative procedure continues to be available for international travel and domestic public health regulations, then we propose that an impact assessment should be laid before the legislature alongside any such made negative instrument. The negative instrument should also be subject to a six month sunset period. If any provision within the negative statutory instrument is to be continued in substantially the same form beyond those six months then an impact evaluation should be provided to the legislature when the instrument is laid before it. This recommendation is made in light of the importance we attach to impact assessments and sunset clauses in respect of emergency legislation.

Recommendation 7: If the negative procedure continues to be available for international travel regulations and some domestic health protection regulations under Part 2A of the Public Health (Control of Disease) Act 1984, then an impact assessment should be laid before the legislature alongside such negative regulations, and the regulations should expire after six months. If any provision within the made negative regulations is to be continued in substantially the same form beyond those six months, an impact evaluation should be provided to the legislature.

Should the legislatures be granted a power to amend statutory instruments under the Public Health Act framework?

168. Numerous witnesses advised the Commission that the UK legislatures should have the power to amend statutory instruments. We note that a power for the UK Parliament to amend emergency regulations exists in the Civil Contingencies Act: section 27(3) enables emergency regulations to be amended if each House of Parliament “passes a resolution that emergency regulations shall have effect with a specified amendment.” However, to date this power has never been used and it is unclear what procedures each House would adopt to provide for textual amendment of any such regulations, and to reconcile any differences of opinion between the two Houses.

169. A number of witnesses advised us that there are other ways in which legislatures might secure changes to regulations prior to an approval vote. Lord Blencathra considered that the safest way for an amending power to work in the UK Parliament would be if the Lords had the power to ask the Commons to think again, with the Commons having the absolute right to reject this suggestion and continue to approve a statutory instrument. In a similar vein, Dr Ronan Cormacain, a consultant legislative drafter who gave us evidence in a personal capacity, suggested that it would be “a huge mistake” to allow parliamentarians to directly amend emergency regulations as they pass through the legislature because statutory instruments “are complex and very technical”. He, however, proposed having “a procedure where parliamentarians can make some form of narrative statement about what changes they want to see, vote on it, and then it is for the government officials to make the necessary drafting changes to give effect to that policy”.¹⁷⁵

¹⁷⁵ Written evidence from Dr Ronan Cormacain ([Appendix 2](#))

170. Other witnesses did not favour granting legislatures the power to amend emergency public health regulations. Lord Anderson expressed caution. He stated that he wished there were restricted powers in the UK Parliament to amend statutory instruments, but emergency pandemic situations might be an odd place to start, where the impact on people's liberties is very great but the need for swift government action is perhaps greater still. Lord Anderson also advised that it is quite difficult in the public health context to let Parliament loose via amendments on what has been decided. Expressing stronger sentiments, Daniel Greenberg CB informed us that he is never in favour of statutory instruments being amendable by Parliament because he thinks this would lead to chaos, where statutory instruments that are not urgent would never be passed, and those that are urgent wouldn't get passed in time. Instead, he felt it is more important to focus on ways of influencing the quality of secondary legislation so that it does not need to be amended, and enhancing other aspects of the scrutiny of secondary legislation.
171. We spent some time discussing whether the four UK legislatures should be granted some form of power to amend statutory instruments made under the Public Health Act framework as part of the parliamentary approval process. Helpfully, two of our commissioners – Dr Ruth Fox and Professor Jeff King – are involved in the Hansard Society's review of the delegated legislation system at Westminster. Dr Fox, Director of the Hansard Society, informed the wider Commission that the Delegated Legislation Review's cross-party advisory panel has considered the question of amendability at length and has determined that direct textual amendment of statutory instruments is impractical, because it raises the spectre of some form of legislative 'ping-pong' requiring a procedure for securing the agreement of both Houses of Parliament to a single text. This would present practical difficulties in relation to the management of parliamentary and legislative time. Rather than direct textual amendment of a statutory instrument, the Society's [review](#) will therefore recommend a procedure whereby amendments can be tabled to approval motions for statutory instruments, which would outline in narrative form the parliamentarian's concern with the instrument that must be addressed before it is made into law. In light of this we are not proposing a power of amendment, but instead recommend that the Hansard Society's proposals should be given careful consideration when they are published.

Recommendation 8: The proposals of the Hansard Society's [review](#) of the delegated legislation system at Westminster, as to whether the UK Parliament should be empowered to amend statutory instruments, should be given careful consideration when they are published.

Human rights and public consultation

172. The final section of this Chapter on the Public Health Act framework discusses amendments to the legislative framework to better integrate human rights and equalities considerations into an emergency response.
173. We received evidence from across the UK about instances when human rights and equalities considerations appear not to have been properly taken into account by decision makers during the Covid-19 pandemic. To give some examples: we were informed by organisations based in Northern Ireland that “decisions were made by the Northern Irish and UK governments without considering the impact on deaf and disabled people”, and that the differential impact of the pandemic on men and women was compounded by “unhelpfully gender-blind government responses, both from Westminster and Stormont.”¹⁷⁶ Meanwhile, the Equality and Human Rights Commission informed us that, during the first lockdown in England and Wales, “blanket rules were laid down which considered the [European Convention on Human Rights] Article 8 right to a family life of one group of people, the children of separated parents, but did not consider the Article 8 rights of a different group of people, disabled people living in care homes”.¹⁷⁷ The Scottish Police Federation also criticised the lockdown response in Scotland, explaining that the Scottish government did not properly take account of the concerns and interests of marginalised and disadvantaged groups when drafting lockdown regulations.¹⁷⁸
174. We sought evidence on why these problems occurred. Sanchita Hosali, the CEO of the British Institute of Human Rights, a UK-wide human rights charity, advised us that human rights must be considered at every stage of decision-making to ensure they do not get lost somewhere along the line, but that this did not happen during Covid-19. We heard a similar account from David Isaac CBE, who was Chair of the Equality and Human Rights Commission (‘EHRC’) from 2016 to August 2020 and who spoke to us in a personal capacity. Mr Isaac felt that difficulties were caused by the UK government’s relative tardiness and reluctance to listen to the points being made by human rights bodies. He stated that human rights bodies acknowledged the many challenges for government in responding to Covid-19, but he considered that human rights and equalities were wrongly seen by ministers as only secondary-level issues.
175. In addition, both Mr Isaac and Ms Hosali emphasised that governments prioritised protecting the right to life during the Covid-19 pandemic, without properly considering other rights impacted by public health interventions. Mr Isaac explained that the very binary approach to saving life for the majority of people led to the government treating some people as second class citizens. For example, Mr Isaac took the view that, if the EHRC had not brought issues to the government’s attention, then the government would not have considered the particular needs of the elderly and disabled and people in care homes.
176. We considered whether amendments could be made to the Public Health Act framework to mitigate these issues. When asked this question, Mr Isaac informed us that the pre-existing legal frameworks are probably adequate if they are used in a confident and transparent way so that there is more dialogue and less binary thinking. He advised that rather than imposing new legal obligations, an acceptable way forward would be to increase training, improve understanding of current frameworks, and ensure there is more listening and a greater willingness to embrace the challenges of complex situations. Ms Hosali made a similar point,

¹⁷⁶ Written evidence from Disability Action (Appendix 4) and the Women’s Policy Group Northern Ireland (Appendix 18)

¹⁷⁷ Written evidence from the Equality and Human Rights Commission (Appendix 5)

¹⁷⁸ Written evidence from the Scottish Police Federation (Appendix 13)

noting the general failure to integrate pre-existing human rights duties into government decision-making during the Covid-19 pandemic, as a consequence of which decisions were made with insufficient consideration of and respect for human rights.

Introducing enhanced consultation requirements

177. We spent some time discussing Mr Isaac and Ms Hosali’s evidence, and considering whether further mechanisms should be built into the Public Health Act framework to try and ensure that governments properly observe their existing obligations, and take equalities and human rights considerations into account at each stage of an emergency response. We concluded that the best way to achieve this aim is to insert statutory consultation requirements into the Public Health Act framework.
178. Much of the written evidence we received in response to our questions about human rights and equalities discussed the need for better government consultation and engagement with marginalised and disadvantaged groups in future public health emergencies. For example, the Northern Ireland Women’s Policy Group stressed the need for future emergency planning to include women and reflect their lived experiences by engaging meaningfully with stakeholders.¹⁷⁹ Disability Action made a similar point in relation to Disabled people. The charity referenced a report from Oxford University which concluded that “the government failed to take appropriate steps to include d/Deaf and Disabled people in planning across all policy areas in response to the Covid-19 crisis”.¹⁸⁰
179. The need for better government consultation and engagement was also emphasised by Ms Hosali in oral evidence. She stated that experiential evidence is needed from both rights holders and duty bearers (i.e. frontline staff in public bodies) when considering the use of emergency powers. As an example, she noted that carer led organisations and care homes were raising at an early stage the likely impact of government discharge policies during the Covid-19 pandemic, which led to a “terrible situation” nationally whereby older individuals who had asymptomatic cases of Covid-19 were discharged from hospitals into care homes without being tested for the virus or isolated from other residents. Around 20,000 care home residents in England died of Covid-19 during the first wave of the pandemic in 2020. Ms Hosali noted that problems with discharge policies would have been flagged very early on if evidence from carer led organisations and care homes had been sought and given proper weight at an early stage. She explained that effective evidence gathering needs to go beyond issuing a consultation, and that a more proactive approach is needed where groups are actively sought out and provided with a forum in which they can share their views. We note that governments could draw upon citizen jury or online patient engagement models as exemplars of this type of proactive engagement.
180. We recognise that this type of consultation may simply not be possible during the acute stage of a public health emergency, when decisions need to be made extremely quickly. However, consultation of this type did take place with different groups during the Covid-19 pandemic. We were informed by the EHRC that the “Welsh government took a different approach to the UK government by proactively reaching out for engagement with various advisory groups, such as the Covid Moral Ethical Advisory Group, the Disability Equality Forum and the Covid-19 Black, Asian and Ethnic Minority Advisory Group”.¹⁸¹ One of our commissioners, Reema Patel, also served on the Scottish Government’s Covid-19 Public Engagement Expert Advisory Group, which she found to be very effective. In addition, in written evidence, Dr Ronan Cormacain

¹⁷⁹ Written evidence from the Women’s Police Group Northern Ireland ([Appendix 18](#))

¹⁸⁰ Written evidence from Disability Action ([Appendix 4](#))

¹⁸¹ Written evidence from the Equality and Human Rights Commission ([Appendix 5](#))

informed us that grassroots sporting bodies and their representatives were “heavily consulted when it came to making legislation in [Northern Ireland] which would cater to their needs” and “[p]olicy was changed in response to their requests”.¹⁸²

181. We therefore recommend that planning for future public health emergencies should identify points when certain groups should be consulted in a proactive, participatory manner to help embed equalities and human rights considerations in policy-making. In the event of a public health emergency, the task of ensuring that certain groups are consulted as part of the legislative drafting process could be assigned to a particular individual. This would help properly integrate human rights and equalities considerations into the drafting process, and is in line with written evidence we received from Dr Cormacain. He considered that the “process for human rights proofing of regulations is... too ad hoc, and too much reliant upon individual lawyers picking up points” and an “internal challenge function within the team in charge of developing policy and drafting the legislation would be helpful – someone whose job it is to question why a particular provision is actually needed.”¹⁸³
182. In addition, we consider that governments should have a statutory duty to have regard to any advice produced by national human rights institutions (“NHRIs”) in their jurisdiction during a public health emergency, namely the EHRC, the Scottish Human Rights Commission, the Equality Commission for Northern Ireland and the Northern Ireland Human Rights Commission. This duty could also be extended to other independent rights institutions that represent groups likely to be affected by public health interventions – such as the Children’s Commissioners, and in Wales and Northern Ireland the Commissioners for Older People. The effect of this duty would be that governments would have to justify diverging from the advice of those organisations, and there would be public law remedies if governments failed to have proper regard to such advice. The duty could apply when making or continuing urgent public health situation declarations and when laying or continuing public health regulations. Section 9(1) of the Climate Change Act 2008 provides a model for this duty. It requires the Secretary of State to “take into account” advice that the Committee on Climate Change is required to produce around carbon budgets.
183. We considered whether the NHRIs and analogous bodies should also have imposed upon them a duty to provide advice to government. We received feedback on this point from the EHRC, the Scottish Human Rights Commission, the Northern Ireland Human Rights Commission, the Equality Commission for Northern Ireland, the Northern Ireland Commissioner for Children and Young People, the Children’s Commissioner for Wales, and the Children and Young People’s Commissioner for Scotland. All of these bodies supported a duty that required the government to have regard to their advice, but there were mixed views as to whether a reciprocal obligation to provide advice should be imposed upon them. Some of the organisations we approached, such as the Northern Ireland Human Rights Commission, already have a duty to provide advice when requested by government.¹⁸⁴ However, others do not. For example, the EHRC has a power to provide advice, but not a duty to do so.¹⁸⁵ The reasons for ambivalence towards a statutory duty to provide advice were largely that the organisations had limited capacity, and being required to advise government ministers upon request would jeopardise the organisations’ independence to determine their own agenda and activities. We have therefore decided not to recommend that the NHRIs and other representative bodies should have a reciprocal duty to provide advice to government.

¹⁸² Written evidence from Dr Ronan Cormacain ([Appendix 2](#))

¹⁸³ *Ibid.*

¹⁸⁴ [Section 69\(3\)\(a\)](#) Northern Ireland Act 1998

¹⁸⁵ [Sections 11](#) and [13](#) Equality Act 2006

Recommendation 9: Planning for future public health emergencies should identify points when certain groups should be consulted in a proactive, participatory manner to help embed human rights and equality considerations in policy-making. In the event of a public health emergency, the task of ensuring that certain groups are consulted as part of the legislative drafting process should be assigned to a particular member of the team in charge of developing policy and drafting the legislation.

Recommendation 10: Ministers should have a statutory duty to have regard to any relevant advice produced by National Human Rights Institutions in their jurisdiction when making or continuing a declaration of an urgent health situation and when laying or continuing public health regulations. This duty might also usefully be extended to other independent rights institutions that represent groups likely to be affected by public health interventions, such as the Children’s Commissioners.

Should human rights expertise be included in the Scientific Advisory Group for Emergencies?

184. Both Ms Hosali and Mr Isaac advised us to consider including human rights expertise on a body such as the Scientific Advisory Group for Emergencies (“SAGE”), which provides the government with scientific and technical advice during emergencies. We carefully discussed this recommendation, but ultimately decided not to endorse it. On the one hand, we consider that it is important to approach a public health emergency in an interdisciplinary fashion, and members of SAGE or other scientific advisory groups should consider human rights and equality issues when they give advice to government. However, on the other hand, SAGE serves an important function providing the government with scientific advice, and we do not wish to dilute that function. Ultimately, we consider that decisions on how scientific advice is balanced with other considerations – whether those be human rights and equality issues or impacts on the economy – are a matter for government and legislatures. We nevertheless agree with Ms Hosali and Mr Isaac that human rights expertise should be provided to governments in a manner analogous to the way scientific advice is provided through SAGE. We therefore recommend that, when responding to a public health emergency, governments should convene or recognise a group whose function is to provide independent expert advice on equalities and human rights issues arising from potential or existing public health interventions, and that such advice be considered alongside the scientific advice provided by SAGE and analogous bodies in the devolved governments.

Recommendation 11: When responding to a public health emergency, governments should convene or recognise a group whose function is to provide independent expert advice on human rights and equality issues arising from potential or existing public health interventions. Such advice should be considered alongside the scientific advice provided by the Scientific Advisory Group for Emergencies and analogous bodies in the devolved governments.

CHAPTER FOUR:

Emergency- responsive Primary Legislation

Introduction

185. In this Chapter we focus on bespoke primary legislation enacted during a public health emergency in order to respond to the health threat. Throughout this report we have referred to this type of legislation as “emergency-responsive” primary legislation. As noted in Chapter Two at paragraphs 19-20, we consider that any legal framework designed in advance of a public health emergency will likely need to be supplemented during the emergency by additional, responsive primary legislation in order to address unforeseen aspects of the threat at hand. During Covid-19, emergency-responsive statutes were enacted by both the UK and Scottish governments, and nearly all the foreign jurisdictions we reviewed. Out of the ten countries we considered, nine adopted coronavirus-responsive statutes, with Germany being the only exception, although the country did significantly amend its existing public health legislation (the Infection Protection Act 2000) in response to the Covid-19 pandemic.
186. The enactment of primary legislation during a public health emergency poses problems for parliamentary scrutiny, especially when that legislation is fast-tracked. The UK and Scottish Parliaments made a herculean effort to scrutinise in only a few days the fast-tracked coronavirus-responsive statutes their governments proposed. However, we heard evidence on how difficult it was to carry out this task. Professor Adam Tomkins, who sat in the Scottish Parliament during the early stages of the pandemic, strongly impressed upon us how the attention of elected representatives during an emergency is primarily directed towards their constituents rather than the detail of the law. Lord Blencathra also noted the huge pressure all parliamentarians were placed under during the Covid-19 pandemic to vote in favour of measures that they were told were necessary to protect the lives of millions of people.
187. The impediments to proper parliamentary scrutiny of emergency-responsive legislation create a number of risks. The swift enactment of emergency legislation in the heat of a crisis creates a risk of governments using the cover of an emergency to take on unwarranted powers. On a more prosaic level, rushed policy-making with limited parliamentary scrutiny can lead to legislative oversights, errors and inconsistencies that hinder an effective public health response.
188. In this Chapter, we consider how the four UK legislatures can provide appropriate oversight and accountability over emergency-responsive primary legislation, to try and ensure that it complies with the rule of law and principles of good governance. We start by reviewing oversight and accountability mechanisms within the three key pieces of coronavirus-responsive legislation adopted by the UK and Scottish Parliaments: the Coronavirus Act 2020, the Coronavirus (Scotland) Act 2020 and the Coronavirus (Scotland) (No.2) Act 2020. We then make recommendations for additional safeguards that could be put in place in a future public health emergency.

Legislation enacted during Covid-19

Coronavirus Act 2020

189. On 25th March 2020, at the start of the Covid-19 pandemic in the UK, the UK Parliament enacted the Coronavirus Act 2020 (“the UK Coronavirus Act”) in four sitting days. The Act contained provisions which applied in all four nations, including matters which fell within devolved competencies. The Scottish and Welsh Parliaments and Northern Ireland Assembly were therefore required by convention to consent to the UK Coronavirus Act being passed, which they did via legislative consent motions on 24th March 2020.
190. Although the UK Coronavirus Act was enacted specifically in the context of Covid-19, it was based on a draft Pandemic Influenza (Emergency) Bill designed almost eight years earlier following Exercise Cygnus: a three-day, cross-government simulation exercise led by the UK Department of Health in 2016 to test the UK’s response to a serious influenza pandemic. The draft Pandemic Influenza (Emergency) Bill was worked upon by the UK and devolved governments following Exercise Cygnus, but was not made public or subjected to scrutiny by parliamentarians before the start of the Covid-19 pandemic. A contents page of the draft Pandemic Influenza (Emergency) Bill dated 21st January 2020 has been published by the UK Covid-19 Inquiry.¹⁸⁶ It contains a number of measures that were seen in the UK Coronavirus Act a few months later, including the emergency registration of health professionals, the temporary modification of mental health and mental capacity legislation, and indemnities for health service activities.
191. The re-working of the Pandemic Influenza (Emergency) Bill into the Coronavirus Bill is said to have taken place over a period of three months, from January to March 2020.¹⁸⁷ We heard from Lord Bethell that this drafting exercise was not particularly strategic. Instead, it was a fast-paced, administrative “tidying up” exercise to address any additional provisions that government departments thought they might need to respond to Covid-19, in addition to the “big measures” which the Department of Health and Social Care considered could be introduced through the regulation-making powers in the England and Wales Public Health Act.
192. Nonetheless, the UK Coronavirus Act was particularly important in extending to Northern Ireland and Scotland equivalent regulation-making powers to those in Part 2A of the England and Wales Public Health Act¹⁸⁸ and introducing the power under which the furlough scheme was created: a very broad power for the Treasury to direct HM Revenue and Customs (“HMRC”) to have functions “in relation to coronavirus”.¹⁸⁹ The Act also contained measures which had the potential to significantly impact civil liberties, although most were rarely or never used during the pandemic, such as the reduction of social care duties for local authorities in England and Wales,¹⁹⁰ the loosening in all four nations of safeguards around the detention of people with mental ill health,¹⁹¹ and the introduction of powers to detain potentially infectious people in all four nations.¹⁹² The UK Coronavirus Act also expanded the use of live links in criminal proceedings, which has now been made a permanent feature of the criminal justice system in England and Wales.¹⁹³

¹⁸⁶ Available at: <https://covid19.public-inquiry.uk/documents/inq000023118_0001-0003-draft-pandemic-influenza-emergency-bill-dated-21-01-2020/> (accessed 1 February 2024); see also the UK government’s policy paper ‘UK Pandemic Preparedness’, available at <<https://www.gov.uk/government/publications/uk-pandemic-preparedness/uk-pandemic-preparedness>> (accessed 1 February 2024)

¹⁸⁷ See comments made by the then Health Secretary Matt Hancock at [HC Deb](#) 23 March 2020, vol 674, col 38

¹⁸⁸ Schedules 18 and 19 UK Coronavirus Act

¹⁸⁹ Section 76 UK Coronavirus Act

¹⁹⁰ Section 15 and Schedule 12 UK Coronavirus Act

¹⁹¹ Section 10 and Schedules 8, 9, 10 and 11 UK Coronavirus Act

¹⁹² Section 52 and Schedule 22 UK Coronavirus Act

¹⁹³ Sections 53 to 57 UK Coronavirus Act and sections 198 to 200 Police, Crime, Sentencing and Courts Act 2022

193. Since the Coronavirus Bill was fast-tracked through the UK Parliament and time for scrutiny was therefore truncated, it contained a number of measures that were designed to provide an opportunity for post-enactment scrutiny and review. We now turn to those.

Safeguards for post-enactment scrutiny and review in the UK Coronavirus Act

194. The principal safeguard in the UK Coronavirus Act is a two-year sunset clause, which applies to most of the Act's main provisions.¹⁹⁴ The Act also contains some "permanent" provisions, which continue to remain fully or partially in force. For example, the power for the Treasury to direct HMRC to have functions "in relation to coronavirus" is a permanent provision which remains in force.¹⁹⁵ When giving evidence to the House of Commons Public Administration and Constitutional Affairs Committee, Sajid Javid, the Health Secretary at the time, explained that it was necessary for the Act to contain some permanent provisions in order to provide legal certainty, and to safeguard measures taken during the pandemic.¹⁹⁶

SUNSET CLAUSES

Sunset clauses set a time limit on the period for which legislation remains in force, and are a common feature of emergency legislation. Once sunsetted provisions in legislation pass their expiry date they cease to be law, but any actions taken under that legislation while it was in force remain valid.

195. In addition, the two-year sunset clause in the UK Coronavirus Act is not a hard brake on the measures to which it applies. Ministers are able to use made affirmative or draft affirmative regulations to extend the two-year sunset clause for any provision for an indefinite amount of time, so long as each extension lasts no more than six months.¹⁹⁷ This power has been used to keep in force some provisions which would otherwise have expired in March 2022, such as an expansion in Northern Ireland of the use of live links in legal proceedings.¹⁹⁸ Ministers are also able to sunset any provision of the UK Coronavirus Act earlier than it would otherwise expire.¹⁹⁹ This power was used during Covid-19 to sunset measures early in all four nations.²⁰⁰ Moreover, some parts of the UK Coronavirus Act can be suspended and then revived at a later date.²⁰¹ When the Act was introduced, the Health Secretary explained that this provision would allow the UK and devolved governments to turn powers "on and off individually as necessary."²⁰²

196. The House of Commons (but not the House of Lords) had some say in deciding whether the temporary, non-devolved parts of the UK Coronavirus Act remained in force (i.e. the parts of the Act that were subject to the two year sunset period, and which could be expired by a UK minister without needing the consent of any of the devolved governments). If the UK government wanted any of these temporary provisions to remain law at the end of each six

¹⁹⁴ [Section 89](#) UK Coronavirus Act

¹⁹⁵ [Section 76](#) UK Coronavirus Act

¹⁹⁶ Public Administration and Constitutional Affairs Committee, *Coronavirus Act 2020 Two Years On* (2021-22, HC 978), paragraph 22

¹⁹⁷ [Sections 90\(2\)-\(3\)](#), [93\(2\)](#) and [\(5\)](#), [94\(2\)](#) and [\(5\)](#), [95\(2\)](#) and [\(5\)](#), and [96\(2\)](#) and [\(5\)](#) UK Coronavirus Act

¹⁹⁸ [Section 57](#) and [Schedule 27](#) UK Coronavirus Act

¹⁹⁹ [Section 90\(1\)](#) UK Coronavirus Act

²⁰⁰ To give some examples: [Coronavirus Act 2020 \(Expiry of Mental Health Provisions\) \(England and Wales\) Regulations 2020/1467](#); [Coronavirus Act 2020 \(Early Expiry of Provisions\) \(Scotland\) Regulations 2021/439 \(Scottish SI\)](#); [Coronavirus Act 2020 \(Early Expiry\) \(No. 2\) Regulations 2021](#)

²⁰¹ [Section 88](#) UK Coronavirus Act

²⁰² [HC Deb 23](#) March 2020, vol 674 col 36

month period, it had to move a motion in the House of Commons “that the temporary provisions of the UK Coronavirus Act should not yet expire.”²⁰³ The House of Commons would then vote as to whether to renew the temporary provisions. This renewal vote was an all or nothing decision: MPs could choose to expire all or none of the non-devolved temporary provisions, they could not vote to expire only some of the provisions.

197. If the House of Commons voted to expire the non-devolved temporary provisions, then the minister had to make regulations implementing this decision within 21 days of the vote.²⁰⁴ To assist the House of Commons in making this decision, the Secretary of State was required to publish two-monthly reports on the status of the non-devolved provisions for the length of the sunset period.²⁰⁵ These status reports had to be laid before the UK Parliament, and set out whether each non-devolved provision was in force, and whether the Secretary of State had brought any dormant provisions into force, suspended or revived any provisions, or altered the sunset period for any provisions.²⁰⁶ The reports also had to include a statement that the Secretary of State was satisfied that the status of the non-devolved provisions was appropriate.²⁰⁷
198. None of the temporary, non-devolved parts of the UK Coronavirus Act remain in force, and so the two-monthly status reports and six-monthly renewal motions tabled in the House of Commons are no longer taking place. The last status report was published in September 2022.

The Coronavirus (Scotland) Act 2020 and the Coronavirus (Scotland) (No.2) Act 2020

199. The Scottish Parliament enacted two further Scottish Acts to supplement the UK-wide Coronavirus Act 2020: the Coronavirus (Scotland) Act 2020 (the “Coronavirus Scotland Act”) and the Coronavirus (Scotland) (No.2) Act 2020 (the “Coronavirus Scotland No.2 Act”).
200. The Coronavirus (Scotland) Bill was introduced into the Scottish Parliament on 31st March 2020. The Scottish Parliament approved a motion which enabled the Bill to be fast-tracked as an emergency Bill, so that it was enacted on 1st April after one day’s consideration by a Committee of the Whole Parliament.²⁰⁸ The Coronavirus (Scotland) (No.2) Bill was also treated as an emergency Bill and fast tracked through Parliament, although the time-scales for scrutiny were a little longer: the Bill was introduced to the Scottish Parliament on 11th May 2020 and enacted just over a fortnight later, on 26th May. By this time the Scottish Parliament’s COVID-19 Committee had been established, so the detail of the Bill was reviewed by this specialist Committee rather than a Committee of the Whole Parliament.

²⁰³ [Section 98](#) UK Coronavirus Act. In principle the renewal motion was amendable, however the Speaker received legal and procedural advice to the effect that any amendment to the motion would risk “giving rise to uncertainty about the decision the House has taken. This then risks decisions that are rightly the responsibility of Parliament ultimately being determined by the courts. Lack of clarity in such important matters risks undermining the rule of law,” see [HC Deb](#) 30 September 2020, vol 681 col 331.

²⁰⁴ [Section 98\(1\)](#) UK Coronavirus Act

²⁰⁵ [Section 97](#) UK Coronavirus Act

²⁰⁶ [Section 97\(3\)](#) UK Coronavirus Act

²⁰⁷ [Section 97\(1\)\(b\)](#) UK Coronavirus Act

²⁰⁸ [Rule 9.21](#) of the Standing Orders governs the procedure for Emergency Bills

COMMITTEE OF THE WHOLE PARLIAMENT

In the Scottish Parliament, legislative scrutiny of Bills is normally led by one of the Parliament's specialist committees. For example, the Criminal Justice Committee will take the lead on the scrutiny of Bills relating to the court system. However, where a Bill needs to be fast tracked, it will usually be scrutinised by a Committee of the Whole Parliament, of which all MSPs are members and the Presiding Officer is the convener.

201. The Coronavirus Scotland Act provided the Scottish government with substantial emergency powers in addition to those contained in the UK Coronavirus Act. These powers included measures increasing the use of live links in court proceedings,²⁰⁹ extending the expiry of orders used to remove a child from their family home,²¹⁰ and loosening protections which govern when local authorities are able to make decisions on behalf of vulnerable adults.²¹¹ The Coronavirus Scotland No.2 Act was less wide-ranging, but still contained some significant provisions, such as extending time periods in criminal proceeding.²¹²

Safeguards for post-enactment scrutiny and review in the Scottish Coronavirus Acts

202. The post-legislative scrutiny mechanisms which apply to both the Coronavirus Scotland Act and Coronavirus Scotland No.2 Act are similar to, although in some ways more robust than, those in the UK-wide Coronavirus Act. Both of the Scottish Acts contained an initial expiry date for their substantive provisions of 30th September 2020, which equates to a six-month sunset period for the first Act and a four-month period for the second.²¹³ The Scottish government could extend this initial sunset period twice for six-months at a time, using draft affirmative (or in cases of urgency, made affirmative) regulations and laying before the Scottish Parliament a statement of their reasons why the Acts should be extended.²¹⁴ This meant that the maximum period for which the Acts could remain in operation was, respectively, 18 and 16 months. It was foreseen in early debates that it might be necessary or desirable to continue some of the Acts' provisions beyond their intended expiry date.²¹⁵ This prediction was borne out when the Scottish government fast-tracked through Parliament new primary legislation in June 2021, which extended the lifespan of both the first and second Coronavirus Scotland Acts by an additional six months to 31st March 2022, and gave the Scottish ministers the power to use draft affirmative regulations to extend the Coronavirus Scotland Acts for a further six months to 30th September 2022.²¹⁶ The substantive provisions of both Acts then expired on 1st October 2022.

203. As with the UK-wide Coronavirus Act, Scottish ministers were able to suspend and later revive any of the Scottish Coronavirus Acts' substantive provisions, and sunset any provision early.²¹⁷

²⁰⁹ [Section 5](#) and [Schedule 4](#), Coronavirus Scotland Act

²¹⁰ [Section 4](#) and [Schedule 3](#), Coronavirus Scotland Act

²¹¹ [Section 4](#) and [Schedule 3](#), Coronavirus Scotland Act

²¹² [Section 3](#) and [Schedule 2](#), Coronavirus Scotland No. 2 Act

²¹³ [Section 12\(1\)](#) Coronavirus Scotland Act and [Section 9\(1\)](#) Coronavirus Scotland No.2 Act

²¹⁴ [Section 12](#) Coronavirus Scotland Act and [Section 9](#) Coronavirus Scotland No.2 Act

²¹⁵ For example, see comments by Michael Russell MSP, the then Cabinet Secretary for the Constitution, Europe and External Affairs, at Scottish Parliament Covid-19 Committee, *4th Meeting 2020, Session 5* (12 May 2020), page 23

²¹⁶ [Section 1](#) Coronavirus (Extension and Expiry) (Scotland) Act 2021

²¹⁷ [Sections 11](#) and [13](#) Coronavirus Scotland Act and [sections 8](#) and [10](#) Coronavirus Scotland No.2 Act

The Scottish Coronavirus Acts also contained a two-month reporting requirement for Scottish ministers. Parts of this requirement were expressed in the same way as the equivalent reporting requirement in the UK Coronavirus Act: ministers must prepare and lay before the Scottish Parliament a report which includes whether each of the Acts' substantive provisions are in force, and whether the minister has brought any dormant provisions into force, suspended or revived any provisions, or brought forward the sunset period for any provisions.²¹⁸ However, the Scottish Coronavirus Acts also placed a number of additional requirements on the Scottish ministers.

204. First, the Scottish ministers were required to undertake a review every two months of the operation of the substantive provisions in the Acts and to consider whether they remained necessary. The two-monthly reports to the Scottish Parliament are framed as being reports of that review.²¹⁹ Ministers were also required to set out how the powers granted to them had been exercised.²²⁰ Further additions were then made to the reporting requirements throughout the pandemic. For example, the Coronavirus Scotland No.2 Act expanded the reporting requirement beyond the operation of the Scottish Coronavirus Acts: it required ministers also to review and prepare a report for the Scottish Parliament every two months on all the Scottish statutory instruments made with the main purpose of responding to coronavirus.²²¹ This was an important addition made to address the fact that most of the major coronavirus interventions had been introduced via statutory instrument under the Public Health Act framework rather than under the Coronavirus Scotland and Coronavirus Scotland No.2 Acts. From August 2021, Scottish ministers were required to report on further additional matters, such as the number of eviction orders issued in the reporting period because of rent arrears.²²²

Discussion

205. The above summary of post-legislative review mechanisms in the UK and Scottish Coronavirus Acts reveal some examples of good practice which could be built upon in future public health emergencies, but also some areas where we consider that significant changes need to be made. The rest of this Chapter sets out our recommendations to enhance parliamentary oversight of emergency-responsive legislation in future public health emergencies. We consider three ways in which oversight can be better facilitated:

- a) Improving the use of sunset clauses and post-legislative review;
- b) Enhancing reporting requirements; and
- c) Ensuring publication of any draft legislation designed to be adapted into emergency-responsive legislation.

Improved use of sunset clauses and post-legislative review

206. The UK and Scottish Coronavirus Acts contained sunset clauses and mechanisms for post-legislative review by the UK and Scottish Parliaments. In principle, these are positive ways to enhance parliamentary oversight of emergency law-making and ensure that it complies with

²¹⁸ [Section 15](#) Coronavirus Scotland Act and [section 12](#) Coronavirus Scotland No.2 Act

²¹⁹ [Section 15\(1\)](#) Coronavirus Scotland Act and [section 12\(1\)](#) Coronavirus Scotland No.2 Act

²²⁰ [Section 15\(2\)\(a\)](#) Coronavirus Scotland Act and [section 12\(2\)\(a\)](#) Coronavirus Scotland No.2 Act

²²¹ [Section 14](#) Coronavirus (Scotland) (No. 2) Act 2020

²²² [Section 6](#) Coronavirus (Extension and Expiry) (Scotland) Act 2021

the rule of law and principles of good governance. We consider that all emergency-responsive primary legislation should include a sunset clause which brings the powers in the Act to an end. Any extensions to the sunset clause should also be time limited and require justification by government. This will ensure that there is a clear limit to the period during which emergency-responsive legislation will operate, and make less likely the normalisation of emergency powers and their use beyond the emergency period.²²³ In addition, where emergency legislation has been fast-tracked through Parliament, there must be an opportunity for post-enactment parliamentary review of the provisions of the Act. This review must provide a substantive opportunity for parliamentarians to influence the operation of the Act.

207. We consider that the sunset clauses and post-legislative review mechanisms in the Scottish Coronavirus Acts were preferable to those in the UK Coronavirus Act, but neither were perfect. Our main concern is that members of both the UK and Scottish Parliaments had very little opportunity to influence the operation of the UK or Scottish Coronavirus Acts other than deciding every six months whether most of the provisions in the Acts should be expired.

208. As noted above at paragraph 196, the House of Commons was able to vote every six months on whether the non-devolved temporary provisions in the UK Coronavirus Act should be expired or continued. However, MPs were only able to vote to renew all or none of the non-devolved temporary provisions, they could not choose to sunset individual measures. MPs and Peers,²²⁴ parliamentary committees,²²⁵ and commentators from academia and civil society,²²⁶ including several of our commissioners, have noted that MPs who are presented with an “all or nothing” vote are likely to feel obligated to vote to renew an emergency-responsive Act, even if it contains some objectionable elements, in order not to vote down the whole edifice of public health protection that the Act contains. We agree with these concerns.

209. In addition, the parliamentary time allocated to each of the three renewal debates for the UK Coronavirus Act was too short to allow for proper scrutiny, a point that was emphasised during the Covid-19 pandemic by MPs and commentators.²²⁷ The renewal motion, as a procedure under an Act, engaged the provisions of the House of Commons Standing Orders which cap the length of debate on such procedures at just 90 minutes. As the Speaker of the House noted, however, this time limit could and would have been extended had this been requested by the Secretary of State.²²⁸ For the second six-month renewal debate, the House of Commons agreed a government business motion which lengthened the time for debate to three and a half hours, but also required three other coronavirus-related matters to be considered during that time (the one-year status report on the UK Coronavirus Act; a set of coronavirus lockdown regulations; and a motion to extend coronavirus-related procedures in the House).

²²³ See discussions by Ronan Cormacain, ‘Keeping Covid-19 emergency legislation socially distant from ordinary legislation: principles for the structure of emergency legislation’ (2020) 8(3) *The Theory and Practice of Legislation*, pages 252-255 and Adam Wagner, *Emergency State* (n 170), pages 14-16. Adam Wagner is one of our commissioners.

²²⁴ See, for example, comments made by David Davis and Chris Bryant at [HC Deb](#) 23 March 2020, vol 674 col 117-120, 135-136, 145; and Lord Falconer at [HL Deb](#) 24 March 2020, vol 802 col 1655 and [HL Deb](#) 25 March 2020, vol 802 col 1767

²²⁵ Joint Committee on Human Rights, *The government’s response to COVID-19: human rights implications* (n 82), paragraph 219; Public Administration and Constitutional Affairs Committee, *Coronavirus Act 2020* (n 196), paragraphs 29-36

²²⁶ See for example, Daniella Lock, Pablo Grez Hidalgo and Fiona de Londras ‘Parliament’s One-Year Review of the Coronavirus Act 2020: Another Example of Parliament’s Marginalisation in the Covid-19 Pandemic’ (2021) 92(4) *The Political Quarterly*, pages 702-3 and Big Brother Watch, *Emergency Powers and Civil Liberties Report [Aug – Sept 2020]* (19 October 2020), pages 27-29 <<https://bigbrotherwatch.org.uk/wp-content/uploads/2020/10/Emergency-Powers-and-Civil-Liberties-Report-AUG-SEPT-2020.pdf>> accessed 1 February 2024

²²⁷ See comments by Charles Walker at [HC Deb](#) 30 September 2020, vol 681 col 411 and Dawn Butler and Munira Wilson at [HC Deb](#) 19 October 2021 vol 701 col 650 and 666; and Meg Russell, Ruth Fox, Ronan Cormacain and Joe Tomlinson, ‘The marginalisation of the House of Commons under Covid has been shocking; a year on, parliament’s role must urgently be restored’ (*UCL Constitution Unit Blog*, 21 April 2021) <<https://constitution-unit.com/2021/04/21/covid-and-parliament-one-year-on/>> accessed 1 February 2024

²²⁸ See [Standing Order Number 16](#), as the renewal motion is a proceeding under an Act, and [HC Deb](#) 30 September 2020, vol 681 col 393

210. The Scottish Parliament had a greater opportunity to consider whether or not to continue the operation of the Scottish Coronavirus Acts. As discussed at paragraph 202, these Acts contained a six-month sunset period that was extended in six-month increments by draft affirmative regulations. The use of draft affirmative regulations to extend the sunset period allowed the Scottish Parliament's Covid-19 Committee and, later, Covid-19 Recovery Committee to consider in detail the regulations extending the Acts and to take evidence on the decision to renew from relevant figures in the Scottish government, including the First Minister and the Chief Medical Officer, before the regulations were approved by the Scottish Parliament. However, the Scottish Parliament was still presented with a binary choice of accepting or rejecting the regulations extending the Acts, without a chance to sunset individual clauses within the Scottish Coronavirus Acts or vote on amendments.
211. MSPs were first able concretely to influence the operation of the Scottish Coronavirus Acts only when the Acts' longstop sunset periods expired, 18 months after the first Scottish Coronavirus Act was enacted. Thereafter the Scottish government could not use draft affirmative regulations to extend the Acts any further. This meant that any further extension could only be achieved by the Scottish government bringing forward new primary legislation, and so in June 2021 the government introduced the Coronavirus (Extension and Expiry) (Scotland) Bill ("the Extension Bill"). The Extension Bill was enacted in August 2021, and amended the Coronavirus Scotland Act and Coronavirus Scotland No.2 Act to extend their lifespans by an additional six months from 30th September 2021 to 31st March 2022. It also empowered Scottish ministers to extend this period for a further six months to 30th September 2022.
212. There was some criticism around the way in which the Extension Bill was introduced to the Scottish Parliament.²²⁹ Nonetheless, the use of primary legislation to extend the sunset periods in the Scottish Coronavirus Acts enabled MSPs to propose and vote upon amendments to those Acts for the first time following their enactment, by tabling amendments to the Extension Bill during its parliamentary approval process. Opposition MSPs from the Labour, Conservative and Liberal Democrat parties successfully introduced amendments which expired provisions in both the Coronavirus Scotland Act and Coronavirus Scotland No.2 Act.²³⁰ A further amendment tabled by a Labour MSP removed the Scottish ministers' ability to use the made affirmative procedure to make regulations under both the Coronavirus Scotland Act and Coronavirus Scotland No.2 Act.²³¹ Another amendment added an additional reporting requirement to those already contained in the Coronavirus Scotland Act – requiring Scottish ministers to report on measures put in place to protect tenants from eviction, the number of evictions due to rent arrears, and the total value of rent arrears in the social housing sector.²³²

²²⁹ The Scottish government introduced the Extension Act as an emergency Bill and fast-tracked it through Parliament shortly before summer recess, explaining that it needed to be enacted quickly in order to give sufficient notice that the Scottish Coronavirus Acts would be extended beyond 30th September 2022. Nonetheless, many MSPs felt that debate on the Extension Bill should have been postponed and the summer recess period used to consult upon the extension, with time then allocated for MSPs to debate the Extension Bill more fully when Parliament returned in early September 2021. These critiques were echoed by academic commentators, including one of our commissioners, see: Pablo G. Hidalgo, Fiona de Londras and Daniella Lock, 'Parliamentary scrutiny of extending emergency measures in the two Scottish Coronavirus Acts: On the question of timing' (*UK Constitutional Law Blog*, 21 June 2021) <<https://ukconstitutionallaw.org/2021/06/21/pablo-g-hidalgo-fiona-de-londras-and-daniella-lock-parliamentary-scrutiny-of-extending-emergency-measures-in-the-two-scottish-coronavirus-acts-on-the-question-of-timing/>> accessed 1 February 2024

²³⁰ For examples, see sections 2(4)(a), 2(5) and 2(6)(b), introduced via amendments tabled by Pauline McNeill MSP (Labour), Graham Simpson MSP (Conservative) and Alex Cole-Hamilton MSP (Liberal Democrats) – see amendments 8, 12 and 13 in the [Marshalled List of Amendments for Stage 2](#)

²³¹ [Section 2\(7\)\(b\)](#) Coronavirus (Extension and Expiry) (Scotland) Act 2021, introduced via an amendment tabled by Jackie Baillie MSP – see amendment 15 in the [Marshalled List of Amendments for Stage 2](#)

²³² [Section 6](#) Coronavirus (Extension and Expiry) (Scotland) Act 2021, introduced via an amendment tabled by John Swinney MSP, a member of the SNP, adapting an earlier proposed amendment tabled by Mark Griffin MSP (Labour) and Ariane Burgess MSP (Green Party) – see amendment 5 in the [Marshalled List of Amendments for Stage 2](#) and amendment 6 in the [Marshalled List of Amendments for Stage 3](#)

213. Therefore, the Scottish Parliament gained its first real opportunity to influence the operation of the Scottish Coronavirus Acts when primary legislation had to be used to extend their expiry dates. Members of the UK legislatures had no equivalent opportunity in relation to the UK Coronavirus Act: ministers used statutory instruments to extend the long-stop two-year sunset period in the UK Coronavirus Act for some provisions, presenting parliamentarians with another “yes” or “no” vote.²³³
214. Taking this into account, we consider that the best way to enhance post-legislative scrutiny of a future emergency-responsive public health Act is to ensure this legislation includes a relatively short sunset period that cannot be renewed by statutory instrument.

Ensuring emergency-responsive primary legislation contains a sunset period of no longer than 9-12 months. That period should not be extendable by statutory instrument

215. We recommend that emergency-responsive primary legislation should contain a sunset period no longer than 9-12 months. That duration should not be extendable by statutory instrument. If it is necessary for provisions within the emergency-responsive Act to continue beyond this period, the government would have to introduce new primary legislation. Such primary legislation could be used to extend the life of the original emergency-responsive Act, together with any additional conditions Parliament may wish to stipulate. However, our recommendation would be for government to introduce a new Bill, carrying over such provisions as are still appropriate but providing opportunities to amend them and introduce new provisions having regard to the experience of the public health emergency thus far.
216. The House of Lords Delegated Powers and Regulatory Reform Committee made a similar recommendation at the start of the Covid-19 pandemic, when they advised the UK government that the UK Coronavirus Act should be subject to a one-year sunset clause with no power to extend, in order to enable “the government to exercise the powers needed in the immediate future while allowing a further bill to be introduced and subject to parliamentary scrutiny in slower time”.²³⁴ We heard oral evidence from the Chair of the Committee at that time, Lord Blencathra, who expanded upon this recommendation. He noted that the UK Coronavirus Bill went through all stages of scrutiny in the House of Commons in one day and then the Lords in one day. The Delegated Powers Committee recommended that, to make up for this limited scrutiny, the UK Coronavirus Act should go through the normal pre-legislative scrutiny procedures in the months following its enactment. This would mean that, when it came to renewing the UK Coronavirus Act at the end of the proposed one-year sunset period, it would have been debated properly at the committee stage, and Parliament would have an opportunity to make recommendations to amend, strengthen or remove powers.
217. The UK government rejected this recommendation from the Delegated Powers and Regulatory Reform Committee. Writing on behalf of the Department of Health, Lord Bethell explained to the Committee that the UK government considered the two-year lifespan of the UK Coronavirus Act to be appropriate, given that it was not possible to predict the course of the pandemic, nor the level of resource and capacity that might be available after one year.²³⁵

²³³ [Coronavirus Act 2020 \(Delay in Expiry: Inquests, Courts and Tribunals, and Statutory Sick Pay\) \(England and Wales and Northern Ireland\) Regulations 2022](#); [Coronavirus Act 2020 \(Extension of Powers to Act for the Protection of Public Health\) Order \(Northern Ireland\) 2022](#); [Coronavirus Act 2020 \(Alteration of Expiry Date\) \(Scotland\) Regulations 2022](#); [Coronavirus Act 2020 \(Alteration of Expiry Date\) \(Wales\) Regulations 2022](#).

²³⁴ Delegated Powers and Regulatory Reform Committee, *9th Report of Session 2019–21* (2019-21, HL 42), paragraph 16

²³⁵ Delegated Powers and Regulatory Reform Committee, *11th Report of Session 2019-21* (2019-21, HL 48), page 2

However, we are not convinced by this explanation. A one-year sunset clause does not mean that the measures in the Act cannot be continued after that year: the government could choose to re-introduce the Act if they felt it was still needed.

218. Nonetheless, we recognise that there are some potential downsides to a Parliament re-legislating an Act that is already in force and being used to respond to a public health emergency. We queried whether there could be a negative impact on compliance if members of the legislature are seen critiquing and potentially rejecting the necessity of some parts of a Bill that is identical to an Act already being used to impose public health interventions. Could that negatively impact the willingness of the public to comply with these interventions? We posed this question to Dr Fu-Meng Khaw, National Director of Health Protection and Screening Services and Executive Medical Director at Public Health Wales, who agreed that this may be detrimental to compliance. This issue would therefore have to be carefully considered with behavioural scientists before our recommendation is taken any further.
219. In addition, Dr Khaw noted the potential risks, from a public health perspective, of re-legislating an emergency-responsive public health Act and potentially removing some aspects of it at an early stage of a public health emergency, when such emergencies often have “twists and turns” that are difficult to predict in advance. Dr Khaw noted that, if the sunset clause for the UK Coronavirus Act had been debated in the summer of 2020, the modelling would have shown some low virus activity but not a significant increase, and the UK Parliament would therefore probably have made a decision to downgrade some of the Act’s measures only to find the country had to put emergency measures back in force in September 2020 when the alpha variant appeared. These are valid concerns that should be further explored.

Recommendation 12: Emergency-responsive primary legislation should be subject to a sunset period of no longer than 9-12 months. That duration should not be extendable by statutory instrument. If it is necessary for provisions within the emergency-responsive Act to continue beyond this period, new primary legislation should be used to introduce a new Bill, carrying over such provisions as are still appropriate but providing opportunities to amend them and introduce new provisions.

A rejected option: giving the legislature the ability to vote to amend provisions in an emergency-responsive Act

220. Initially, we considered whether the legislature should be able to amend an emergency-responsive public health Act, following a period of post-legislative scrutiny. In 2022, the House of Commons Public Administration and Constitutional Affairs Committee advised that greater consideration should be given in future to Parliament’s ability to scrutinise and amend provisions in an emergency-responsive Act while not affecting the overall integrity of the legislation.²³⁶ In response, the UK government explained that “the issue of which provisions could or should be retained on a ‘pick and mix’ basis is... problematic, if some parts [of the Act] become inoperable as a result of interdependencies with other provisions. It is standard legislative process that Parliament is not able to amend primary legislation once an Act has gained Royal Assent.”²³⁷ We share some of these concerns and given the procedural challenges involved we rejected this option.

²³⁶ Public Administration and Constitutional Affairs Committee, *Coronavirus Act 2020* (n 196), paragraph 36

²³⁷ House of Commons Public Administration and Constitutional Affairs Committee, *Coronavirus Act 2020 Two Years On: Government response to the Committee’s Seventh Report of Session 2021–22* (2022–23, HC 211), page 3

Enhanced reporting requirements

221. As noted above at paragraphs 197 and 203-204, the UK Coronavirus Act, Coronavirus Scotland Act and Coronavirus Scotland No.2 Act all contained two-monthly reporting requirements. The UK Coronavirus Act required the Secretary of State to report on whether each non-devolved provision in the Act was in force, and whether he or she had brought any dormant provisions into force, suspended or revived any provisions, or altered the sunset period for any provision.²³⁸ There was no obligation for the Secretary of State to provide any evaluative material as to how well the UK Coronavirus Act was functioning in practice and whether it was having any negative impacts. As a consequence, the two-month status reports initially contained almost no evaluative material and were criticised as being insufficiently detailed to enable proper parliamentary scrutiny, although their quality improved somewhat over the course of the pandemic.²³⁹
222. The reporting requirements in the Coronavirus Scotland Act and Coronavirus Scotland No.2 Act were initially largely similar to those in the UK Coronavirus Act: the Scottish ministers were required to set out whether each provision in the Scottish Coronavirus Acts was in force, how any regulation-making powers had been exercised, and whether the minister had brought any dormant provisions into force, suspended or revived any provisions, or brought forward the sunset period for any provisions. As noted at paragraph 204, from August 2021, the Scottish Parliament enacted new legislation requiring the Scottish ministers to report on additional matters such as the number of eviction orders issued in the reporting period because of rent arrears.²⁴⁰ Nonetheless, the reporting requirements in the Scottish Coronavirus Acts still contained limited obligations for the Secretary of State to provide evaluative material as to how well the Acts were functioning in practice.
223. Scottish ministers, however, voluntarily chose to go beyond these legal duties, and include significantly more detail in the two-monthly reports than the Scottish Coronavirus Acts required. This led to the reports generally being commended for assisting parliamentary scrutiny, including by the Scottish Parliament's Covid-19 Committee and one of our commissioners.²⁴¹ In its Legacy Report, the Scottish Parliament's Covid-19 Committee explained that:

“The government has gone further than the minimum reporting requirements set out in the Scottish Coronavirus Acts. In its two-monthly reports to parliament, the government has reviewed the provisions of the Coronavirus Act 2020 for which the Scottish Parliament gave legislative consent. The government has also taken steps to provide detailed updates on its reasons for determining the continued necessity of provisions that may have greater impact on certain individuals or groups (in relation to the protected characteristics identified in the Equality Act 2020), or their wider implications for equality and human rights.”

²³⁸ [Section 97](#) UK Coronavirus Act

²³⁹ Public Administration and Constitutional Affairs Committee, *Coronavirus Act 2020* (n 196), paragraphs 37-41; Public Administration and Constitutional Affairs Committee, *Parliamentary Scrutiny* (n 82), paragraphs 60-64; Katie Lines, *18 Months of COVID-19 Legislation* (n 148), paragraphs 45-47

²⁴⁰ [Section 6](#), Coronavirus (Extension and Expiry) (Scotland) Act 2021

²⁴¹ Scottish Parliament COVID-19 Committee, *Legacy Report* (n 149), paragraphs 14-19, Fiona de Londras, Pablo Grez Hidalgo and Daniella Lock, 'Rights and parliamentary oversight' (n 105), pages 598-9

The Committee has prioritised scrutiny of the two-monthly reports in its work by seeking views on what has been reported and taking evidence from Scottish ministers on their publication. This has enabled the Committee to highlight stakeholders' concerns about provisions within the emergency legislation, such as those relating to adults with incapacity. It has also enabled the Committee to seek clarification of policy measures where these have been defined in guidance rather than regulation...

The Committee considers that the reporting requirements set out in the Coronavirus Scotland Acts have worked well in supporting parliamentary scrutiny.”²⁴²

224. We moreover received oral evidence praising the Scottish government’s transparency in their two-monthly reports, and noting how important this transparency was in helping identify and address provisions that were negatively impacting human rights and equalities. Sanchita Hosali – the CEO of the British Institute for Human Rights – considered that there was more transparency in Scotland than in other parts of the UK. Ms Hosali gave the example of the Scottish government explaining in its two-monthly reports whether local authorities had used the UK Coronavirus Act to reduce the level of care and support they would otherwise be required to provide vulnerable individuals. She stated that this level of transparency opened an avenue for organisations to give evidence and influence the review processes for the UK Coronavirus Act. Ms Hosali noted that it was particularly important for governments to be very transparent if and when a precautionary approach was taken to public health protection, because a precautionary approach has the potential to slip into a blanket approach that does not properly take account of human rights.
225. In the light of the above discussion, we consider that emergency-responsive primary legislation should include a regular (i.e. two-monthly) reporting requirement that requires reports with **evaluative**, not purely narrative, criteria to be prepared for the legislature.
226. When we sought feedback on this recommendation, Matt Hancock MP advised us that such reports would be “extremely onerous and would risk becoming a meaningless pro forma”. He instead suggested that the reports should be required to be produced “half-yearly or quarterly”. However, we consider it important that the UK legislatures are provided with regular updates on the functioning of emergency-responsive Acts that are enacted at speed without the usual levels of parliamentary scrutiny and oversight. We do not consider that a two-monthly, evaluative reporting requirement would place an undue burden on governments, given that the Scottish government produced evaluative reports every two months throughout the Covid-19 pandemic.

Recommendation 13: Legislatures should be provided with two-monthly reports on the functioning of emergency-responsive primary legislation, with reference to evaluative criteria such as the continued need for and impact of the emergency measures.

²⁴² Scottish Parliament COVID-19 Committee, *Legacy Report* (n 149), paragraph 15-19

Publication of draft legislation for pre-legislative scrutiny and public consultation

227. Our final recommendation in this Chapter concerns the publication of draft legislation designed to be adapted into emergency-responsive legislation. We have noted that, although the UK Coronavirus Act was enacted specifically in response to Covid-19, some of its provisions had been designed almost eight years earlier as part of a draft Pandemic Influenza (Emergency) Bill. This Bill was the product of work by the UK and devolved governments, but was not made public or subjected to scrutiny by parliamentarians before the start of the Covid-19 pandemic.
228. In oral evidence, Sir Bernard Jenkin expressed a view that it would be much better to publish any future draft primary legislation that was designed to be revised and enacted in response to a specific public health threat, so as to increase transparency and the opportunity for discussion and debate. Sir Bernard emphasised that private consultation with the opposition is not an adequate substitute to publishing draft public health legislation, because there is no assurance as to how meaningful any private consultation is unless it is in the open. Lord Anderson agreed “wholeheartedly”, pointing to an earlier example of this approach in relation to control orders. He explained that, when the Coalition government decided to abolish control orders in 2011, they also prepared a draft Bill which would have enabled control orders to be effectively re-introduced in case the decision to abolish them turned out to be the wrong one.²⁴³ That Bill was exposed to pre-legislative scrutiny, which Lord Anderson found to be plainly sensible.
229. We agree with these suggestions. We consider that publication of a draft Bill would both enhance parliamentary oversight and promote transparency, participation and accountability of government policy-making. We therefore recommend that, if a draft Bill is designed in anticipation of a specific public health emergency with a view to it being revised and enacted when an emergency occurs, then such legislation should be drafted only after the widest practicable stakeholder consultation and engagement. The draft Bill should then be published and subject to pre-legislative scrutiny, and kept under periodic review (at least once per Parliament). We note that a similar recommendation was made by the House of Commons Public Administration and Constitutional Affairs Committee.²⁴⁴

Recommendation 14: If a draft Bill is designed in anticipation of a public health emergency with a view to its being revised and enacted as responsive legislation, then it should be drafted only after the widest practicable stakeholder consultation and engagement. The draft Bill should then be published and subject to pre-legislative scrutiny, and kept under periodic review (at least once per Parliament).

²⁴³ Draft Enhanced Terrorism Prevention and Investigation Measures Bill, September 2011.

²⁴⁴ Public Administration and Constitutional Affairs Committee, *Coronavirus Act 2020* (n 196), paragraph 58

CHAPTER FIVE:

Parliamentary Procedures

Introduction

230. We now turn to look at the operation of the UK legislatures during a public health emergency. This Chapter explores how parliamentary procedures can best be adapted so that legislatures can provide appropriate oversight of an emergency response. We focus on four topics: parliamentary committees, adaptations of parliamentary procedure (i.e. virtual working), contingency planning and inter-parliamentary dialogue and cooperation.

Parliamentary Committees

231. When we looked at parliamentary practices in international jurisdictions, we were struck that legislatures in six out of the ten countries we reviewed established specialised Covid-19 Committees (New Zealand, Canada, Belgium, Israel, Ireland and Norway). These Committees played different roles in different countries. In New Zealand, an Epidemic Response Committee effectively became the country's "parliament in miniature" in the early stages of the pandemic, before usual parliamentary conditions were restored at the end of May 2020.²⁴⁵ In Ireland, no ordinary committees sat between January and October 2020, but a "Special Committee on Covid-19 Response" was established in May 2020 and was charged with examining the state's response to the pandemic.²⁴⁶ We heard that these specialist parliamentary committees were generally effective in providing robust scrutiny of executive action, but in countries where committees acted as "parliaments in miniature" they tended to become more partisan and less effective over time.

Image: The Welsh Parliament building



²⁴⁵ Dean Knight, 'New Zealand: Legal Response to Covid-19' (n 138), paragraph 43

²⁴⁶ Eoin Carolan, Silvia Gagliardi, Seána Glennon, and Ailbhe O'Neill 'Ireland: Legal Response to Covid-19' in Jeff King and Octavo Ferraz (eds.) *The Oxford Compendium of National Legal Responses to Covid-19* (April 2021) <<https://oxcon.ouplaw.com/display/10.1093/law-occ19/law-occ19-e19>> accessed 1 February 2024, paragraphs 58-62. The Oxford Compendium was co-edited by one of our commissioners, Professor Jeff King.

The Role of Parliamentary Committees in the four UK legislatures

Committees in the UK Parliament

In the UK Parliament, the organisation and function of select committees in the House of Commons differs somewhat from that in the House of Lords. The majority of select committees in the House of Commons are departmental select committees concerned with examining the work of government departments. House of Lords Committees tend to focus their scrutiny on thematic, cross-cutting policy issues (for example the constitution). There are also joint select committees that draw their members from both the House of Commons and the House of Lords. Some committees exist permanently to scrutinise and report upon particular policy issues, such as the Joint Committee on Human Rights. Others are ad hoc committees established to look at specific issues over a limited time period, including conducting pre-legislative scrutiny of draft proposals for Bills.

Beyond pre-legislative scrutiny, the role of select committees in the legislative process is limited. While select committees sometimes review and report upon proposed primary legislation, the core scrutiny of government Bills is not undertaken by permanent select committees but by temporary legislative committees (known as Public Bill Committees) in the House of Commons and Grand Committees in the House of Lords. The task of scrutinising statutory instruments is primarily carried out by several specialised select committees: the Joint Committee on Statutory Instruments,²⁴⁷ the House of Lords Secondary Legislation Scrutiny Committee, and for certain EU-related statutory instruments the European Statutory Instruments Committee. These committees look at the legal and technical merits of a statutory instrument, the policy merits, whether matters are likely to be of political or legal interest, and whether certain measures justify a debate.

Committees in the Scottish Parliament

Committees in the Scottish Parliament conduct inquiries and report upon specific subjects, such as criminal justice, the economy, and rural affairs. In addition, the Standards, Procedures and Public Appointments Committee reviews parliamentary procedural rules on issues such as MSPs' behaviour and conduct.

Committees in the Scottish Parliament play a key role in examining both primary and secondary legislation. Bills are assigned to a "lead committee" based on the committee's expertise and the subject matter of the Bill. In the first stage of scrutiny, the lead committee will discuss the Bill, receive evidence, write a report on its deliberations and recommend whether Parliament should support the purpose of the Bill. If Parliament votes in favour of the purpose of the Bill, then a committee (usually the same committee that first considered the Bill) will also debate and decide upon amendments proposed by MSPs. The amended Bill, and any further proposed amendments, are then debated and decided upon by all MSPs in the Chamber.

Committees are usually also responsible for most of the scrutiny of secondary legislation. The Delegated Powers and Law Reform Committee reviews all statutory instruments for legal and technical accuracy, while a lead committee scrutinises the policy changes that the statutory instrument will implement, before any debate and vote in the Chamber.

²⁴⁷ For statutory instruments that must be laid before the House of Commons, only the Commons members of this Committee sit as the Commons Select Committee on Statutory Instruments

Committees in the Welsh Parliament, or “Senedd Cymru”

Committees in the Welsh Parliament examine areas of law that fall within the Parliament’s legislative competencies, and deal with its internal administration.

As with the Scottish Parliament, committees are central to the scrutiny of both primary and secondary legislation. Their involvement in the scrutiny of primary legislation follows a similar procedure as in the Scottish Parliament. A lead committee will be allocated to the Bill based on the committee’s subject area expertise. The committee will conduct initial scrutiny of the Bill by reviewing its main purpose, taking evidence, writing a report on the committee’s findings and recommending whether the Welsh Parliament should vote to agree with the general principles of the Bill. If the Parliament votes in favour of the Bill’s general principles, then the committee will scrutinise the Bill in detail and decide upon any amendments proposed by Members of the Welsh Parliament. The amended Bill, and any further proposed amendments, are then debated and decided upon by all Members of the Parliament.

The scrutiny of secondary legislation is primarily carried out by the Legislation, Justice and Constitution Committee before any debate and vote by the wider Parliament. This Committee considers all statutory instruments and reports on whether the Parliament should pay special attention to the instrument because, for example, the instrument contains defective drafting. Other committees are also able to consider and report upon statutory instruments that fall within their remit.

Committees in the Northern Ireland Assembly

Committees in the Northern Ireland Assembly have a number of different functions. Statutory committees examine the work of the nine Executive Departments. Standing committees are mostly concerned with the internal running of the Assembly, with some exceptions, such as the Public Accounts Committee which examines and reports on accounts laid before the Assembly by Executive Departments and other relevant public bodies. Ad-hoc committees are established to consider specific issues over a limited period of time. Where matters are of interest to more than one committee, then joint committees can be established for a limited period of time.

Committees take part in the detailed scrutiny of Bills. After the general principles of a Bill have been debated by the whole Assembly and a vote is taken to allow a Bill to pass this stage, the Bill is then referred to the relevant statutory committee for detailed review. The committee will usually take evidence from departmental officials and stakeholders, as well as scrutinising the detail of the Bill and discussing possible amendments. The committee cannot amend the face of a Bill directly, but will prepare a report for the Assembly containing proposals for amendments. The Bill then returns to the whole Assembly where Members vote on each part of the Bill and any proposed amendments, and ultimately decide whether to pass the Bill in its final form following these amending stages.

The scrutiny of secondary legislation, or statutory rules, is primarily carried out by statutory committees. Every piece of secondary legislation which is put before the Assembly is referred to the appropriate committee for scrutiny before any debate in the Assembly. Further scrutiny then takes place once secondary legislation has been laid before the Assembly. The Examiner of Statutory Rules will scrutinise the technical aspects of the legislation, while the relevant statutory committee considers the policy being implemented and recommends to the Assembly that the rule be annulled, approved, or affirmed.

Should a specialist committee be established in each of the UK legislatures during public health emergencies?

232. A specialist Covid-19 Committee was established in the Scottish Parliament on 21st April 2020.²⁴⁸ Its remit was to “consider and report on the Scottish government’s response to Covid-19, including the operation of powers under primary and secondary legislation used to respond to Covid-19”.²⁴⁹ This remit was drafted so as to avoid duplication with the work of the Scottish Parliament’s subject committees, which scrutinised the pandemic response in relation to their own areas of expertise.²⁵⁰ The Covid-19 Committee’s Chair and Deputy Chair were members of the main opposition parties in Scotland: the Conservative Party and the Labour Party. As well as undertaking legislative scrutiny, the Covid-19 Committee conducted inquiries into the Scottish government’s coronavirus response, including the use of emergency powers. It also held weekly sessions where members of the committee took evidence on the coronavirus response from Scottish ministers and public health officials.²⁵¹ Moreover, the committee undertook public consultation on major policy decisions, including commissioning a citizens’ panel to consider and provide recommendations on the priorities that should inform the Scottish government’s strategy and approach to restrictions in 2021.²⁵² Expert advisors – Professor Linda Bauld²⁵³ and Dr Helen Stagg²⁵⁴ – provided the committee with technical advice on epidemiological and wider policy and health protection measures.
233. There had been early fears that the Covid-19 Committee would cut across other subject committees, but commentators have concluded that these fears “proved unfounded”.²⁵⁵ A study by three researchers, including one of our commissioners, found the Covid-19 Committee to be one of two “significant accountability practices” that made parliamentary scrutiny of the pandemic response in Scotland “impressive”, especially when “considered against the somewhat less robust process in Westminster.”²⁵⁶
234. We therefore considered whether a specialist committee might enhance parliamentary scrutiny of executive action in the other UK legislatures during future public health emergencies. We received mixed feedback on this proposal from two members of the Scottish Parliament’s Covid-19 Committee. Murdo Fraser MSP, who was the onvenor of the Committee, advised that “in [his] experience the creation of a Coronavirus Committee in the Scottish Parliament was an appropriate measure, and allowed scrutiny of Scottish government decisions being taken.” He was in favour of emergency-responsive committees being created in all four legislatures in the UK during future public health emergencies.
235. Professor Adam Tomkins, a former MSP and member of the Scottish Covid-19 Committee, was more equivocal. He was not convinced that the Covid-19 Committee provided a useful model for the Westminster context, given that the purpose and structure of committees in Scotland is different to that in Westminster, in that the committees in the Scottish Parliament do more legislative work. He was also sceptical about the impact of the Covid-19 Committee’s work. He praised the Committee as having a useful agenda which did not trespass or replicate the work of other committees, and saw the Committee as serving a useful function by holding

²⁴⁸ The Covid-19 Committee continued to function until June 2021, when it was replaced at the start of a new parliamentary session with a Covid-19 Recovery Committee.

²⁴⁹ See the parliamentary motion establishing the Committee at <<https://www.parliament.scot/chamber-and-committees/votes-and-motions/S5M-21506>> accessed 1 February 2024

²⁵⁰ Stephen Imrie, Jim Johnston, Katy Orr and Hugh Williams, ‘The Scottish Parliament’s Response’ in *Parliaments and the Pandemic* (Study of Parliament Group, January 2021), pages 167-8

²⁵¹ Scottish Parliament COVID-19 Committee, *Legacy Report* (n 149), paragraphs 17-18

²⁵² *Ibid.*, paragraphs 28-30

²⁵³ Bruce and John Usher Professor of Public Health, University of Edinburgh

²⁵⁴ Reader, University of Edinburgh

²⁵⁵ Stephen Imrie, Jim Johnston, Katy Orr and Hugh Williams, ‘The Scottish Parliament’s Response’ (n 250), page 168

²⁵⁶ Pablo G. Hidalgo, Fiona de Londras and Daniella Lock, *Parliamentary scrutiny of extending emergency measures* (n 229)

public, on the record meetings where ministers were required to explain and account for their policy choices. However, Professor Tomkins considered that the Committee was not successful if the measure of achievement was to get ministers to change their minds. Instead, he found that the Committee was unable to “impose any collective will” on the government to remove elements of lockdown restrictions that the Committee felt were no longer justified, or needed to be lifted more quickly. He considered that the Committee failed to achieve this measure of success partly because MSPs took a partisan approach to their work on it. He contrasted this with committees in the House of Commons, which he felt engendered a sense of non-partisan commitment to the Committee’s independence and integrity, whether members sit on the government or opposition benches.

236. We recognise Professor Tomkins’ frustration at being unable to persuade the Scottish government significantly to change its pandemic response, but we consider that there is inherent value in the increased accountability and transparency provided by a forum where ministers are required to explain and account for their policy choices. In addition, the work of the Covid-19 Committee did lead to some policy changes being made. For example, in reporting on its work scrutinising the Coronavirus (Scotland) (No.2) Bill, the Covid-19 Committee explained how it:

“considered the equality and human rights impact of requiring people to stay at home during lockdowns. At its meeting on 12 May 2020 the Committee took evidence from the Law Society of Scotland on the human rights implications of the Coronavirus (Scotland) (No.2) Bill at Stage 1. Following this, at its meeting on 19 May 2020, the Committee agreed amendments that ensured information about the incidence of domestic abuse is collated and monitored during the pandemic. As a result, the bill was amended such that section 15A of the first Scottish Act and section 13 of the second Scottish Act require Scottish ministers to take account of any information about the nature and number of incidents of domestic abuse occurring during the pandemic.”²⁵⁷

237. Nonetheless, we were initially concerned as to whether a new, specialist committee would add any value to the work already being done by existing committees in the UK, Northern Irish and Welsh legislatures. We are conscious that existing committees in these legislatures conducted in depth scrutiny of government responses to Covid-19, and produced excellent and insightful reports. We therefore sought evidence as to whether members of those legislatures considered that anything would be gained by introducing a new, specialist committee in future public health emergencies. We heard from members of the UK and Welsh Parliaments who generally gave positive feedback.
238. Lord Bethell, who was responsible for taking coronavirus regulations through the House of Lords as Parliamentary Under Secretary of State at the Department of Health and Social Care between 9th March 2020 to 17th September 2021, strongly favoured the introduction of an emergency-responsive committee. In oral evidence, he informed us that it was “disappointing” and a “mistake” that there was no specialist Covid-19 Committee in the Westminster Parliament. He stated that a specialist committee would have helped his job as a junior minister taking coronavirus legislation through Parliament, and the absence of such a committee meant that many debates were low quality. Lord Bethell took the view that a specialist committee could have contained parliamentarians who covered the spread of clinical, legal, and civic issues, and who took a deep-dive on the subject matter and were keeping up with fast changing events. He stated that this committee could have held sessions with ministers that would have been more thoughtful, substantial and probing than the debates which were had on coronavirus

²⁵⁷ COVID-19 Committee, *Annual Report 2020-21* (2021, SP 1022), paragraph 56

regulations, which he felt did not get under the skin of the issues. He noted that these debates were limited to 30 minutes, during which he was often being defensive and doing crowd management. Lord Bethell suggested that a specialist emergency committee should span both Houses of the UK Parliament, and that the Joint Committee on the National Security Strategy could provide a model.

239. From an Opposition perspective, Baroness Thornton also favoured the establishment of what she described as a “National Emergency Committee” which would be cross-party and span both Houses of Parliament. Baroness Thornton considered that the government should not have responded to a major national emergency – taking on major powers and asking Parliament to approve laws retrospectively – without establishing a better basis of trust by working cross-party and cross-parliament, with cooperation and consent. She thought that an emergency committee could in effect bring opposition parties into a national government, and that management of the Covid-19 pandemic would have benefitted from greater support across the nations and the political spectrums. She stated that the government had made itself very vulnerable by internalising the running of the pandemic response and not exposing itself to higher levels of accountability, and that better checks on processes like procurement might have led to an improved pandemic response with higher levels of accountability and fewer mistakes. Baroness Thornton also noted that the UK Parliament works cross-party and cross-parliament all the time, in committees like the Joint Committee on Human Rights.
240. We were informed by David Melding, a former Member of the Senedd, that the Welsh Parliament had discussed setting up a specialised Covid-19 Committee and it had been a 50/50 call whether to proceed, although the Parliament ultimately decided not to proceed. Mr Melding noted that the Welsh Parliament Health Committee focussed on big picture issues related to Covid-19, the Legislation, Justice and Constitution Committee reviewed regulations, and other committees reviewed specific issues falling within their area of expertise – such as the Culture Committee reporting on the impact of Covid-19 on the arts sector. Mr Melding said that he might favour a dedicated committee being set up in future public health emergencies, if a planning exercise showed this to be the best route forward. He noted that a dedicated committee would allow a certain level of focus, which he felt the Welsh Parliament did not have during the pandemic.
241. Unfortunately, we were unable to speak with any members of the Northern Ireland Assembly. However, our research team read a number of transcripts from meetings of the Northern Ireland Assembly’s Committee for Health. While that committee took the lead on scrutinising the Northern Ireland government’s response to Covid-19, it did not cover the entire pandemic response because it only scrutinised the Department of Health. This is the standard approach of the Assembly’s Statutory Committees, whereby each scrutinises a specific Department. The potential limitations of this approach were shown in June 2020, when controversy arose over the policing of a Black Lives Matter protest by the Police Service of Northern Ireland. Some members of the Health Committee felt that, as part of its legislative scrutiny role, the committee should address the policing of the protest when reporting on the regulations that underpinned the police response. The committee’s chair suggested writing to the Chief Constable to obtain further information on the enforcement of the regulations. However, others in the Committee felt that this went beyond their role, with one member commenting that they did not see “how the operational stuff that the police have been involved with has anything to do with this Committee. This is the Health Committee” ... “I really do not want to be involved in any type of criticism of the police or for the Committee to be involved in

anything that is not to do with health".²⁵⁸ This suggests that the Assembly may benefit in future public health emergencies from having a specialist committee that is able to take a more holistic approach.

242. Not all those to whom we spoke were in favour of establishing a specialist committee. Sir Bernard Jenkin MP, Chair of the House of Commons Liaison Committee, informed us that the chairs of the House of Commons select committees spent a great deal of time discussing whether the UK Parliament should establish a specialist Covid-19 Committee, but it was felt that each of the departmental committees had so much to do in their own sphere of activity a specialist committee would have been otiose. Sir Bernard stated that the Liaison Committee was in some ways the overarching committee during Covid-19, and he would not support a specialised committee in future public health emergencies.
243. We have taken Sir Bernard's comments into account, and do not want to make any recommendations that would diminish the role of other committees in the UK Parliament. However, taking into account the experience of the Scottish Covid-19 Committee and the evidence given by Lord Bethell and Baroness Thornton which we have summarised above, we have concluded that:
- a) The Scottish Parliament's Covid-19 Committee should provide a model for the establishment of a similar committee in the Scottish Parliament in future public health emergencies; and
 - b) The UK Parliament would also benefit from establishing a specialist emergency committee in a future public health emergency.
244. It seems probable that a specialist emergency-responsive committee would also have value in the Welsh Parliament and the Northern Ireland Assembly, but we have not received sufficient evidence on this point to be able to recommend this with certainty.

How would an emergency-responsive public health committee function in the UK Parliament?

245. Any committee established in the UK Parliament during a future public health emergency should focus on reviewing government policy, while the technical scrutiny of regulations should continue to be carried out by the existing designated committees in this area. This would provide space in Parliament for parliamentarians to take a longer-term view and holistically consider the policy behind the legislative response to the emergency. The trigger for the establishment of an emergency-responsive committee could be the declaration of an urgent health situation.
246. The committee should be chaired by a member of the largest opposition party, and its membership should include senior parliamentarians, including some nominated by other relevant select committees, in order for the committee to make a strong start and ensure it draws on and links up with existing areas of policy and technical expertise. By drawing from the departmental select committees, the specialist public health emergency committee would also have a strategic cross-departmental focus.

²⁵⁸ Northern Ireland Assembly Committee for Health, *Health Protection (Coronavirus, Restrictions) (Amendment No. 5) Regulations (Northern Ireland) 2020: Department of Health* (18 June 2020) accessible at < <http://data.niassembly.gov.uk/HansardXml/committee-22729.pdf>> accessed 1 February 2024

247. The committee could use some of the practices of the Scottish Parliament’s Covid-19 Committee as a model. For example, from the autumn of 2020 the Covid-19 Committee reviewed drafts of proposed made affirmative regulations before they were made into law. The Covid-19 Committee explained that Scottish ministers would:

“make a weekly ministerial statement on COVID-19 on Tuesday afternoons; provide a draft copy of proposed regulations on Wednesday afternoon; and make Scottish ministers available to give evidence to the Committee each week on Thursday morning. The draft regulations were often made into law on Thursday afternoon or on the following day.”²⁵⁹

248. This way of working enables legislatures to feed into even extremely fast-moving, emergency law-making. In oral evidence, Lord Bethell reflected that a similar model could have worked in the UK Parliament, noting that there were times when data would arrive on Thursday morning, a “Covid-O” meeting would be convened at midday to implement a lockdown, a “Covid Gold” meeting would be held at 3pm or 4pm, and then the government would operationalise the relevant decision by midnight. Lord Bethell felt that bringing Parliament into that process would be very difficult, but the decision could be run past the members of a specialist committee.

249. In addition, the Scottish Covid-19 Committee undertook public consultation on major policy decisions, including commissioning a citizens’ panel to consider and provide recommendations on the priorities that should inform the Scottish government’s strategy and approach to coronavirus restrictions. An emergency-responsive public health committee could provide a space to ensure there is some level of public consultation on government policy even in the midst of an emergency. This could assist governments and parliamentarians to understand public sentiment, so they can better assess the potential effectiveness of future interventions.

250. Finally, the committee should have expert advisors to help it understand the science surrounding the public health threat. When commenting upon this recommendation, Daniel Greenberg CB expressed his “doubts about enabling the responsive committee to obtain advice”, stating that “it is the government’s role to obtain scientific advice and to act on it, and a multiplicity of sources of ‘officially authoritative’ scientific advice can be significantly unhelpful. The multiplicity even of informal sources of advice during Covid was a significant factor in causing confusion at various stages”.

251. We agree with Mr Greenberg’s comments on the problems that can be caused by having multiple sources of scientific advice in the public domain. However, we do not suggest that the advice provided by the committee’s expert advisors should be in the public domain. The purpose would not be to provide the committee with alternative advice that is then published, but rather to assist the committee in understanding the wider context and potential impact of government policies, and enabling the committee to understand and contextualise the government’s own scientific advice, the work of SAGE, and other complex information sometimes taken in evidence. As we saw in Chapter 3 at paragraphs 145-149, parliamentarians struggled to access information on the likely impact of government policies when it was not provided to them by ministers. Moreover, in a meeting on 11th March 2021, the Scottish Covid-19 Committee specifically commented on how valuable its expert advisors had been, with one member noting that the committee had “made substantial progress in the past six months. In particular, bringing in independent advisers has led to real progress, as we have deepened our understanding as a committee and increased our ability to scrutinise government.”²⁶⁰

²⁵⁹ Scottish Parliament COVID-19 Committee, *Legacy Report* (n 149), paragraph 17

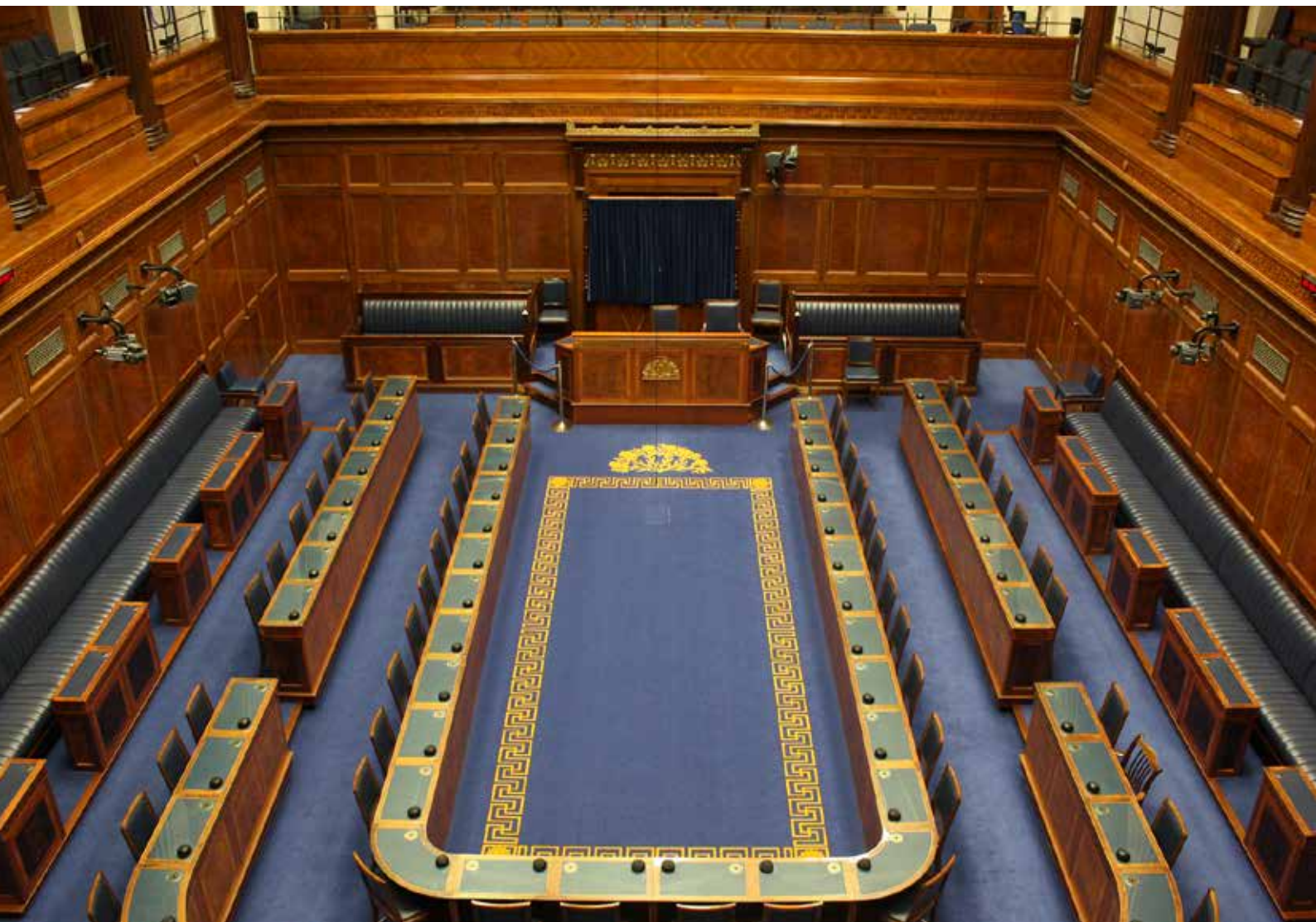
²⁶⁰ Scottish Parliament COVID-19 Committee, *10th Meeting 2021, Session 5* (11 March 2021), col 23 accessible at <<https://archive2021.parliament.scot/parliamentarybusiness/report.aspx?r=13193&mode=pdf>> accessed 1 February 2024

Recommendation 15: In future public health emergencies, the UK and Scottish Parliaments should establish a specialist emergency committee similar to the Covid-19 Committee established by the Scottish Parliament. It seems probable that such a committee would also have value in the Northern Ireland Assembly and Welsh Parliament, but we have not received sufficient evidence on this point to be able to recommend it with confidence. The specialist committee should:

- (a) Review government policy, while the technical scrutiny of statutory instruments should continue to be carried out by the existing designated committees in this area.
- (b) Be chaired by a member of the largest opposition party, and its membership include senior parliamentarians, including some nominated by other relevant select committees.
- (c) Consider the practices of the Scottish Parliament's Covid-19 Committee as a model.
- (d) Have expert advisors to help it understand the science surrounding the public health threat.

Image: The Northern Ireland Assembly Chamber.

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Adaptations of parliamentary procedures during a public health emergency

Procedural adaptations during the Covid-19 pandemic

The UK Parliament - House of Commons

The House of Commons adopted virtual ways of working at an early stage of the Covid-19 pandemic. Select committees began meeting virtually in the last week of March 2020.²⁶¹ MPs then adopted hybrid procedures for some proceedings in the main Chamber in mid-April 2020.²⁶² This enabled Members to participate remotely in ministerial statements and questions, second reading legislative debates, and when voting. The government initially decided not to continue these temporary arrangements beyond May 2020. However, there was opposition to this approach, and over June 2020 some hybrid measures were re-introduced for MPs who were unable to attend Westminster due to medical or public health reasons related to the Covid-19 pandemic, although in-person attendance was required for debates on motions and legislation.²⁶³ Remote participation was then expanded on 30th December 2020, when the option of virtual attendance was extended to all MPs and permitted for debates on motions and legislation in anticipation of the debate on the legislation putting into law the government's Brexit deal with the EU.²⁶⁴ After 22nd July 2021, the House mostly reverted to pre-pandemic procedures.²⁶⁵

The UK Parliament - The House of Lords

Peers agreed to implement mostly virtual proceedings after the House of Lords returned from Easter recess in April 2020, with only some items of business taken in the Chamber.²⁶⁶ The House then moved to a fully hybrid model in June 2020.²⁶⁷ In the same month, it was agreed that all voting would take place virtually through a new app: 'PeerHub'.²⁶⁸ These temporary measures continued a few months longer than those in the House of Commons, with Peers agreeing to implement new 'post-pandemic' procedures from September 2021. Under the 'post-pandemic' procedures some pandemic adaptations continue to remain in force. For example, virtual participation continues to be used for some committee meetings, and to allow "eligible disabled members who cannot attend the House" to participate in proceedings in the Chamber.²⁶⁹

²⁶¹ Sara Priddy, 'Coronavirus timeline: How the Commons virtually went virtual' (*House of Commons Library*, 16 September 2020), accessible at <<https://commonslibrary.parliament.uk/coronavirus-timeline-how-the-commons-went-virtual/>> accessed 1 February 2024

²⁶² *Ibid.*

²⁶³ David Natzler, 'How the House of Commons has adapted to the pandemic' in *Parliaments and the Pandemic* (Study of Parliament Group, January 2021), pages 8-9

²⁶⁴ Mark Hutton et al, *Erskine May: Parliamentary Practice* (25th edition, LexisNexis 2019, updated July 2022), paragraph 17.7a

²⁶⁵ *Ibid.*

²⁶⁶ Edward Scott and Nicola Newson, 'House of Lords: timeline of response to Covid-19 pandemic' (*House of Lords Library*, 1 March 2022), accessible at <<https://lordslibrary.parliament.uk/house-of-lords-timeline-of-response-to-covid-19-pandemic/>> accessed 1 February 2024

²⁶⁷ *Ibid.*

²⁶⁸ Sir David Beamish, 'The House of Lords after the pandemic' (*Hansard Society Blog*, 8 October 2021) accessible at <<https://www.hansardsociety.org.uk/blog/the-house-of-lords-after-the-pandemic>> accessed 1 February 2024

²⁶⁹ *Ibid.*

The Scottish Parliament

In the Scottish Parliament, adaptations to working arrangements were led by the Parliamentary Bureau with sitting arrangements agreed by the wider Parliament. Initially, the Parliament continued to work mostly in-person with reduced numbers of MSPs present in the Chamber, alongside provision for virtual question times and committee meetings.²⁷⁰ However, virtual meetings of the wider Parliament were introduced from early May 2020, and by mid-May a hybrid Parliament was established.²⁷¹ During June 2020 a digital voting system was set up. After public health restrictions were lifted in April 2022, Members began primarily to attend Parliament in person but some continued to make use of the virtual participation facility, usually for health reasons.²⁷² A significant proportion of MSPs also continue to vote remotely.²⁷³

The Welsh Parliament, or “Senedd Cymru”

The Welsh Parliament began holding virtual plenary sessions on 1st April 2020, before switching to a hybrid parliament format in July 2020. Remote voting was introduced on 8th July 2020. The Parliament has retained the hybrid meeting format as its normal way of doing business, and the option of holding a fully virtual meeting has continued to be available (for example for recall meetings during recess).²⁷⁴

The Northern Ireland Assembly

The Northern Ireland Assembly’s statutory committees began holding hybrid and virtual meetings during the Covid-19 pandemic, but the wider Assembly continued to meet in-person throughout. Social distancing was put in place which meant that only 23 of the Assembly’s 90 MLAs could be seated in the chambers at any one time. The allocation of seating was broadly proportional to party representation.²⁷⁵ A system was also introduced to extend provision for proxy voting. These changes to normal procedures were formulated by Assembly staff, agreed by the Business and Procedures Committee and approved as temporary standing orders on 31st March 2020.²⁷⁶

252. All four UK legislatures adapted their ways of working to respond to the Covid-19 pandemic. The impact of these adaptations on parliamentary scrutiny was investigated and reported on by a number of parliamentary committees. The general sense of these reports is that procedural changes were a cumbersome but necessary solution to enable the legislatures to conduct business during the pandemic. Unsurprisingly, the three parliaments that incorporated virtual proceedings across all or most parliamentary business noted some negative impact on the quality of scrutiny. These effects included a “loss of spontaneity” in debates which affected

²⁷⁰ Stephen Imrie, Jim Johnston, Katy Orr and Hugh Williams, ‘The Scottish Parliament’s Response’ (n 250), page 164

²⁷¹ *Ibid.*, page 165

²⁷² Scottish Parliament Standards, Procedures and Public Appointments Committee, *Report on inquiry into future parliamentary procedures and practices* (2022, SP 213), paragraph 80

²⁷³ *Ibid.*, 80

²⁷⁴ Written evidence from the Welsh Parliament ([Appendix 17](#))

²⁷⁵ Jenny McCullough, ‘A citizen’s account of Stormont’s response’ in *Parliaments and the Pandemic* (Study of Parliament Group, January 2021), pages 156-7

²⁷⁶ *Ibid.*, pages 156-7

the ability of parliamentarians to “press ministers for better answers”,²⁷⁷ and a reduction in informal interactions “within parties, on a cross-party basis, or with ministers, stakeholders and the public”.²⁷⁸ However, the House of Lords Constitution Committee reported that hybrid working had “supported the participation of members who were geographically distant from Westminster, had disabilities, needed to shield or self-isolate or had caring responsibilities, or who, in normal times, find it difficult to get in”.²⁷⁹

253. These findings are broadly reflective of the evidence we received from parliamentarians. For example, Lord Janvri stated that in his view the House of Lords was not as effective in scrutinising and holding ministers to account during the virtual Parliament, while David Melding informed us that the virtual Welsh Parliament somewhat diminished the effectiveness of parliamentary scrutiny, but the impact should not be exaggerated. Lord Anderson and Baroness Grey-Thompson²⁸⁰ meanwhile, impressed upon us how much of a success story they considered the virtual House of Lords to have been. Baroness Grey-Thompson noted that some measures – such as the use of call lists and the switch to virtual select committees – made it harder to challenge ministers, which she suspected was a difficulty felt even more keenly in the House of Commons where proceedings are more adversarial. But, overall, Baroness Grey-Thompson considered that Peers had still been able to hold the government to account despite the procedural limitations. She also noted that, while the House of Lords should be more open to facilitating contributions from Peers who cannot always be present in the building, the decision to continue some of the changes created during the virtual Parliament had helped a small number of disabled Peers who struggled with the presenteeism in the Lords and who can now work online. She noted that, in contrast, those same innovations were “done away with very quickly” in the House of Commons because of the value that is given to presenteeism.
254. Baroness Grey-Thompson was not the only witness to highlight the potential negative impacts caused by requiring parliamentarians to work in-person when this is not possible or practical. In written evidence, Dr Louise Thompson²⁸¹ and Dr Alexandra Meakin²⁸² drew upon their research into the role of small parties in the UK’s legislatures and explained how, during the Covid-19 pandemic:

“MPs representing constituencies in Northern Ireland, Scotland and Wales experienced far greater difficulties travelling to and from [the UK] Parliament than the vast majority of MPs representing constituencies in England. We found that this prevented them from taking part in proceedings on a regular basis, particularly in the first few months of the pandemic. At this time for example, MPs flying to Westminster from Northern Ireland saw travel options reduce from twelve flights to London each day to just one. Attending the House of Commons on Mondays meant that they missed the first few hours of business. It also prevented them from attending on Thursdays because of the new flight schedule. Those who did remain in Westminster on Thursdays would find themselves stuck in London for the weekend. In one case, Northern Ireland Alliance MP Stephen Farry had to ask Liberal Democrat MP Wendy Chamberlain to represent him in an Urgent Question in the chamber, as he was unable to travel to London at short notice (See HC Deb, 4 Jun 2020, c1024).”²⁸³

²⁷⁷ House of Lords Constitution Committee, *Covid-19 and Parliament* (2021-22, HL 4), paragraph 72 and House of Commons Procedures Committee, *Back to the future? Procedure after coronavirus restrictions* (2019-21, HC 1282), paragraph 13

²⁷⁸ Welsh Parliament Committee on Senedd Electoral Reform, *Senedd reform: The Next Steps* (September 2020), paragraph 34, and Scottish Parliament Standards, Procedures and Public Appointments Committee, *Report on inquiry into future parliamentary procedures* (n 272), paragraph 64

²⁷⁹ Constitution Committee, *Covid-19 and Parliament* (n 277), paragraph 61

²⁸⁰ Crossbench Member of the House of Lords and former Paralympic athlete

²⁸¹ Senior Lecturer, University of Manchester

²⁸² Lecturer in Politics, University of Leeds

²⁸³ Written evidence from Dr Louise Thompson and Dr Alexandra Meakin ([Appendix 15](#))

255. Dr Meakin and Dr Thompson stated that these problems arose partly because “[c]onsultation with opposition parties on changes to parliamentary proceedings were poor and this meant that the adaptations made were a) very London-centric and b) disproportionately affected members of the smaller opposition parties, especially those with constituencies in Northern Ireland, Scotland and Wales”. They went on to note that “[s]mall party MPs felt they had been excluded from the decision-making process around virtual and hybrid proceedings”.²⁸⁴
256. Taking into account the above evidence, we recommend that, if a public health emergency necessitates the introduction of special provisions, such as virtual parliamentary proceedings or hybrid working, then decisions about those provisions should be made in consultation with Members from all political parties, via the relevant procedure committee of each legislature. Ideally, measures should be adopted with cross-party support where possible. We also note that special provisions developed during emergencies, such as the introduction of hybrid ways of working, should not be abandoned too swiftly following the end of the emergency period, without first considering whether they may have lasting value in facilitating greater participation by all Members.

Recommendation 16: If a public health emergency necessitates the introduction of special arrangements in legislatures, such as virtual proceedings or hybrid working, decisions about those provisions should be made in consultation with Members from across all political parties, via the relevant procedure committee of each legislature, with the aim of achieving cross-party support. Special parliamentary provisions developed during emergencies, such as the introduction of hybrid ways of working, should not be abandoned too swiftly following the end of the emergency period, without first considering whether they may have lasting value in facilitating greater participation by all Members.

Contingency planning and inter-parliamentary dialogue and cooperation

257. Our final recommendation in this Chapter relates to the involvement of legislatures in government contingency planning for future public health emergencies. A number of witnesses emphasised the importance of parliaments being involved in this process. Sir Bernard Jenkin felt that this was the “most salient question” to be asked. He considered that future public health emergencies would be much improved if the UK Parliament’s Select Committees were invited into emergency planning operations like Exercise Cygnus and asked at each step of the plan what Parliament would be doing, what the Chairman of the Committees would be doing, and so on. Lord Bethell, Lord Janvrin and David Melding also considered that the four UK legislatures should be included in government contingency planning for future emergencies. Lord Janvrin noted that it would be hugely beneficial to involve parliaments in thinking about how they can scrutinise and add value to the legislative process in advance of the next emergency.
258. We strongly agree. We recommend that, in addition to their own contingency planning in respect of public health emergencies, all four legislatures should be involved in UK government planning exercises (e.g. any successors to Exercise Cygnus) given the significant role that legislation (primary and secondary) plays during an emergency and the role a legislature plays at such times as the focal point for democratic accountability.

²⁸⁴ Ibid.

259. We would encourage this contingency planning to involve inter-parliamentary dialogue and cooperation. This would give all four parliaments an opportunity to share lessons learned from the Covid-19 pandemic, including examples of best practice, and develop complementary contingency plans. We note that an Inter-parliamentary Forum already exists, having been established during Brexit and relaunched in February 2022.²⁸⁵
260. We also recommend that all four UK legislatures consider how inter-parliamentary dialogue and cooperation could be pursued to beneficial effect once a public health emergency occurs. This could provide a more neutral forum for discussion and collaboration between the four nations if intergovernmental working becomes strained or overly politicised. If emergency responsive committees are established in each parliament, then inter-parliamentary working could take the form of regular meetings between these four committees.

Recommendation 17: In addition to their own contingency planning for public health emergencies, the legislatures should be involved in government planning exercises (e.g. any successors to Exercise Cygnus). We would encourage contingency planning to involve inter-parliamentary dialogue and cooperation. We also recommend that all four legislatures consider how inter-parliamentary dialogue and cooperation could be pursued to beneficial effect once a public health emergency occurs.

²⁸⁵ Consideration is given to how the Inter-parliamentary Forum could be strengthened in Paul Silk and Paul Evans, *A new structure for interparliamentary relations in a devolved Great Britain and Northern Ireland* (Study of Parliament Group and Hansard Society, February 2023)



12:42:48



CHAPTER SIX:

Legal Certainty

Introduction

261. Legal certainty is a key aspect of the rule of law.²⁸⁶ In order for people to understand what the law requires them to do, legal rules must be sufficiently clear, stable and accessible, and should enable people to foresee with reasonable confidence when they might be sanctioned for not following the law. This is particularly important when legal rules are underpinned by criminal sanction, due to the weighty penalties a person may face for breaching the criminal law.
262. The impacts of legal uncertainty in a public health emergency are potentially severe. In studies of public compliance with coronavirus restrictions in the UK, legal uncertainty was one of the most common self-reported reasons for members of the public failing to comply with restrictions.²⁸⁷ People reported being unsure about what was legally prohibited due to complex, frequently changing law and a lack of clarity and consistency in the way in which rules were made and communicated.²⁸⁸ Legal uncertainty has also been cited as the reason for some of the high-profile errors in the enforcement of Covid-19 restrictions, such as the police attempting to prevent people from buying Easter eggs during the first UK-wide lockdown, which may have also undermined legitimacy and trust in the police.²⁸⁹ We were informed that trust in the police was further impacted when members of the public misunderstood which actions were unlawful, and reported non-compliance that did not in fact amount to a breach of the law. The Scottish Police Federation informed us that a lack of enforcement by the police in these scenarios led to “perceptions that law-breaking was being tolerated” and caused “resentment in some parts of our communities”.²⁹⁰
263. There has already been much written about legal uncertainty during the Covid-19 pandemic, including excellent reports by committees in the UK Parliament.²⁹¹ We draw from and build upon that work in this chapter in order to make recommendations for improvements in future public health emergencies. We focus on three main areas of legal uncertainty that have been common threads throughout the evidence we have received: uncertainty caused by (1) how the law is made (2) the communication of the law, guidance and public health advice, and (3) the different responses to Covid-19 between the four UK nations.

²⁸⁶ European Commission for Democracy through Law (“Venice Commission”), *The Rule of Law Checklist* (Council of Europe, 2016), Benchmark B3 available at <https://www.venice.coe.int/images/SITE%20IMAGES/Publications/Rule_of_Law_Check_List.pdf>

²⁸⁷ Simon Williams, Christopher Armitage, Tove Tampe and Kimberly Dienes, ‘Public perceptions of non-adherence to pandemic protection measures by self and others: A study of COVID-19 in the United Kingdom’ (2021) 16(10) PLoS One; Liam Wright, Elise Paul, Andrew Steptoe and Daisy Fancourt, ‘Facilitators and barriers to compliance with COVID-19 guidelines: a structural topic modelling analysis of free-text data from 17,500 UK adults’ (2022) 22(34) BMC Public Health

²⁸⁸ *Ibid.*

²⁸⁹ Camilla De Camargo, ‘We were the Guinea pigs’: Police uncertainty enforcing coronavirus regulations in the UK’ (2023) 72 *International Journal of Law, Crime and Justice*, page 10

²⁹⁰ Written evidence from the Scottish Police Federation ([Appendix 13](#))

²⁹¹ In particular, Constitution Committee, *COVID-19 and the use and scrutiny of emergency powers* (n 82) and the Joint Committee on Statutory Instruments, *Rule of Law Themes from Covid-19 Regulations* (2021-2022, HL 57 HC 600)

How the law is made

Simplifying the law

264. The UK was not alone in experiencing problems with the clarity of coronavirus laws. Most of the foreign jurisdictions we reviewed reported a lack of clarity in the legislation used to respond to Covid-19. One exception appears to be New Zealand. Dr Dean Knight, Associate Professor in Public and Government Law at Victoria University of Wellington, informed us that Covid-19 regulations in New Zealand were generally clear enough that members of the public could read them with relative ease. He ascribed this clarity to a tradition in New Zealand in which legislative drafting is often focussed on standards and principles rather than very prescriptive minutia. This meant that the country's Covid-19 legislation expressed high-level structural principles and generalised standards, and did not set out a great deal of operational detail (for example, essential personal movement was permitted in outdoor places that were 'readily accessible' from someone's home). Regulations also adopted language which people could understand – such as making reference to 'shared bubble arrangements' – and used examples, tables, and tick boxes.
265. We asked Dr Knight whether rule of law issues could in fact stem from regulations being drafted at such a level of abstraction. A large amount of discretion appears to be granted to the New Zealand police to enforce high-level principles and generalised standards, and government ministers seem to be able to shape the detail of restrictions via explanatory guidance. Dr Knight took the view that there was minimal negative effect on the rule of law, as government messaging generally explained which restrictions were legally obligatory and which were advisory (after the government was criticised by the courts for failing to distinguish advisory-only messages in the early days of the pandemic), and there was a notable lack of enforcement and criminalisation in New Zealand. Dr Knight accepted that the New Zealand style of drafting is not necessarily transferable to countries where a greater emphasis is placed on enforcement of public health restrictions through criminalisation.
266. We do not recommend that the UK adopts the New Zealand approach to drafting. There are, however, important lessons to be learned about the value of simplifying emergency public health legislation. The House of Lords Secondary Legislation Scrutiny Committee gave us an example of how the UK's coronavirus legislation could have been simplified. After reading every coronavirus statutory instrument made in relation to England, the Committee concluded that "the content of each of the local lockdown instruments rapidly became too detailed, leading to frequent amendments as it was deemed safe to reopen gyms in one town, but gyms and dance studios had to be closed in another". The Committee considered that the "simplified Tiered approach adopted later in the pandemic where the restrictions were set in bands at national level and many towns can be switched between bands using a single instrument, provided a much more manageable legislative solution and was also easier to communicate to the public".²⁹² While we heard some criticism of the tiered approach adopted in England during parts of the Covid-19 pandemic,²⁹³ we see the force in the Secondary Legislation Scrutiny Committee's suggestion that, in principle, using standardised sets of restrictions for different levels of public health risk could help avoid government law-making becoming overly complicated.

²⁹² Written evidence from the Secondary Legislation Scrutiny Committee ([Appendix 14](#))

²⁹³ For instance, Baroness Thornton informed us that there were occasions where Labour councils and MPs were first informed that their local authority was going to be moved into a different Tier a day before – or sometimes on the same day – that restrictions were introduced.

Recommendation 18: Emergency public health laws should be kept as simple as possible. In principle, emergency regulations could be simplified by using standardised sets of restrictions for different levels of public health risk.

Reducing the frequency of changes to the law

267. The sheer number of regulations that were made in all four nations during the Covid-19 pandemic is startling. In January 2021, one of our commissioners calculated that the law governing lockdown in England had changed 64 times, with new regulations passing into law on average every four and a half days.²⁹⁴ Many coronavirus regulations made amendments to previous regulations. In just over three months at the start of the pandemic between 28th March and 15th July 2020, the regulations implementing lockdown restrictions were amended 11 times in Northern Ireland,²⁹⁵ eight times in Scotland,²⁹⁶ and seven times in Wales.²⁹⁷
268. We received much evidence of the legal uncertainty caused by regulations being updated and amended so frequently. The Secondary Legislation Scrutiny Committee observed that “the speed and volume of legislation meant that it was not always clear which regulations had been superseded or revoked or had expired.”²⁹⁸ This naturally caused problems for parliamentarians trying to scrutinise government policy and law-making, and confused those tasked with enforcement. Research published by the Police Foundation in January 2022 found that 73% of police superintendents in England and Wales reported challenges in keeping pace with the changes to policies and regulations.²⁹⁹ In Scotland, the Police Federation felt that anyone attempting to “understand the law in effect at any moment in time faced an incoherent maze of legislative revocations and additions to navigate.”³⁰⁰ In addition, members of the public cited confusion and “alert fatigue” as a reason for non-compliance with restrictions, with participants in one research study describing feeling “lost” and reporting that it was “impossible to keep up with the rules.”³⁰¹
269. Matt Hancock MP, who led the development of much of England’s coronavirus policy as Secretary of State for Health, suggested to us that a government presiding over a future public health emergency should aim not to “change the rules as often”. Similar comments were made by others who provided us with written or oral evidence. Liam Laurence Smyth CB, Clerk of Legislation in the House of Commons who submitted evidence in a personal capacity, considered that there was “too much hasty and panicky secondary legislation” and governments should “make less law” during future public health emergencies.³⁰² Peter Neyroud, formerly Chief Constable of Thames Valley Police and now Associate Professor in Evidence-based Policing at the University of Cambridge, informed us that it is essential to have only a

²⁹⁴ Rajeev Syal, ‘English Covid rules have changed 64 times since March, says barrister’ *The Guardian* (12 January 2021) <<https://www.theguardian.com/world/2021/jan/12/england-covid-lockdown-rules-have-changed-64-times-says-barrister>>, and see the discussion of this period in Adam Wagner, *Emergency State* (n 170) pages 124-5

²⁹⁵ [Health Protection \(Coronavirus, Restrictions\) \(Amendment No. 11\) Regulations \(Northern Ireland\) 2020](#)

²⁹⁶ [Health Protection \(Coronavirus\) \(Restrictions\) \(Scotland\) Amendment \(No. 8\) Regulations 2020](#)

²⁹⁷ [Health Protection \(Coronavirus Restrictions\) \(Wales\) \(Amendment\) \(No. 7\) Regulations 2020](#)

²⁹⁸ Written evidence from the Secondary Legislation Scrutiny Committee ([Appendix 14](#))

²⁹⁹ Elisabeth Aitkenhead, Jon Clements, Jessica Lumley, Rick Muir, Harvey Redgrave, and Michael Skidmore, *Policing the Pandemic* (The Police Foundation, January 2022), page 49

³⁰⁰ Written evidence from the Scottish Police Federation ([Appendix 13](#))

³⁰¹ Simon Williams et al, ‘Public perceptions of non-adherence’ (n 287), pages 6-7

³⁰² Written evidence from Liam Laurence Smyth CB ([Appendix 8](#))

small number of regulations that are tied to the evidence in order to enhance police officers' understanding of the law. We recognise that a public health emergency is likely to necessitate changes to the law in order to respond to developments in the scientific evidence or the nature of the public health threat. Almost all of the international experts we questioned on this issue noted that there was legal uncertainty in their country caused by coronavirus laws changing frequently, which points to some level of inevitability. Nonetheless, policy makers should be conscious of the potential negative impacts of a government producing large quantities of laws that change frequently in the midst of a public health emergency. Governments should have regard to these negative impacts when deciding how best to respond to a public health threat, and whether to change legal measures already in place.

270. Moreover, it is important to note that a number of the regulations that amended earlier coronavirus laws were made not because the health situation had changed, but because errors had been made in the earlier laws and needed to be corrected.³⁰³ Lord Bethell emphasised that “bundles of statutory instruments” were brought in addressing mistakes in other statutory instruments – particularly around lockdown. Some drafting errors were significant. For example, in Northern Ireland, a drafting error meant that a prohibition on outdoor gatherings of more than six people was not underpinned by criminal sanction when it should have been. This gap in enforcement powers lasted from 19th May 2020 until the error was noticed on 5th June 2020. Until 5th June, the police were under the mistaken impression that they could sanction people for failing to comply with the prohibition on outdoor gatherings, although it appears that no fixed penalty notices were wrongly issued as a result. The drafting error was corrected – and the police granted enforcement powers in relation to outdoor gatherings – the day before a ‘Black Lives Matter’ protest was due to take place in Belfast.³⁰⁴ This caused some to infer that the Police Service of Northern Ireland had sought the amendment to the regulations to allow the police to take enforcement action at the protest, although after investigating the issue the Police Ombudsman for Northern Ireland concluded that this was not the case.³⁰⁵
271. Given the speed at which legislative drafters were required to write regulations, it is understandable that mistakes were made. We recognise the immense pressure that government lawyers were placed under, and that some level of human error will be unavoidable. We echo comments made by Dr Ronan Cormacain, who highlighted in his written evidence the “dedication, professionalism and commitment of the civil servants who prepared and drafted regulations”.³⁰⁶ Nonetheless, there are ways to try and reduce the number of drafting mistakes and inconsistencies made in future public health emergencies.
272. We heard evidence that many drafting mistakes were caused by last minute policy changes. In written evidence, Sir Jonathan Jones, who was Head of the UK Government Legal Department during the early stages of Covid-19 and spoke with us in a personal capacity, explained that the last-minute nature of policy changes during the Covid-19 pandemic affected the accuracy of the legislation implementing those policies. Discussing the situation in England, Sir Jonathan noted that “in some cases it was not clear – even to the lawyers drafting the legislation – what controls were to apply until the Prime Minister personally announced them, sometimes just hours before they were intended to take effect. That inevitably had implications for ... the quality and

³⁰³ For some examples in relation to England, see Hansard Society, ‘Coronavirus Statutory Instruments Dashboard, 2020-2022’ (June 2022) <<https://www.hansardsociety.org.uk/publications/data/coronavirus-statutory-instruments-dashboard#making-and-addressing-technical-errors-and-omissions>> accessed 1 February 2024

³⁰⁴ Northern Ireland Assembly Committee for Health, *Health Protection* (n 258)

³⁰⁵ The Police Ombudsman for Northern Ireland, *An Investigation into Police Policy and Practice of Protests in Northern Ireland* (22 December 2020) Paragraph 9.12-9.13

³⁰⁶ Written evidence from Dr Ronan Cormacain ([Appendix 2](#))

timeliness of the resultant legislation.”³⁰⁷ Sir Jonathan stated that if policy is “not well thought-through, or last-minute changes are made, concessions granted, exemptions inserted, this will tend to produce less coherent, more complex legislation, with the risk of errors, anomalies and unintended consequences”. As a consequence, the legislation may “need to be amended quickly, adding to the risk of confusion or disruption”.³⁰⁸

273. We agree with Sir Jonathan’s comments that:

*“policy should as far as possible be developed in a coherent way, reflecting expert scientific, health and other policy advice and the available evidence. There may be a need for the most difficult and sensitive decisions, balancing (for example) the respective impacts on public health, personal freedoms and the economy; on different sectors, societal groups, or parts of the United Kingdom; or long-term and short-term effects. That in turn argues for as much consultation as time and circumstances permit with expert bodies, different parts of government, Parliament, and the devolved administration”.*³⁰⁹

274. In addition, the UK Parliament’s Secondary Legislation Scrutiny Committee suggested to us that “the checking process for both the content and legal drafting of emergency Statutory Instruments might benefit from review with the aim of finding a more effective and efficient method when dealing with legislation at speed”.³¹⁰ We endorse such a review taking place within the legal teams of the four UK administrations, if this has not already occurred, in order to help minimise drafting errors in future public health emergencies.

275. We also hope that the revised legislation scheme we have proposed in Chapter Three will, if implemented, reduce drafting errors by ensuring that the made affirmative procedure is only used to implement restrictions in cases of genuine urgency, and that emergency public health regulations are more often made at a slower pace using the draft affirmative procedure. This latter procedure gives the legislature and others an opportunity to review regulations before they become law, and draw the government’s attention to any anomalies, errors in drafting, or unintended consequences that should be resolved. More frequent use of the draft affirmative procedure may also encourage ministers to ensure that policy changes are well thought-through and communicated to drafting lawyers with as much time as circumstances permit, so that regulations can pass more quickly and smoothly through the stages of parliamentary approval.

Recommendation 19: Legal certainty would be improved in future public health emergencies if less secondary legislation was made. Policy makers should be conscious of the potential negative impacts of producing large quantities of regulations that change very frequently, and should have regard to these impacts when deciding whether to change legal measures that are already in place. Last minute policy changes should be avoided as far as possible.

³⁰⁷ Written evidence from Sir Jonathan Jones ([Appendix 6](#))

³⁰⁸ Ibid.

³⁰⁹ Ibid.

³¹⁰ Written evidence from the Secondary Legislation Scrutiny Committee ([Appendix 14](#))

Recommendation 20: The legal teams of the four UK administrations should consider whether the checking process for both the content and legal drafting of emergency regulations would benefit from review with the aim of finding a more effective and efficient method when dealing with legislation at speed.

Consolidation of regulations

276. When coronavirus regulations were changed by government, these changes were often not implemented by making a new, consolidated set of regulations, but rather by using amending regulations to adjust the previous legislation in a manner that made it hard to read even for legal experts. This led to complex and ever-expanding laws with multiple modifications accumulating over time. To give two examples: in Wales, the fifth and final set of regulations implementing lockdown were amended 26 times, while in Scotland the equivalent regulations were amended 32 times.³¹¹ Liam Laurence Smyth CB, Clerk of Legislation in the House of Commons who submitted evidence in a personal capacity, explained in written evidence that the “style of drafting successive regulations as modifications of earlier regulations meant the state of the law was a palimpsest that any Member of Parliament, let alone a member of the public, would struggle to comprehend”.³¹² One particularly striking example of the legal confusion this caused is that the Public Prosecution Service in Northern Ireland decided not to prosecute attendees at a large funeral for Bobby Storey, a senior republican figure, for alleged breaches of coronavirus regulations which restricted gatherings. The Public Prosecution Service explained that this decision was made partly because “it was difficult to ascertain the specific provisions in force at the relevant time” “given the large number of amendments [to the lockdown regulations]”.³¹³
277. In addition, one of our commissioners, Tom Hickman KC, has noted that the layering of amendments created uncertainty as to what the law would be if any amending legislation was subsequently rejected by the legislature. It was not clear whether the previous, un-amended version of the legislation would spring back into life, or if the provisions that had been replaced by the rejected amendments would not be revived. The latter scenario would mean that some statutory instruments would be left with blank spaces in the middle of important provisions.³¹⁴ Hickman concluded that “since there is clearly no prospect of Parliament rejecting regulations where the consequences of it doing so are unforeseeable and may cause administrative and legal chaos, this contributed to the reasons why parliamentary accountability in this period was more apparent than real”.³¹⁵
278. Even if an emergency necessitates the law being amended frequently, legal clarity can be improved by regular consolidation. We recommend that, if a public health emergency lasts longer than six months, then legislation should be thoroughly consolidated at least in the sixth month and every three months thereafter. By this we mean that the various laws implementing public health interventions should be reviewed and, if necessary, combined, redrafted and re-

³¹¹ [Health Protection \(Coronavirus Restrictions\) \(No. 5\) \(Wales\) \(Amendment\) \(No. 26\)](#) and [Health Protection \(Coronavirus\) \(Restrictions and Requirements\) \(Local Levels\) \(Scotland\) Amendment \(No. 32\) Regulations 2021](#)

³¹² Written evidence from Laurence Smyth CB ([Appendix 8](#))

³¹³ Public Prosecution Service for Northern Ireland, *Public Statement Relating to Decisions not to Prosecute 24 individuals reported for Breaches of the Coronavirus Regulations in Connection with Attendance at the Funeral of Bobby Storey on 30 June 2020* (30th March 2021) paragraph 22(iii), available at <https://www.ppsni.gov.uk/files/ppsni/publications/PPS%20Public%20Statement%20on%20Covid%20funeral%2030%20March%202021_0.pdf> accessed 1 February 2024

³¹⁴ Tom Hickman, ‘Abracadabra law-making’ (n 154), page 47

³¹⁵ *Ibid.*

enacted in a manner that prioritises clarity and coherence. We note that this did happen at some points during the pandemic, but not with sufficient consistency and regularity across the four nations. For example, in written evidence, Dr Ronan Cormacain informed us that Northern Ireland produced some consolidations of its international travel regulations, which was “at least an attempt to simplify” whereas the English regulations “worked by a process of accretion, layering more and more new rules on top of the existing structure”.³¹⁶ In addition, a Welsh government official informed us that the Welsh regulations governing the main public health restrictions, such as “stay at home” requirements, were consolidated five times.

Recommendation 21: If a public health emergency lasts longer than six months, then legislation should be thoroughly consolidated at least in the sixth month and every three months thereafter. By this we mean that the various laws implementing public health interventions should be reviewed and, if necessary, combined and redrafted in a manner that prioritises clarity and coherence.

Making it easier to understand the changes made by regulations

Using clear titles

279. During the Covid-19 pandemic, it was not always clear from the title of regulations what legal changes were being made. For example, in the summer of 2021 the UK government introduced a compulsory vaccination scheme for care home workers. The title of the regulations introducing this measure was “The Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) Regulations” – which gave no indication that the regulations related to care home workers or vaccinations. In written evidence, the House of Lords Secondary Legislation Scrutiny Committee also discussed how “many [statutory instruments] related to the pandemic did not include the word “Coronavirus” in the title” leading the Committee to question “how pandemic legislation can be properly evaluated if about a fifth of it cannot be identified”.³¹⁷

280. When a large volume of new laws are introduced to tackle a public health emergency, it is vital that it is as easy as possible for legislatures and members of the public to identify the substance of each piece of legislation. This will enable legislatures to target their scrutiny towards the most consequential regulations, and enhance understanding of the legal changes that are being made. In light of this, we consider that the titles of statutory instruments should make clear their content in at least broad brush terms. We also endorse recommendations made in written evidence by the Secondary Legislation Scrutiny Committee. The Committee considered that all legislation relevant to a future pandemic or other emergency “should use the designated key word for example “coronavirus” or “foot and mouth disease” consistently in every title and the Cabinet Office Parliamentary Business and Legislation Committee should enforce that convention”. The Secondary Legislation Scrutiny Committee also advised that “the government might wish to identify in advance [of a future public health emergency] how legislation can be sensibly titled on a regional or local basis or where a tiered approach would be better” and that “[a]ll drafting lawyers should have access to that information to ensure a uniform approach”.³¹⁸

³¹⁶ Written evidence from Dr Ronan Cormacain ([Appendix 2](#))

³¹⁷ Written evidence from the Secondary Legislation Scrutiny Committee ([Appendix 14](#))

³¹⁸ *Ibid.*

Recommendation 22: The titles of emergency public health regulations should make clear their content in at least broad-brush terms. All legislation relevant to the emergency should use the designated keyword, for example “coronavirus” or “foot and mouth disease”, consistently in every title. Governments should also identify in advance how emergency public health regulations can be sensibly titled on a regional, local or tiered basis. All drafting lawyers should have access to that information to ensure a uniform approach.

Producing high-quality supporting material

281. When regulations are introduced which amend a previous set of regulations, it is often very difficult to make sense of the changes that have been made without engaging in a complex process of overlaying the new provisions on the old. A typical example of amending regulations, taken from those which implemented hotel quarantine in England, is as follows:

(f) “In regulation 4 –

...

(g) in paragraph (5), at the beginning insert “Except where P falls within paragraph (1) (d)”; in paragraph (7)(a) for “last departed from or transited through a non-exempt country or territory” (5) substitute “arrived in England or, if later, the end of any period that applies by virtue of paragraph 2 or 3 of Schedule 2C”;

(h) omit paragraph (7A);

(i) after paragraph (7A) insert –

“(7B) Paragraphs (8) to (13A) do not apply where P falls within paragraph (1)(d) (and thus Schedule B1A applies).”³¹⁹

282. Amending regulations that appear to make small changes, such as changing “or” into “and”, or deleting a clause that narrows the application of a restriction, could in fact have very substantial effects that are difficult to identify. This creates problems in deciphering the legal effect of the regulations, even for experienced lawyers, and impedes democratic oversight of the regulation-making process.

283. It is our view that, when regulations are introduced which amend a previous set of regulations, legal clarity would be greatly improved if the government produced a document which shows the original set of regulations and highlights in a reader-friendly fashion the changes made by the amending regulations (in technical terms, a “Keeling Schedule”). This approach was recommended by the House of Lords Constitution Committee during the Covid-19 pandemic³²⁰ and was also advocated in their evidence to us by Sir Jonathan Jones, the Law Society of Scotland, and David Melding.³²¹

³¹⁹ [Health Protection \(Coronavirus, International Travel\) \(England\) \(Amendment\) \(No. 7\) Regulations 2021 \(SI 2021/150\)](#)

³²⁰ Constitution Committee, *COVID-19 and the use and scrutiny of emergency powers* (n 82), paragraph 188

³²¹ Written evidence from the Law Society of Scotland ([Appendix 7](#))

284. There were some examples of good practice in this area during the Covid-19 pandemic. In particular, the Welsh government published on their website in both Welsh and English up to date, consolidated versions of the regulations which imposed public health restrictions. The consolidated regulations were published in a clean version and a separate version which clearly set out the amendments that had been made. In addition, the Office of the Legislative Counsel in Wales informed us that they have been considering “a fairly radical change to how we make any regulations that change existing regulations - instead of having amending regulations in the traditional way, in a digital age we think we could remake the regulations in their entirety but with tracking showing parliamentarians how they have been changed.” We consider that such an approach could greatly assist legal certainty in a future public health emergency.
285. High quality explanatory memoranda are also crucial, and their importance was emphasised by a number of witnesses. Explanatory memoranda are documents that clearly explain, in non-technical terms, the legal changes that are made by a piece of legislation. They are therefore very helpful in enabling individuals without technical legal training to understand regulations. During the Covid-19 pandemic, the Select Committee on the Constitution advised that, for every set of amending regulations, the government should set out in the explanatory memorandum: (i) the regulations that are being amended; (ii) the substance of the amendments being made; and (iii) the reason for those amendments.³²² We received similar feedback from Daniel Greenberg CB, who highlighted the explanatory memoranda for statutory instruments published by the National Archives as examples of “impressive explanations for non-professional readers of the effect of a legislative change”. We acknowledge that it may not be possible to produce high quality explanatory memoranda at the start of an emergency or for extremely urgent measures, but governments should recognise them as a priority for respecting the rule of law.

Recommendation 23: When emergency public health regulations are introduced which amend an earlier set of regulations, a document should be produced which shows the original set of regulations and highlights in a reader-friendly fashion the changes made by the amending regulations, similar to a “track changes” version of a Microsoft Word document.

Recommendation 24: While it may not be possible to produce high quality explanatory memoranda at the start of an emergency, governments should ensure this type of supporting material is produced as soon as possible.

³²² Constitution Committee, *COVID-19 and the use and scrutiny of emergency powers* (n 82), paragraph 187

The communication of law, guidance and public health advice

286. During the Covid-19 pandemic, a vital role was played by government communication in press conferences, via the media, and on government websites. In his oral evidence, Sir Bernard Jenkin expressed his view that what was communicated about the meaning of the law and government guidance was far more important in terms of public understanding than the technical detail of the law. We now turn to consider how far the communication of law, guidance, and public health advice can be improved in future public health emergencies

Timely communication of the law

287. Despite the advantages that digital communication provided to governments, during the Covid-19 pandemic the law was not always published or otherwise communicated in a timely manner to the public and/or the professional bodies of frontline workers. In written evidence submitted to us in a personal capacity, Dr Ronan Cormacain, who drafted a number of coronavirus regulations for the Northern Ireland Department of Health as a consultant legislative drafter, noted that laws were sometimes published at 3am and came into force at 4am which “does not give anyone sufficient time to know what the law is before they are liable under it”.³²³ The impact of this on the police in particular was outlined by His Majesty’s Inspectorate of Constabulary and Fire & Rescue Services (‘HMICFRS’) in a report on the policing of the pandemic in England and Wales. HMICFRS explained that government communication about restrictions and regulations to the police was “often at short notice and subject to change” which “affected the police service’s ability to produce guidance and to brief staff”.³²⁴

288. We recognise that in some cases regulations will need to be made and come into force very quickly. Dr Ronan Cormacain stated that “from personal experience, sometimes the law isn’t drafted until 2am, then signed, then uploaded and then [comes] into force. I am not sure how to resolve the absolute need to have something in force within an extremely short deadline, and having accessible legislation.”³²⁵ However, as a general rule, we agree with Sir Jonathan Jones that “[i]t is not acceptable for publication to occur a matter of an hour or so before changes are to take effect” and “ministers and officials need to factor in time for the publication process to take place well before the legislation comes into force”.³²⁶ Unless there is a particularly acute and urgent public health reason for proceeding without any delay, we recommend that regulations should be published at least two days before they come into force. The Scottish Parliament’s Delegated Powers and Law Reform Committee gave similar advice to the Scottish government in 2022, recommending that regulations which had to be enacted on an urgent basis should be “published as quickly as possible” and “prior to them coming into force” “so that all those impacted might fully understand the detailed changes being made to the law”.³²⁷

³²³ Written evidence from Dr Ronan Cormacain ([Appendix 2](#))

³²⁴ HMICFRS, Policing in the pandemic *The police response to the coronavirus pandemic during 2020* (April 2021), page 2

³²⁵ Written evidence from Dr Ronan Cormacain ([Appendix 2](#))

³²⁶ Written evidence from Sir Jonathan Jones ([Appendix 6](#))

³²⁷ Delegated Powers and Law Reform Committee, *Inquiry into the use of the made affirmative procedure* (n 106), paragraphs 59 and 75

289. In addition, in order to ensure that the criminal law is sufficiently foreseeable, where laws come into force at the same time, or within three days, of their being published, then this should be taken into account in any enforcement action considered. For example, police guidance could state that enforcement action would not always be in the public interest, i.e. if the law being applied had materially changed within the past 24 hours and it was likely that the individual against whom enforcement action was being considered did not know of or fully understand the law change.

Recommendation 25: Unless there is a particularly acute and urgent public health reason for proceeding without any delay, regulations should be published at least two days before they come into force. In addition, where laws come into force at the same time, or within three days of their being published, then this should be taken into account in any enforcement action considered.

Linking restrictions with their underlying rationale

290. A number of individuals who provided us with oral and written evidence emphasised the need for governments clearly to explain the rationale behind legal restrictions, in order to make it easier for people to understand the actions they are being asked to take. Discussing the UK government's coronavirus guidance, Professor Peter Neyroud found that each piece of guidance illustrated the temptation to add restrictions without tying them to the medical evidence. Professor Neyroud stated that this should be avoided at all costs, and governments should instead tie evidence to risk in as tight a way as possible which would make the process a great deal easier for police officers on the ground to explain. Professor Susan McVie³²⁸ concurred, noting that government must evidence why the law was created, what its purpose is, how it diminishes risk and how it protects lives. This recommendation plainly makes sense, and we endorse it in relation to government guidance and other public messaging. Moreover, we received evidence based on a large-scale study that found linking restrictions with their underlying rationale can also help engender higher levels of compliance.³²⁹

Recommendation 26: Government guidance and other public messaging should clearly explain the rationale behind public health restrictions to make it easier for people to understand the actions they are being asked to take.

³²⁸ Chair of Quantitative Criminology at Edinburgh Law School.

³²⁹ Written evidence from Professor Joe Tomlinson (Professor of Public Law, University of York), Professor Simon Halliday (Professor of Socio-Legal Studies, University of York) and Dr Jed Meers (Senior Lecturer in Law, University of York) ([Appendix 16](#)). This is consistent with the results of several studies. For example, the COVID-19 Social Study, a large panel study of the psychological and social experiences of adults in the UK, found that participants "often did not see the logical basis" underpinning legal restrictions and the "lack of a clear rationale for certain rules was cited as reducing motivation to comply" with restrictions - Liam Wright et al., 'Facilitators and barriers to compliance' (n 287), pages 18-19

Better use of communication tools

291. We were informed about some positive examples of government effectively utilising different communication tools during the Covid-19 pandemic. For instance, David Melding praised the Welsh government’s website for clearly communicating the law. When we spoke with senior officials in the Welsh government in a personal capacity, they informed us that their legal team and others had worked hard to make the Welsh government website as informative as possible. They drew our attention in particular to a frequently updated FAQ document that became the most read document on the gov.wales website.
292. However, other evidence we received was more critical of the tools governments used to communicate the law. The Scottish Police Federation found that the lack of a “simple and engaging public health app or website” was “unforgivable”, expressing its view that people were often on a “virtual hamster wheel” having to click through links to find information.³³⁰ Similarly, in relation to the UK government, the Secondary Legislation Scrutiny Committee observed that the publicly available resources on new legislation were “sparse”, with “the main organ of government communication” being the guidance on the gov.uk webpages. The Committee found this “lack of information limited the public’s ability to respond to or influence the legislation being made”, and suggested that [governments] should “provide one central dashboard, updated daily, that sets out in a searchable format (including by geographical area) all of the temporary legislation, guidance and public health advice that is currently in force and its date of sunseting”.³³¹ We think this is a sensible suggestion that would also aid parliamentary scrutiny of regulations so long as any regulations that have been amended appear in consolidated form, as discussed above at paragraph 283. We also recommend that an App containing this information be available for mobile devices.
293. As part of our international comparators work, we considered how governments in other jurisdictions communicated coronavirus laws. We noted that traffic light systems were used in a number of countries to convey which laws applied at any point in time. Under this system, different traffic light colours were used to illustrate different legal restrictions and requirements (i.e. if the government announced that the country was in the “red” category, then this meant that gatherings and travel were restricted). When we sought feedback on the merits of this approach, Dr Fu-Meng Khaw informed us that it was very similar to what happened in Wales where there were five alerts in the coronavirus response plan. Dr Khaw explained that the Welsh government took the approach of reviewing evidence every three weeks and deciding an alert level for the nation, which determined what measures would be put in place. He considered that the alert system worked well in Wales, as it was a regular, planned event and people would pay attention to it. Dr Khaw began working in Wales a year into the pandemic, having previously been based in England, and found that having alert levels seemed to enhance public understanding of the restrictions in Wales. We also note that there was an attempt to introduce alert levels in England once the tiered system was adopted in the winter of 2020.³³² We therefore recommend that governments should explore building a traffic light, or alert level, system of communication into their contingency planning for future public health emergencies.

³³⁰ Written evidence from the Scottish Police Federation ([Appendix 13](#))

³³¹ Written evidence from the Secondary Legislation Scrutiny Committee ([Appendix 14](#))

³³² See the alert level posters at <<https://www.gov.uk/government/publications/tier-posters-medium-high-and-very-high>> accessed 1 February 2024

Recommendation 27: Governments should provide one central dashboard, updated daily, that sets out in a searchable format (including by geographical area) all the guidance, public health advice and legislation that is currently in force and its date of sunset. Any legislation that has been subject to amendments should appear on this dashboard in consolidated form. An App containing this information should be available for mobile devices.

Recommendation 28: Governments should explore building a traffic light, or alert level, system of communication into their contingency planning for future public health emergencies.

Clarity in government guidance

294. We received a lot of evidence discussing legal uncertainty caused by government guidance and ministerial statements made during the Covid-19 pandemic. There are two different types of government guidance that it is important to distinguish between: guidance which seeks to explain the law, and guidance which gives public health advice and is not legally obligatory. One of the recurring problems identified by witnesses was government statements failing to clearly distinguish what was the law and what was public health advice. In oral evidence, Daniel Greenberg CB informed us that he felt this was the biggest rule of law problem during Covid-19.
295. We were informed that this problem existed throughout all four UK nations. In written evidence, the Scottish Police Federation stated that government guidance “in almost all instances” went beyond the law and was “deliberately designed to imply the reach of the law, rather than state it”.³³³ Similar observations were made by academic commentators in relation to Northern Ireland.³³⁴ In addition, David Melding informed us that confusion was caused by Welsh government guidance containing public health advice that was more restrictive than the law, without making this clear. Mr Melding’s comments chime with findings made by the Welsh Parliament’s Legislation, Justice and Constitution Committee, which reported instances where guidance or messaging from the Welsh government did not reflect the law entirely accurately, and the distinction between law and public health advice was not clear.³³⁵ When we spoke with senior officials in the Welsh government, who met with us in a personal capacity, they noted that Wales had some incidents early on where some of the guidance “possibly went a little too far”, but we were told that once legislative counsel became aware of that, they carefully read all of the guidance with this issue in mind, and made changes where necessary to ensure it did not happen again.

³³³ Written evidence from the Scottish Police Federation ([Appendix 13](#))

³³⁴ Katharina Ó Cathaoir and Christie MacColl, ‘COVID-19 restrictions in Ireland and Northern Ireland: a comparison of the legal framing of reasonableness’ (2022) 73(2) Northern Ireland Legal Quarterly, pages 241-4

³³⁵ Welsh Parliament Legislation, Justice and Constitution Committee, *Fifth Senedd Legacy Report* (March 2021), paragraph 13

296. The clarity of government messaging has been analysed in depth in relation to England. Parliamentary committees and commentators, including one of our commissioners, found that legal uncertainty in England was caused by:

- Guidance giving public health advice that was usually stricter than restrictions imposed by legal regulations;³³⁶
- Government publications and statements not distinguishing between public health advice and legal requirements;³³⁷
- Rules being identified by the government as having legal effect without any law having been made;³³⁸
- Guidance being used to gloss legal terms and fill in gaps in the law as if it were the law itself;³³⁹
- Guidance containing the government’s interpretations of the law or its view as to how the law should be applied;³⁴⁰ and
- Guidance not identifying the laws underpinning it.³⁴¹

297. These issues caused confusion amongst members of the public as to what the law actually was. For example, survey data collected in June 2020 showed that 82% of the UK public thought that the law prohibited them from coming within two metres of anyone who was not a member of their household.³⁴² However, this restriction was never a legal requirement in any of the four UK nations, it was only ever public health advice.

298. There are a number of rule of law problems caused by government guidance not making clear what is the law and what is public health advice. As one of our commissioners has noted, the UK government blurred the line between the executive and the legislature by presenting public health advice or government interpretations of the law as though they had legal force.³⁴³ We heard in oral evidence that this caused consternation in the House of Lords. Lord Blencathra explained that Peers were “very annoyed” by ministers making comments that the Lords felt did not reflect the law and was not what they voted for. Government guidance was also used to interpret the criminal law – which is properly the role of the courts and prosecuting authorities, not ministers.³⁴⁴

299. Moreover, the lack of clarity in government messaging caused problems in enforcement. In its written evidence, the Police Foundation stated that “[t]he distinction between legal obligation and guidance was at times ambiguous and presented a challenge both for the public and the police officers”.³⁴⁵ Public health advice is not enforceable, and the police should not have been sanctioning people for failing to comply with government guidance that had no legal underpinning. Nonetheless, the Police Foundation informed us that “differences between

³³⁶ Joint Committee on Human Rights, *The government’s response to COVID-19: human rights implications* (n 82) paragraph 44

³³⁷ Constitution Committee, *COVID-19 and the use and scrutiny of emergency powers* (n 82), paragraph 128

³³⁸ *Ibid.*

³³⁹ Joint Committee on Statutory Instruments, *Rule of Law Themes*, (n 82) paragraphs 42-44; Tom Hickman KC, ‘The Use and Misuse of Guidance during the UK’s Coronavirus Lockdown’ (4 September 2020) SSRN, pages 19-24 available at <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3686857> accessed 1 February 2024

³⁴⁰ Tom Hickman KC, ‘The Use and Misuse of Guidance’ (n 339), page 15

³⁴¹ *Ibid.*, page 18

³⁴² Simon Halliday, Naomi Finch, Jed Meers, Joe Tomlinson and Mark Wilberforce, ‘Why the UK Complied with COVID-19 Lockdown Law’ (2022) 33(3) *King’s Law Journal*, page 405

³⁴³ Tom Hickman KC, ‘The Use and Misuse of Guidance’ (n 339), pages 25-26

³⁴⁴ *Ibid.*

³⁴⁵ Written evidence from the Police Foundation ([Appendix 12](#))

the lists of “reasonable excuses” for leaving home provided for in law and guidance” led to concern among police forces that “they had sometimes tried to enforce advice rather than the letter of the law”.³⁴⁶ This chimes with findings by HMICFRS that “to many, the distinction between law and guidance remained uncertain” which caused “some well-publicised mistakes” in police enforcement.³⁴⁷ HMICFRS emphasised that it “is essential that the police are seen to be enforcing the criminal law, and not appearing to act as the coercive agents of ministers”... “nothing must be allowed to be done which leads the public to believe ministers can criminalise actions by edict then enforced by the police”.³⁴⁸

300. A failure to distinguish between law and public health advice can also have a negative impact on levels of compliance. We received written evidence from Professor Joe Tomlinson, Professor Simon Halliday and Dr Jed Meers of the University of York, who conducted a large-scale study of how the public “perceived and responded to Covid-19 ‘lockdown’ law and guidance”.³⁴⁹ Their study found that the “law/guidance distinction mattered to compliance” as people were “more likely to comply with a lockdown rule if they thought it had the status of law and was not just guidance”.³⁵⁰ One paper that Professor Tomlinson, Professor Halliday and Dr Meers published with two colleagues found that these differing levels of compliance occurred partly because “people confer legitimacy on law and legal authority”.³⁵¹ While this finding may tempt future governments to portray public health advice as if it had force of law, in order to try and engender compliance, the researchers warn that “guidance which itself misrepresents the law or is communicated in a way that seems to misrepresent the status of certain rules risks having long-term negative effects on the legitimacy of the law and so of legal compliance”.³⁵²

301. We make four recommendations to address the issues identified above. First, governments should consider as an integral part of policy planning which public health interventions should be given a legal basis, which should only take the form of public health advice, and how that distinction can best be communicated. We agree with Professor Tomlinson, Professor Halliday and Dr Meers, who, in their written evidence, recommended these matters “ought to be seen as an essential component of the design and implementation of the policy intervention.”³⁵³

302. Second, we endorse the following five suggestions made by the House of Lords Constitution Committee in its report on Covid-19 and the scrutiny of emergency powers:

(a) Guidance should clearly distinguish information about the law from public health advice. It should not suggest that instructions are based on law when they are not. We note that guidance produced in other contexts (e.g. the Highway Code) clearly distinguishes between parts that are mandatory and those that are not, and could be used as a model.

(b) Where guidance provides information about the law, this should be accurate and complete. Where the law is too complex to be set out in full, guidance should make clear that the account is partial.

³⁴⁶ Ibid.

³⁴⁷ HMICFRS, *Policing in the pandemic* (n 324) page 35

³⁴⁸ Ibid., page 36

³⁴⁹ Written evidence from Professor Joe Tomlinson, Professor Simon Halliday and Dr Jed Meers ([Appendix 16](#))

³⁵⁰ Ibid.

³⁵¹ Naomi Finch, Simon Halliday, Joe Tomlinson, Jed Meers, Mark Wilberforce, ‘Undermining loyalty to legality? An empirical analysis of perceptions of ‘lockdown’ law and guidance during COVID-19’ (2022) *The Modern Law Review* page 1438

³⁵² Ibid.

³⁵³ Written evidence from Professor Joe Tomlinson, Professor Simon Halliday and Dr Jed Meers ([Appendix 16](#))

(c) All relevant legal instruments should be identified wherever legal requirements are referred to in guidance, accompanied by up-to-date hyperlinks to the underlying regulations on legislation.gov.uk.

(d) Guidance should make clear when opinions are being offered about the interpretation of the law, including a clear statement of the source and status of such opinions.

(e) A consistent approach to use of the terms “advice”, “guidance”, “recommendation”, “rules” and “restrictions” should be adopted in all government publications and public statements, in each case making clear whether the term is referring to obligations required by law, or to public health advice.³⁵⁴

303. Third, if the government wishes to issue guidance that is relevant to the interpretation of legislation, or how legislation should be applied by enforcement bodies, then this guidance should ideally have an express statutory basis and in any event be laid before the legislature when made and amended, so that it is presented for democratic scrutiny and the legislature can see what changes have been made. Definitions that affect the scope of application of the law should always be in the legislation itself. This latter point was made in written evidence by the Secondary Legislation Scrutiny Committee.³⁵⁵

304. Fourth, some of the key actors during the Covid-19 pandemic were public health officials and the police, who primarily operate according to guidance produced by their professional bodies. We consider that, where time allows, professional bodies representing frontline workers, such as the police and public health officials, should develop implementation guidance in collaboration with lawyers so as to help ensure this guidance is faithful to the law but also in-line with the professional requirements of these representational bodies. If it is not possible for collaboration to happen in advance of the guidance being produced, then small and nimble working groups should be set up to review the guidance, with representatives from the relevant professional bodies.

Recommendation 29: Governments should consider as an integral part of policy planning which public health interventions should be given a legal basis, which should only take the form of public health advice, and how that distinction can best be communicated.

³⁵⁴ Constitution Committee, *COVID-19 and the use and scrutiny of emergency powers* (n 82), paragraph 166

³⁵⁵ Written evidence from the Secondary Legislation Scrutiny Committee ([Appendix 14](#))

Recommendation 30: We endorse the following five suggestions made by the House of Lords Constitution Committee during the Covid-19 pandemic:

(a) Guidance should clearly distinguish information about the law from public health advice. It should not suggest that instructions are based on law when they are not. We note that guidance produced in other contexts (e.g. the Highway Code) clearly distinguishes between parts that are mandatory and those that are not, and could be used as a model.

(b) Where guidance provides information about the law, this should be accurate and complete. Where the law is too complex to be set out in full, guidance should make clear that the account is partial.

(c) All relevant legal instruments should be identified wherever legal requirements are referred to in guidance, accompanied by up-to-date hyperlinks to the underlying regulations on the relevant government website.

(d) Guidance should make clear when opinions are being offered about the interpretation of the law, including a clear statement of the source and status of such opinions.

(e) A consistent approach to use of the terms “advice”, “guidance”, “recommendation”, “rules” and “restrictions” should be adopted in all government publications and public statements, in each case making clear whether the term is referring to obligations required by law, or to public health advice.

Recommendation 31: If governments issue guidance that is relevant to the interpretation of emergency public health legislation, or how it should be applied by enforcement bodies, such guidance should ideally have an express statutory basis and in any event be laid before the legislature when made and amended. Definitions that affect the scope or application of the law should always be in the legislation itself.

Recommendation 32: Where time allows, professional bodies representing frontline workers, such as the police and public health officials, should develop implementation guidance in collaboration with lawyers. If it is not possible for collaboration to happen in advance of implementation guidance being produced, then small and nimble working groups should be set up to review the guidance, with representatives from the relevant professional bodies.

Legal uncertainty caused by different policy approaches between the four nations

305. At the start of the pandemic, all four UK nations adopted almost identical policies, but divergence grew over time. Divergence is the nature of devolution, and some we spoke to felt that it led to better policy development. Professor Adam Tomkins informed us that different governments wanting to go at different paces was positively healthy for democracy, because it meant that different policy approaches were compared, debated and challenged. David Melding gave similar evidence, explaining that a coordinated four-nations approach can lead to things not getting discussed and challenged as much as they need to be.
306. However, a significant amount of legal confusion resulted from the differing approaches taken by the four administrations. We heard how residents in Scotland and Wales would take their news from UK-wide media, which led to confusion with the public as to what was and was not permitted at any particular time. When it came to enforcement in England and Wales, the Crown Prosecution Service informed us that two of the most common reasons for incorrect charges were “offences under Welsh Regulations charged in England” and “offences under English Regulations charged in Wales”.³⁵⁶
307. Therefore, from a rule of law perspective, we consider that collaboration and consistency between the four nations should be encouraged, unless different approaches are necessitated on grounds of public health. We understand that the UK Covid-19 Inquiry is reviewing intergovernmental working as one of its core strands of work, and so we have not focussed in depth on this topic in our work. However, we recommend that there should be mechanisms for facilitating collaboration not just between ministers from the four nations, but also civil servants and senior public health professionals. There are organisations that provide models for collaboration, such as the Food Standards Agency (which serves three administrations and collaborates with Food Standards Scotland) and the Human Tissue Authority.

Recommendation 33: Collaboration and consistency between the four nations should be encouraged, unless different approaches are necessitated on the grounds of public health. There should be mechanisms for facilitating collaboration not just between ministers from the four nations, but also civil servants and senior public health professionals.

³⁵⁶ Written evidence from the CPS (Appendix 3)



CHAPTER SEVEN:

Enforcement

Introduction

308. Our final Chapter considers the creation and enforcement of criminal offences during a public health emergency. An initial question is whether emergency public health interventions should be backed by criminal sanction at all. A number of witnesses were not convinced that this should be the case. Marie Anderson, the Police Ombudsman for Northern Ireland, was strongly opposed to the criminalisation of people’s behaviour in a public health emergency because of what she perceived to be incidents of disproportionate enforcement of Covid-19 restrictions by the Police Service of Northern Ireland at “Black Lives Matter” protests.
309. We also heard that the use of criminal sanctions may not have had a significant impact on compliance. Two senior members of the UK Health Security Agency urged us to consider the health equity element of public health emergencies. They explained that punitive enforcement is not helpful if people do not have a choice, i.e. if the only way people can have outside space during a lockdown is in a confined area, and if they cannot work without breaking restrictions. They also noted that evidence overwhelmingly indicates that providing assistance and encouragement to aid compliance is more effective than sanctioning non-compliance.
310. A similar point was made by Professor Susan McVie, Chair of Quantitative Criminology at Edinburgh Law School, based on her research into the policing of the pandemic in England, Scotland and Wales. Her view was that support is better than enforcement at achieving compliance. She considered that the vast majority of people who complied with coronavirus restrictions likely did so not because of enforcement but because public health messaging was strong, people wanted to do the right thing, and economic support – including the furlough scheme – provided the necessary assistance for people to feel able to comply. However, Professor McVie also cautioned that it is “almost impossible” to isolate the effectiveness of enforcement from all the other factors that could minimise infection and ensure compliance with restrictions.
311. The complexity of this issue is reflected in the academic literature on criminal enforcement and public compliance with coronavirus restrictions in the UK. Studies of compliance during the first UK wide lockdown indicate that the threat of police enforcement was not in itself a reason why people complied with restrictions. However, the “policing of lockdown mattered” nonetheless because “the prospect of police action had a stigmatising effect, raising the prospect of peer disapproval” and increasing adherence to restrictions.³⁵⁷ In addition, the fact that certain behaviour was made illegal may have strengthened compliance by signalling the importance of the lockdown and creating normative expectations of appropriate behaviour.³⁵⁸ A further study by academics at the University of York, which we discussed in the last Chapter at paragraph 300, indicated that individuals were more likely to comply with legal prohibitions than mere guidance, but that this was due to “commitment to law abidingness” rather than “fear of formal sanction”.³⁵⁹ In addition, enforcement can sometimes be counterproductive. During the Covid-19 pandemic, SAGE’s Policing & Security Sub-Group warned that using coercion to secure compliance could backfire, with excessively draconian enforcement approaches having been shown to undermine public adherence in other public health emergencies.³⁶⁰

³⁵⁷ Simon Halliday et al., ‘Why the UK Complied with COVID-19 Lockdown Law’ (n 342), page 403

³⁵⁸ Jonathan Jackson, Chris Posch, Ben Bradford, Zoe Hobson, Arabella Kyprianides, and Julia Yesberg, ‘The lockdown and social norms: why the UK is complying by consent rather than compulsion’ (LSE Blogs, 27 April 2020), accessible at <<https://blogs.lse.ac.uk/politicsandpolicy/lockdown-social-norms/>> accessed 1 February 2024

³⁵⁹ Naomi Finch et al., ‘Undermining loyalty to legality?’ (n 351), page 1419, at 1437-8

³⁶⁰ SAGE SPI-B Policing & Security Sub-Group, COVID-19: *Assessing the value of an Enforcement based approach to Covid* (21 September 2020) accessible at <https://assets.publishing.service.gov.uk/media/61eab38b8fa8f505893f1dec/SPI-B_PS_Assessing_the_value_of_an_enforcement-based_approach_21_September_2020.pdf> accessed 1 February 2024

312. In light of the above evidence and academic literature, we agree with comments made by Dr Fu-Meng Khaw, National Director of Health Protection and Screening Services and Executive Medical Director at Public Health Wales, who advised that there is no “right or wrong” answer as to whether emergency public health measures should be underpinned by criminal law, but a careful judgement must be made taking into account the threat level, what the public are being asked to do, and what the public sentiment is around compliance and enforcement. We consider this to be a sensible approach, given the complexity of the question. This means that criminal enforcement should not be assumed to be the default position, and the necessity of criminal enforcement should continue to be monitored over the course of an emergency.
313. The rest of this Chapter considers the criminal enforcement of Covid-19 restrictions and makes recommendations where, from a rule of law perspective, enforcement action could be improved in future public health emergencies if restrictions are underpinned by criminal sanctions.

Recommendation 34: In deciding whether emergency public health measures should be underpinned by criminal law, a careful judgement should be made taking into account the threat level, what the public are being asked to do, and what the public sentiment is around compliance and enforcement. The necessity of enforcement and the means by which it is done should continue to be monitored over the course of the emergency response.

The criminal enforcement of Covid-19 restrictions

314. During the Covid-19 pandemic, many public health restrictions were underpinned by criminal sanctions. In the regulations which implemented the first lockdown, enforcement powers were granted to police officers and designated local authority employees in relation to restrictions on businesses (in practice, these employees were Environmental Health and Trading Standards Officers).³⁶¹ The UK Secretary of State, Welsh ministers and Northern Ireland Department of Health also had the power to designate additional persons who could carry out enforcement.³⁶²
315. Enforcement measures included directing and removing a person to their home if they were in breach of restrictions on movement; issuing prohibition notices to businesses that failed to comply with restrictions on their operation; and the power to “take such action as is necessary” to enforce some or all restrictions.³⁶³ It was an offence to contravene the lockdown restrictions without a reasonable excuse; to disobey instructions or prohibitions issued by those enforcing

³⁶¹ [Regulation 8\(12\)](#), Health Protection (Coronavirus, Restrictions) (England) Regulations 2020; [regulation 10\(11\)](#), Health Protection (Coronavirus Restrictions) (Wales) Regulations 2020; [regulation 7\(12\)](#), Health Protection (Coronavirus) (Restrictions) (Scotland) Regulations 2020; [regulation 7\(12\)](#), Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020. In England and Wales enforcement could also be carried out by police community support officers.

³⁶² [Regulation 8\(12\)](#), Health Protection (Coronavirus, Restrictions) (England) Regulations 2020; [regulation 10\(11\)](#), Health Protection (Coronavirus Restrictions) (Wales) Regulations 2020; [regulation 7\(12\)](#), Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020

³⁶³ [Regulation 8\(1\)-\(3\)](#), Health Protection (Coronavirus, Restrictions) (England) Regulations 2020; [regulation 10\(1\)-\(2\)](#), Health Protection (Coronavirus Restrictions) (Wales) Regulations 2020; [regulation 7\(1\)-\(3\)](#) and (10); Health Protection (Coronavirus) (Restrictions) (Scotland) Regulations 2020; [regulation 7\(1\)-\(3\)](#), Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020

the regulations; or to obstruct enforcement.³⁶⁴ Offences were punishable upon conviction by a fine.³⁶⁵ However, instead of arresting and prosecuting suspected offenders, police could instead issue “fixed penalty notices” (“FPNs”) to anyone over the age of 18³⁶⁶ who they reasonably believed had committed an offence.³⁶⁷

FPNs

An FPN is a notice which offers the person to whom it is issued the chance to avoid prosecution for an offence by paying a financial penalty. It is commonly used for low-level motoring and other offences, such as driving without a seatbelt or littering. If an individual accepts the FPN and pays the fine then they will not be prosecuted. If a fixed penalty notice is unpaid within 28 days, then the police can decide to prosecute.

316. During the Covid-19 pandemic, the police in all four nations primarily dealt with individuals who were believed to have breached public health restrictions by issuing them with an FPN, rather than arresting them and charging them with an offence. In evidence to the House of Commons Justice Committee, the then minister for Crime and Policing, Kit Malthouse MP, explained that FPNs were used during the Covid-19 pandemic because they are “a familiar part of the landscape and are proportionate in terms of dealing with human behaviour... [FPNs are] an easy and quick way to make an enforcement point that we felt would be recognised by the public”.³⁶⁸
317. Although FPNs are commonly used to police low-level offending behaviour, witnesses explained to us that they were never designed to be used to enforce public health restrictions as during Covid-19, and there was a scramble for police forces to adapt. We were told that even getting FPN books was a challenge for the Police Service of Northern Ireland, who had to source books from Wales.
318. Initially, the penalty attached to coronavirus FPNs was set at £60 across all UK nations, with a 50% reduction if paid within a set period of time.³⁶⁹ Subsequent offences resulted in the fine doubling, up to a maximum of £960 in England, Scotland and Northern Ireland and £1,920 in Wales. The use of FPNs began to vary further over the course of the pandemic and in different UK nations. Researchers from the University of Edinburgh and the University of Stirling traced the following changes for offences underpinning restrictions on individuals from March 2020 to May 2021:

³⁶⁴ [Regulation 9](#), Health Protection (Coronavirus, Restrictions) (England) Regulations 2020; [regulation 12](#), Health Protection (Coronavirus Restrictions) (Wales) Regulations 2020; [regulation 8](#), Health Protection (Coronavirus) (Restrictions) (Scotland) Regulations 2020; [regulation 8](#), Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020

³⁶⁵ [Regulation 9\(4\)](#), Health Protection (Coronavirus, Restrictions) (England) Regulations 2020; [regulation 12\(4\)](#), Health Protection (Coronavirus Restrictions) (Wales) Regulations 2020; [regulation 8\(6\)](#), Health Protection (Coronavirus) (Restrictions) (Scotland) Regulations 2020; [regulation 8\(4\)](#), Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020

³⁶⁶ In Scotland FPNs could initially be issued to people aged 16 or over, but by 27 May 2020 this had been raised to 18 years following pressure from the Children & Young People’s commissioner.

³⁶⁷ [Regulation 10](#), Health Protection (Coronavirus, Restrictions) (England) Regulations 2020; [regulation 13](#), Health Protection (Coronavirus Restrictions) (Wales) Regulations 2020; [regulation 9](#), Health Protection (Coronavirus) (Restrictions) (Scotland) Regulations 2020; [regulation 9](#), Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020

³⁶⁸ House of Commons Justice Committee, *Oral evidence: Covid and the criminal law* (27 April 2021, HC 1316), accessible here <<https://committees.parliament.uk/oralevidence/2123/html/>> accessed 1 February 2024

³⁶⁹ Victoria Gordon, Ben Matthews, Susan McVie and Kath Murray, *Police Use of Covid-19 Fixed Penalty Notices in Scotland Trends in enforcement from March 2020 to May 2021* (The University of Edinburgh, 4 August 2022), page 6

- The list of offences for which FPNs could be issued expanded in all four nations, as restrictions changed over time;
- While a 50% payment discount applied to FPNs in all four nations, quicker payment was required in England, Northern Ireland and Wales than in Scotland;
- In Scotland, the maximum penalty that could be incurred for repeat offences was reduced to £480 after guidance was issued by the Lord Advocate. In contrast, in England the maximum fine for repeat offences for many FPNs was increased to £6,400.³⁷⁰

319. We also note that from August 2020, an automatic £10,000 fine was introduced in England and Wales for facilitating or organising illegal raves, and, in England, any other unlawful gathering of more than 30 people.³⁷¹

320. By January 2021, the cost for individuals in different UK nations for committing a similar breach of coronavirus restrictions varied considerably (see table below).

Table 1: Value and payment structure of FPNs across the UK at the start of each UK-wide lockdown period.

	Scotland	England	Northern Ireland	Wales
	Snapshot of March 2020			
Value of first FPN	£60	£60	£60	£60
Value of subsequent FPNs	Doubled each time, from £120 to a maximum of £960	Doubled each time, from £120 to a maximum of £960	Doubled each time, from £120 to a maximum of £960	£120 for subsequent offences*
Payment discount for all FPNs	Reduced by 50% if paid within 28 days	Reduced by 50% if paid within 14 days	Reduced by 50% if paid within 28 days	Reduced by 50% if paid within 14 days
	Snapshot at January 2021			
Value of first FPN	£60	£20	£200	£60
Value of subsequent FPNs	Doubled each time, from £120 to a maximum of £960	Doubled each time to maximum of £6,400	NA (single tariff structure)	Doubled each time to maximum of £1,920
Payment discount for all FPNs	Reduced by 50% if paid within 28 days	Reduced by 50% if paid within 14 days	Reduced by 50% if paid within 14 days	Reduced by 50% if paid within 14 days

FPNs could be issued for a number of different offences, which changed during the pandemic. The value and payment structures described in the table are the minimum for breaches committed by individuals. It does not include minimum fines for those offences that applied to businesses or travel regulations, which were typically higher.

Note that, in accordance with Lord Advocate guidelines, no fines larger than £480 were issued in Scotland.

This was amended in May 2020 to doubling each time to a maximum of £1,920 for sixth offence.

Table taken from: Victoria Gordon, Ben Matthews, Susan McVie and Kath Murray, *Police Use of Covid-19 Fixed Penalty Notices in Scotland Trends in enforcement from March 2020 to May 2021* (The University of Edinburgh, 4 August 2022), page 6

³⁷⁰ Ibid., page 7

³⁷¹ [The Health Protection \(Coronavirus\) \(Restrictions on Holding of Gatherings and Amendment\) \(England\) Regulations 2020](#) and [The Health Protection \(Coronavirus Restrictions\) \(No. 2\) \(Wales\) \(Amendment\) \(No. 7\) Regulations 2020](#)

321. In considering where, from a rule of law perspective, enforcement action could be improved in future public health emergencies, the evidence we received has focussed on two main issues. They are:

- a) The use of FPNs as a tool for enforcing public health restrictions.
- b) How police approached decisions of proportionality, particularly in relation to protest rights.

322. The rest of this Chapter considers those issues. However, we first consider it important to note that, while many discussions of the policing of the pandemic have focussed on enforcement and the issuing of FPNs, ultimately we heard that levels of enforcement were low. Only a very small number of people were subject to enforcement action. Professor Susan McVie estimated that less than 0.5% of the population in Scotland and Wales were issued with FPNs, and less than 0.3% in England.³⁷² Adam Wagner, one of our commissioners, has noted that enforcement of coronavirus restrictions in some other major European states was significantly stricter.³⁷³ Police forces across the UK followed what was called a “four E’s” approach, in which “enforcement” was the final stage of action after police had tried engaging with people, explaining the restrictions, and encouraging them to comply.

The use of FPNs as a tool for enforcing public health restrictions

323. We received mixed evidence as to whether FPNs were an appropriate tool in responding to public health emergencies. The issues that were raised can be grouped into three categories:

- a) Whether FPNs issued by the police were the right tool to sanction complex coronavirus offences.
- b) The unequal economic impact of FPNs and the high level of fines.
- c) The inability to challenge FPNs except in court.

Whether FPNs issued by the police were the right tool to sanction complex coronavirus offences

324. The complexity of the offences for which FPNs were issued was noted by a number of individuals who gave evidence, and is a point that has been raised by parliamentary committees and others commenting on the UK government’s Covid-19 response.³⁷⁴ Before the Covid-19 pandemic, FPNs were primarily used for offences without complex or subjective elements where there was little or no room for substantive discretion or interpretation.³⁷⁵ In contrast, the offences for which FPNs could be issued under coronavirus restrictions often included consideration of complex questions such as whether individuals had a “reasonable excuse” for undertaking activities like leaving their home, or meeting another person indoors.³⁷⁶ We are conscious that these questions are not straightforward, and involve an assessment of risk dependent upon knowledge of the local public health situation as well as the position of the individual.

³⁷² Written evidence from Professor Susan McVie ([Appendix 9](#))

³⁷³ Adam Wagner, *Emergency State* (n 170), page 127

³⁷⁴ Joint Committee on Human Rights, *The government response to COVID-19: fixed penalty notices* (2019-21 HC 1364 HL 272), paragraph 13; Tom Hickman, ‘A very English lockdown relaxation’ (*UK Constitutional Law Blog*, 14 May 2020), Tom Hickman KC is one of our commissioners.

³⁷⁵ This is not uniformly the case. For example, before issuing an FPN to a person suspected of being drunk and disorderly, a police officer must make a judgement as to that person has behaved in an “unruly” or “offensive” manner: House of Commons Justice Committee, *Covid-19 and the criminal law* (2021-22 HC 71), paragraph 53

³⁷⁶ Joint Committee on Human Rights, *The government response to COVID-19: fixed penalty notices* (n 374), paragraph 14

325. The UK Parliament’s Joint Committee on Human Rights and the House of Commons Justice Committee have both queried whether FPNs are suitable enforcement tools when offences are “complex, difficult to apply and give rise to significant sanction” and there is “some ambiguity or subjectivity as to exactly what would constitute an offence”.³⁷⁷ The Justice Committee advised that in these circumstances “it should ordinarily be the responsibility of a court, rather than an official to determine liability”.³⁷⁸ The Joint Committee on Human Rights advised that the “enforcement of such laws is better suited to the protections offered by the involvement of the [Crown Prosecution Service] and the courts”.³⁷⁹ Here, both committees are referring to the fact that the decision to issue an FPN is made by police officers without the involvement of the Crown Prosecution Service (‘CPS’), which is staffed by lawyers.
326. Some witnesses made a broader point, querying whether the police were the right organ of the state to be enforcing restrictions which involve matters of judgement in relation to public health. Marie Anderson, the Police Ombudsman for Northern Ireland, considered that it is very difficult for police to make real time decisions regarding proportionality or ‘reasonable excuse’ around individual incidents. Ms Anderson took the view that other bodies – such as public health officials – should have made more use of their enforcement powers in relation to businesses. Likewise, while acknowledging that the use of FPNs “may well have taken pressure off the court system”, the Scottish Police Federation found that placing the police at “the front and centre of an enforcement approach to a public health emergency has arguably caused considerable harm to police and public relationships”.³⁸⁰
327. However, in oral evidence Professor Peter Neyroud stated that it was proper for the police to bear the bulk of the load when enforcing Covid-19 restrictions, as they are the visible arm of the state and the only organisation able to use force if necessary. A report by the Human Rights Advisor to the Northern Ireland Policing Board expressed a similar view. The report acknowledged that the Covid-19 pandemic “is a health emergency not a criminal justice crisis” and there may be better ways of enforcing future public health pandemics rather than relying primarily on the police, but the police are nonetheless “the obvious choice [to enforce restrictions]; they are used to dealing with public order, difficult individuals and have officers on the ground all around the country.”³⁸¹ The findings and recommendations in the report were welcomed by the chair of the Policing Board.³⁸²

The unequal economic impact of FPNs and the high level of fines

328. The House of Commons Justice Committee has previously highlighted the unequal economic impact of FPNs, finding the use of FPNs created “a two-tier system. Those who can afford to pay a penalty can escape criminality” and “the whole FPN process seems to disproportionately impact the least well off.”³⁸³ This point was emphasised by several witnesses. In her written evidence, Professor McVie noted that “FPNs are an inherently inequitable sanction. Due to their fixed value, FPNs do not have an equal punishment effect on every individual: the face value of fines can be trivial and inconsequential to some, but cause financial hardship to others.”³⁸⁴ She explained that “those who were issued with multiple fines were significantly

³⁷⁷ *Ibid.*, paragraph 26 and Justice Committee, *Covid-19 and the criminal law* (n 375) paragraph 54

³⁷⁸ Justice Committee, *Covid-19 and the criminal law* (n 375) paragraph 54

³⁷⁹ Joint Committee on Human Rights, *The government response to COVID-19: fixed penalty notices* (n 374), paragraph 26

³⁸⁰ Written evidence from the Scottish Police Federation ([Appendix 13](#))

³⁸¹ Northern Ireland Policing Board, *Report on the Thematic Review of the Policing Response to Covid 19* (November 2020), pages 6-7

³⁸² *Ibid.* p 3.

³⁸³ Justice Committee, *Covid-19 and the criminal law* (n 375), paragraphs 92-93

³⁸⁴ Written evidence from Professor Susan McVie ([Appendix 9](#))

more likely to be living in the most deprived communities, and were less likely to pay their fines, than those who received only one. This indicates that, while only a very small percentage of the overall population were subject to enforcement action, the use of police FPNs under the Coronavirus Regulations impacted disproportionately on those least able to afford them.”³⁸⁵

329. Similar points were made by the Scottish Police Federation, which informed us that it has “longstanding reservations about the police use of FPNs” as they “deliver a standard uniform sanction for alleged offenders, regardless of their personal circumstances” and have a “disproportionate impact on those from the poorest sections of our society”.³⁸⁶ The Federation explained that poorer sections of society faced disproportionate police attention because they had “the least opportunity to seek to mitigate the effects of enforced isolation”.³⁸⁷ We note that FPNs are accompanied by a fixed financial penalty, whereas if a fine were instead to be imposed by a court then an offender’s financial circumstances would be taken into account.
330. Witnesses were also of the opinion that it was problematic for very large penalties to be attached to FPNs, reinforcing a view previously reached by the Joint Committee on Human Rights.³⁸⁸ Professor McVie informed us that the high penalties issued for repeat breaches of Covid-19 restrictions in some nations, and the automatic £10,000 fine for organising large gatherings in England or illegal raves in England and Wales cannot be justified in the context of an on-the-spot fine issued on the basis of police discretion. Professor Neyroud made a similar point, advising that the Crown Prosecution Service would normally be involved in administering higher level fines.

The inability to challenge FPNs except in court

331. While informal approaches to police forces led to some FPNs being dropped, the only official way to challenge an FPN was for an individual not to pay the penalty, wait to see if the police decide to charge them, and then argue their case before a magistrates’ court where they faced criminal conviction if found guilty.³⁸⁹ In contrast, if an FPN is paid, then an individual will not face prosecution. As the Joint Committee on Human Rights noted, the threat of a criminal prosecution and conviction creates a strong incentive for an individual simply to pay the FPN penalty, even if they believe it was wrongly issued.³⁹⁰
332. Professor Neyroud informed us that a much better and streamlined process needs to be developed to allow appeals of FPNs issued during a public health emergency. He explained that a review mechanism for FPNs was rapidly invented in England and Wales during the first UK-wide lockdown. Professor McVie informed us that FPNs issued in England, Wales and Scotland were usually subject to two levels of internal review, which led to some FPNs being cancelled before being issued: first, a review by individual police forces, and second, by those responsible for processing the FPNs (i.e. ACRO Criminal Records Office or the Scottish Courts and Tribunals Service).³⁹¹ In relation to Northern Ireland, Marie Anderson informed us that initially all decisions were delegated to individual officers, however, by around May 2020 all

³⁸⁵ Ibid.

³⁸⁶ Written evidence from the Scottish Police Federation ([Appendix 13](#))

³⁸⁷ Ibid.

³⁸⁸ Joint Committee on Human Rights, *The government response to COVID-19: fixed penalty notices* (n 374) paragraph 27

³⁸⁹ As discussed by one of our commissioners: Adam Wagner, *Emergency State* (n 170), page 66

³⁹⁰ Joint Committee on Human Rights, *The government response to COVID-19: fixed penalty notices* (n 374), paragraph 77

³⁹¹ Written evidence from Professor Susan McVie ([Appendix 9](#)). This two-level system of review was also outlined by the UK government in response to questions by the Joint Committee on Human Rights: Joint Committee on Human Rights, *The Government response to covid-19: fixed penalty notices: Government Response to the Committee’s Fourteenth Report of Session 2019–21 (2021–22, HC 545)*, page 4

decisions about the issuing of FPNs had to be checked with the Police Service of Northern Ireland Covid central command, after which there was a substantial drop in the number of FPNs being issued.

333. Individuals issued with the FPN had no way of formally feeding into the review processes outlined above.

Discussion

334. In light of the issues surrounding the use of FPNs, we spent some time discussing whether there is an alternative in future public health emergencies. We searched for a solution that did not involve the mass-criminalisation of individuals breaching public health restrictions, in order to avoid overly punitive enforcement and the court system becoming overloaded with prosecutions in the midst of an emergency.

335. We considered the approaches taken in other countries, but these did not offer any neat solutions. Many of the jurisdictions we reviewed took a heavier-handed approach than the UK, imposing even higher fines or imprisonment for breaches of coronavirus restrictions. However, we did note that some countries – such as Israel – primarily issued civil fines that were not backed by criminal sanction (unlike FPNs, where a failure to pay can lead to criminal prosecution). In Israel, criminal sanction was limited to severe or repeat violations, with penalties in those cases being either a high level fine imposed by the court, or imprisonment.³⁹² This approach would solve some of the problems outlined above, but not all of them. Civil fines still disproportionately impact poorer members of society, who are also more likely to be the “repeat offenders” facing criminal prosecution for repeat violations.

336. We asked those who gave oral evidence whether there was an alternative criminal justice response to the use of FPNs. Professor Neyroud considered that “there isn’t another obvious alternative to FPNs”, but Professor McVie drew our attention to the potential use of oral and written warnings. Drawing upon her research of policing in England, Scotland and Wales, Professor McVie advised that all three jurisdictions have generally moved away from using financial penalties to deal with low level offending, and towards other out of court disposals. She suggested that the pre-existing system of police warnings (in Scotland) and cautions (in England, Northern Ireland and Wales) could be used as a first-step enforcement mechanism in public health emergencies. FPNs could then be issued for those who had already been formally warned about their behaviour. Professor McVie noted that the vast majority of individuals who received an FPN received only one such Notice (96% in England and Wales), and stated that this “suggests that a single experience of formal police ‘enforcement’ was effective in reducing the likelihood of further non-compliance for most people”. She also noted that “an enforcement model based on formal police warnings (for a first offence) would arguably have been more consistent with existing police practice, and acted as a more proportionate and equitable first response that would not have discriminated against those who were unable or struggled to pay a fine.”³⁹³

³⁹² Einat Albin, Ittai Bar-Siman-Tov, Aeyal Gross, Tamar Hostovsky-Brandes, ‘Israel: Legal Response to Covid-19 in Jeff King and Octavio Ferraz (eds.), *The Oxford Compendium of National Legal Responses to Covid-19* (OUP 2021), paragraph 120 accessible at <<https://oxcon.ouplaw.com/display/10.1093/law-occ19/law-occ19-e13>> accessed 1 February 2024. The Oxford Compendium was co-edited by one of our commissioners, Professor Jeff King.

³⁹³ Written evidence from Professor Susan McVie ([Appendix 9](#))

337. We find this suggestion compelling, but are not convinced that the existing system of police warnings/cautions would be entirely well suited to an emergency public health response. To take the situation in England and Wales: cautions can only be issued to individuals who admit that they have committed an offence, and there is a right to legal advice before accepting the caution.³⁹⁴ Cautions should also usually be offered in a police station or other official setting, rather than in a public place, and will have a more significant impact than FPNs on an individual's criminal record.³⁹⁵ These factors do not make the existing system of cautions easily applicable to a situation which requires fast, on-the-spot disposals in public settings, without unnecessarily drawing individuals into the criminal justice system. However, we recommend that governments should consider whether some type of formal warning system could be a first-stage alternative to the use of FPNs.

Recommendation 35: Governments should consider whether a formal warning system could be a first-stage alternative to the use of FPNs as an enforcement tool for emergency public health restrictions.

Suggested improvements to the use of FPNs in future public health emergencies

338. If FPNs are to be used in future public health emergencies, we set out below our recommendations on how their use can be improved from a rule of law perspective.

(I) Ensure those enforcing restrictions have necessary training and information

339. We considered whether Environmental Health Officers should play a greater role in enforcing public health restrictions in future public health emergencies, as public health officials are plainly better placed than the police to determine complex matters of judgement in relation to health risks. This would go some way to solving concerns around the complexity of the offences for which FPNs were issued during the Covid-19 pandemic. We, however, recognise that public health workforce numbers have declined significantly in recent years and there may simply be no spare capacity within local authorities, especially as many Environmental Health Officers became part of delivering the local operational public health response during the Covid-19 pandemic. The feasibility of Environmental Health Officers playing a greater role in enforcement should be explored further by central government and local authorities.

340. If the police are to be the principal enforcers of future public health restrictions, then there are ways in which they can be better supported to determine complex questions involving public health risks. Professor McVie advised us that “better training would have prepared police officers – frontline and supervisory – for what they might expect to encounter. Learning from the pandemic should be incorporated into probationary training so that there is a framework

³⁹⁴ Ministry of Justice, *Simple Cautions for Adult Offenders: guidance for police officers and Crown Prosecutors* (2015) paragraphs 77-8 available at <<https://assets.publishing.service.gov.uk/media/5afeacfc40f0b6561ce44093/cautions-guidance-2015.pdf>> accessed 1 February 2024

³⁹⁵ *Ibid.*, paragraph 79. Fixed Penalty Notices issued for coronavirus offences were non-recordable so were not stored on the Police National Computer, although local forces may have kept a record. In contrast, cautions are recorded on the Police National Computer, form part of an individual's criminal record and may be disclosed as part of a criminal record check.

in place that can be adopted whenever necessary in the future”.³⁹⁶ Professor Neyroud made a similar point, advising us that there needs to be a code of practice for pandemics that sets out a range of options, and which needs to be exercised properly with a range of parties in the system. He informed us that there was no exercise conducted on the policing of the pandemic, which was instead “made up as we went along”.

341. We therefore recommend that government contingency planning should involve working with public health officials and the representative bodies of police forces to develop training on the enforcement of public health restrictions. The production of codes of practice for different public health emergencies could form part of this work.

342. In addition, governments should ensure that police forces are clearly informed of the wider objectives underpinning public health restrictions, and are given sufficient data to help them assess public health risks in their local area via the well-established multi agency response systems. During the Covid-19 pandemic, police forces wanted to be kept updated on the public health situation in their local area, and how this should influence enforcement. The Human Rights Advisor to the Northern Ireland Policing Board has stated that:

“if the choice is to use the police to protect our health then there is a very powerful argument for the health experts, at the Department of Health, to take responsibility and to assist the [Police Service of Northern Ireland] by suggesting overall objectives and giving guidance on the level of transmission risks. If the basis of the law was to reduce person to person contact, household to household contact and location to location contacts then that should have been made clear in the Regulations and the [Police Service of Northern Ireland] should have been supplied with daily ‘threat levels’ that could be shared with officers and in turn shared in interactions with members of the public. These threat level assessments would have also helped the [Police Service of Northern Ireland] and officers to gauge how far up the four Es enforcement escalation process they should go to achieve the objective of keeping us safe.”³⁹⁷

343. Similar points were made by HMICFRS in a report on policing in England and Wales. HMICFRS gave some examples of the police using public health data in their decision-making, explaining that “to understand and predict the changing impact of the pandemic locally, some forces and LRFs made use of local data such as death rates and hospital admissions. They then devised proportionate response plans.”³⁹⁸ HMICFRS concluded that:

“It is a fundamental principle of interpretation of legislation (primary and secondary) that it should be construed in the light of and to give effect to its statutory purpose. The purpose in this case was preventing, protecting against, delaying or otherwise controlling the incidence or transmission of coronavirus. With that purpose in mind, it became much easier to understand the cases where members of the public were legitimately outside their homes and where they were not. Regrettably, in too many cases front-line police officers did not receive these explanations which would have made their jobs much easier.”³⁹⁹

344. Ideally, properly disaggregated and localised data would be compiled to help the police make decisions around levels of enforcement, and to identify very quickly where there might be disproportionate enforcement. This would involve police forces and public health officials sharing data with each other to inform their work. However, we heard from Dr Fu-Meng Khaw

³⁹⁶ Written evidence from Professor Susan McVie ([Appendix 9](#))

³⁹⁷ Northern Ireland Policing Board, *Report on the Thematic Review of the Policing Response* (n 381), page 7

³⁹⁸ HMICFRS, *Policing in the pandemic* (n 324), page 13

³⁹⁹ *Ibid.*, page 35

that data acquisition and reporting became very challenging during the Covid-19 pandemic, as a result of data protection issues. Dr Khaw explained that it wasn't clear how far data protection principles prevented localised, sensitive data being shared, and that public health officials could spend a lot of time during an emergency response discussing what may or may not be acceptable to share. We are also aware that there are longstanding problems caused by complex differences between the regimes governing data protection and sharing as they apply to public health, healthcare, social care and education⁴⁰⁰ and most other contexts which are governed by the ordinary statutory provisions. The principles governing the acceptable sharing of data in a public health emergency need to be clearly outlined and rehearsed during emergency planning exercises.

Recommendation 36: The feasibility of Environmental Health Officers playing a greater role in enforcement of emergency public health restrictions should be explored further by central government and local authorities.

Recommendation 37: Government contingency planning should involve working with public health officials and the representational bodies of police forces to develop training on the enforcement of public health restrictions. The production of codes of practice for different public health emergencies could form part of this work.

Recommendation 38: To aid police decision-making during an emergency, governments should ensure that police forces are clearly informed of the wider objectives underpinning public health restrictions, and are given sufficient data to help them assess public health risks in their local area via the well-established multi agency response systems. The principles governing the acceptable sharing of data in a public health emergency need to be clearly outlined and rehearsed during emergency planning exercises.

(II) Increase consultation with police forces

345. Our call for evidence asked whether the creation of new offences during the Covid-19 pandemic reflected rule of law values. In its response, the CPS informed us that “despite the speed with which the various Regulations have been introduced, the CPS has had the opportunity to work with government departments and the police to aid our understanding of the policy intent behind the Regulations and to raise any practical difficulties we have encountered in enforcing them.” The CPS gave the example of their staff viewing and commenting on drafts of the first set of lockdown regulations, to help to “clarify the text and identify any perceived problems”.⁴⁰¹

346. We were pleased to see that the CPS had been able to advise on regulations in this way. However, the CPS was not involved in the vast majority of enforcement action, including prosecutions. Instead, enforcement was led by the police. We therefore considered how far police forces had been involved in advising on coronavirus offences. Professor McVie stated that in Scotland there was a lack of consultation between government and policing organisations around which regulations were feasible. Professor McVie gave an example of

⁴⁰⁰ These areas are covered by partial exceptions from normal GDPR rules under the UKGDPR and the Data Protection Act 2018 as amended, but complemented by the non-statutory “Caldicott Principles”

⁴⁰¹ Written evidence from the CPS ([Appendix 3](#))

the police in Scotland being required to check on people who should be self-isolating, but simply not having sufficient capacity to do so. Marie Anderson, the Police Ombudsman for Northern Ireland, informed us that the Northern Ireland Department of Health, the Northern Ireland Assembly and senior police officers initially appeared to be working in silos. The Police Service of Northern Ireland has confirmed that “there [was] no formal consultation process ahead of [regulations] being tabled or passed during the reporting period. There were however informal contacts, mostly post-event as to the out-workings of [regulations] and what changes or updates might be required and indeed the possible impacts of proposed changes.”⁴⁰²

347. Witnesses advised us that, in future, there should be “consultation with police forces by law makers” in the development (and amendment) of emergency public health regulations to “ensure that they are feasible and enforceable.”⁴⁰³ The Scottish Police Federation emphasised that some of the disproportionate impacts of public health restrictions on poorer sections of society, and the resultant over-policing, could have been “mitigated by government being more willing to listen to practitioner voices from a range of disciplines before passing regulation or amended regulation.”⁴⁰⁴ While consultation with police may be difficult in an emergency, it should be prioritised, and in fact seems to have been successfully facilitated in Wales. In a recent report, HMICFRS found that Welsh forces generally felt properly consulted on draft legislation during Covid-19. The report gave the example of Welsh forces identifying “a potential loophole in the proposal about large gatherings, which was then fixed.”⁴⁰⁵

Recommendation 39: Where at all possible, governments in future public health emergencies should consult on draft restrictions with the professional bodies representing police forces.

(III) Reduce the financial penalty for FPNs

348. The high level of fixed penalties which could be issued for some offences was problematic for a number of reasons. First, from a rule of law perspective, it is wrong to apply a significant sanction without sufficient safeguards. Usually, offences that attract high-level fines of over £1,000 would necessitate the CPS reviewing police decision-making, and a case would be heard before a criminal court where a magistrate would have to be sure that the offence was committed. The fine would also be means tested. During Covid-19, high-level FPNs, including FPNs as high as £10,000, were applied on the spot by police officers, who merely had to ‘reasonably believe’ that an offence had been committed.⁴⁰⁶

349. Second, on a practical level, Professor McVie advised us that, “if enforcement is considered a necessity, it would be best to maintain existing structures and procedures and ensure these remain consistent across the UK. Creating new fining structures and fine amounts created a significant (and, arguably, unnecessary) administrative burden for police forces across the UK.”⁴⁰⁷ Levels of penalties for FPNs tend to be relatively minor, since they are usually used to punish low-level offences such as littering and graffiti. For example, the fixed penalty for being drunk and disorderly in public is £90.⁴⁰⁸

⁴⁰² Northern Ireland Policing Board, *Report on the Thematic Review of the Policing Response* (n 381), page 24

⁴⁰³ Written evidence from Professor Susan McVie ([Appendix 9](#))

⁴⁰⁴ Written evidence from the Scottish Police Federation ([Appendix 13](#))

⁴⁰⁵ HMICFRS, *Policing in the pandemic* (n 324), page 18

⁴⁰⁶ As discussed by one of our commissioners: Adam Wagner, *Emergency State* (n 170), page 66

⁴⁰⁷ Written evidence from Professor Susan McVie ([Appendix 9](#))

⁴⁰⁸ Justice Committee, *Covid-19 and the criminal law* (n 375), paragraph 56

350. We consider that FPNs are ordinarily only appropriate enforcement tools where the level of penalty is low, and they should not be used to impose penalties that exceed a few hundred pounds. If, exceptionally, clear evidence shows that breaches of certain restrictions should attract a higher level penalty in order to manage the public health risk, then those higher level FPNs should be rare, proportionate to the level of risk, and authorised by a senior officer.

Recommendation 40: FPNs are ordinarily only appropriate enforcement tools where the level of penalty is low, and they should not be used to impose penalties that exceed a few hundred pounds. If, exceptionally, clear evidence shows that breaches of certain restrictions should attract a higher level penalty in order to manage the public health risk, then those higher level FPNs should be rare, proportionate to the level of risk, and authorised by a senior officer.

(IV) Enhance review and appeal mechanisms for FPNs

351. As discussed at paragraph 331 above, during Covid-19, there was no formal mechanism for individuals to feed into internal police reviews to determine whether an FPN was correctly issued. During a public health emergency, individuals who believe they have been wrongly issued with an FPN should be able to make representations without having to go before a court and face a criminal conviction. This is important in a fast-moving emergency situation where errors in enforcement are to be expected – data available for England and Wales suggests that FPNs issued during Covid-19 were likely to have had an error rate of 21%.⁴⁰⁹

352. We consider that contingency planning for future emergencies should facilitate a formal mechanism for individuals who believe they have been wrongly issued with an FPN to make representations to the issuing police force. The FPN should be reviewed by a more senior officer who was not involved in issuing it and who has access to legal advice.

Recommendation 41: Contingency planning for future health emergencies should facilitate a formal mechanism whereby individuals who believe they have been wrongly issued with an FPN for breaching public health restrictions can make representations to the issuing police force. The FPN should be reviewed by a more senior officer who was not involved in issuing it and who has access to legal advice.

⁴⁰⁹ House of Commons Justice Committee, *Covid-19 and the criminal law: Government Response to the Committee's Fourth Report of Session 2021-22 (2022-23, HC 644)*, page 11

Proportionality and protest rights

353. We have noted that the structuring of enforcement powers – in particular, the use of FPNs as the primary means of enforcement – disproportionately impacted poorer individuals. However, witnesses impressed upon us that, in general, the actions of the police themselves were proportionate. Professor Susan McVie, who has reviewed police powers in England, Scotland and Wales, stated that the police were very cautious about monitoring public health issues, and that the data she has reviewed shows that there was generally a minimal use of powers. She noted that a very small proportionate of the population was subject to powers, there was a lot of monitoring, and a lot of FPNs were withdrawn. Marie Anderson made a similar point in relation to Northern Ireland. She stated that – apart from issues around a June 2020 Black Lives Matter protest which we discuss below – the Police Ombudsman did not receive many complaints about enforcement and generally the police did not use their powers in a disproportionate way. However, a key exception to these comments was the policing of protests.
354. The right to protest is protected by the rights to freedom of assembly and free expression under Articles 10 and 11 of the European Convention on Human Rights, which are incorporated into UK law by the Human Rights Act 1998. Restrictions on the right to protest may be justified in the interests of reducing the spread of a public health threat, but only if such restrictions are necessary and proportionate. This means that there cannot be a blanket ban on all protests. Public bodies must instead weigh up public health risks against people’s right to protest before deciding whether a protest should be prevented from taking place.⁴¹⁰
355. The lockdown regulations used the concept of “reasonable excuse” to enable this proportionality assessment to be made. The regulations governing each of the lockdowns in the UK prohibited people from leaving their homes without a “reasonable excuse”. They also made it an offence to participate in gatherings of varying sizes “without reasonable excuse”. In principle, taking part in a protest could constitute a reasonable excuse, depending on the risks the protest would pose to public health.⁴¹¹ However, the police sometimes struggled properly to determine whether protests should be allowed to go ahead. In oral evidence, Professor Neyroud explained to us that one of the issues that was never really clear was exactly where the line should be drawn between allowing people to protest and minimising the risks to public health. At times, governments and police forces wrongly issued statements suggesting that protests were uniformly prohibited. For example, in January 2021, Police Scotland posted on their website that “the Scottish government regulations are clear that public processions and static protests are prohibited under the current Level 4 restrictions.”⁴¹² Two months later, the UK Home Office said it was illegal for people to attend protests.⁴¹³
356. Protests were also wrongly shut down or prevented from taking place. In oral evidence, Marie Anderson, the Police Ombudsman for Northern Ireland, discussed a ‘Black Lives Matter’ protest in Northern Ireland held in June 2020. She informed us that the police took a “strong approach” to enforcement – not only issuing FPNs to protestors but also charging some of the organisers of the protest with “intentionally encouraging or assisting an offence” under section 44 of the

⁴¹⁰ *R (Leigh and others) v commissioner of Police of the Metropolis* [2022] EWHC 527 (Admin).

⁴¹¹ *R (Dolan and others) v Secretary of State for the Health Department and the Secretary of State for Education* [2020] EWCA Civ 1605

⁴¹² Police Scotland, ‘Public urged not to attend planned demonstration at Scottish Parliament’ (Police Scotland, January 2021) <<https://www.scotland.police.uk/what-s-happening/news/2021/january/public-urged-not-to-attend-planned-demonstration-at-scottish-parliament/>> accessed 1 February 2024

⁴¹³ BBC, ‘Coronavirus: Protests should be allowed during lockdown, say 60 MPs and peers’ BBC (20 March 2021) <<https://www.bbc.co.uk/news/uk-56466291>> accessed 1 February 2024

Serious Crime Act 2007. Ms Anderson found that to be “entirely disproportionate”.⁴¹⁴ In her report on the policing of the protest, she found that the “overriding police objective for the 6th June 2020 ‘Black Lives Matter’ protests was to have the events cancelled rather than ensuring the protests were policed proportionately” and that there was “no evidence of [the police service] having balanced relevant human rights considerations”.⁴¹⁵

357. A similar finding was made by the High Court in England and Wales in relation to the Metropolitan Police. In March 2021, a campaign group - Reclaim These Streets - planned to organise a vigil at Clapham Common in London following the kidnap and murder of Sarah Everard by a police officer. However, the group cancelled the vigil after being informed by the police that they would be liable to be issued with FPNs of £10,000 if it went ahead. Reclaim These Streets later brought a successful judicial review against the Metropolitan Police for unlawfully restricting their freedom of expression and assembly (the claimants were represented by two of our commissioners - Tom Hickman KC and Adam Wagner).⁴¹⁶ In its judgment, the Divisional Court found that the Metropolitan Police had acted unlawfully by failing properly to consider whether the vigil might constitute a “reasonable excuse” for breaching the prohibition on gatherings. The Court found that the police had misunderstood the nature of the law, which in one instance was partly caused by guidance from the College of Policing containing “an account of the legal position that was incomplete and misleading because it positively asserted that there was no exception for protest, made only passing reference to the requirement of no reasonable excuse, and failed to reflect [relevant legal principles]”.⁴¹⁷
358. We have four key recommendations as to how these types of problems could be avoided in the future. As a starting point, Professor Neyroud informed us that better guidance would have helped. We agree that in future public health emergencies, carefully considered national guidelines should be produced on certain sensitive areas such as control of protests, any restriction of online disinformation, and responses to domestic violence and racially sensitive areas of policing.
359. Second, we consider that there should be more training of frontline decision makers on how to factor human rights considerations into decision-making. We understand that, when the Human Rights Act 1998 was first introduced, police forces were a model of best practice for focussing on teaching junior officers general human rights principles, before then considering how these principles applied in specific situations. Governments and policing bodies should explore whether high-level training on fundamental human rights principles might help police officers better to understand the human rights landscape when faced with a novel situation like a public health emergency.
360. Third, Professor McVie was part of an Independent Advisory Group on policing in Scotland that was appointed two weeks into the pandemic. She informed us that a lot of discussions were had within the group around issues such as protest rights, anti-masking, and anti-vaxxing. The group had discussions with the police the whole way through the Covid-19 pandemic and were clear about taking a human rights based approach, which helped lead to very low level policing in Scotland with a very small number of arrests. The work of the advisory group was praised by the Scottish Parliament Justice Sub-Committee on Policing, which found that

⁴¹⁴ Police Ombudsman for Northern Ireland, *An Investigation into Police Policy and Practice of Protests* (n 305), paragraph 9.18

⁴¹⁵ *Ibid.*, paragraph 9.4

⁴¹⁶ *R (Leigh and others) v commissioner of Police of the Metropolis* [2022] EWHC (Admin) 527

⁴¹⁷ *Ibid.*, [87]

“[t]he establishment of the Independent Assessment Group (IAG) to provide oversight of Police Scotland’s use of new and emergency powers was a welcome development” and may be “a unique model of oversight which is attracting interest from other jurisdictions around the world.”⁴¹⁸ We recommend that as part of contingency planning for future public health emergencies, governments and policing bodies should consider establishing an independent advisor or advisory group on human rights and policing at the start of an emergency.

361. Finally, we are concerned that a “reasonable excuse” provision might not necessarily be sufficient to safeguard the right to protest – and other human rights – in future public health emergencies. Two recent protest law cases have shown the importance of explicitly including human rights as an exception to a prohibition on gatherings and/or a defence against prosecution. In *Director of Public Prosecutions v Elliott Cuciurean*,⁴¹⁹ the High Court held that, where a statute created a criminal offence without an express exception for people with a reasonable or lawful excuse or justification (in that case, aggravated trespass), a defendant could not rely on his exercise of his Convention right to freedom of expression or assembly to excuse his behaviour. In *Reference by the Attorney General for Northern Ireland - Abortion Services (Safe Access Zones) (Northern Ireland) Bill*,⁴²⁰ the UK Supreme Court went further, warning that, even if a statute includes a defence of reasonable excuse or justification, the offence may be one where the ingredients of the offence themselves strike the proportionality balance, so that the court does not need to consider whether a conviction would be proportionate in that particular case. Whatever may be the merits of this finding in relation to a right to protest, it is not obviously appropriate in the case of public health restrictions underpinned by criminal sanction. Therefore, we consider that any criminal offences created by regulation or primary legislation in response to a public health threat should also explicitly specify that (as a minimum) the rights protected by the European Convention on Human Rights should provide a defence against enforcement.

Recommendation 42: In future public health emergencies, carefully considered national guidelines should be produced on the control of protests and certain other sensitive areas that involve human rights and equalities considerations, such as any restriction of online disinformation, and responses to domestic violence and racially sensitive areas of policing.

Recommendation 43: Governments and policing bodies should explore whether high-level training on fundamental human rights principles might help police officers to understand better the human rights landscape when faced with a novel situation like a public health emergency. As part of contingency planning for future public health emergencies, governments and policing bodies should also consider establishing at the start of an emergency an independent advisor or advisory group on human rights and policing.

Recommendation 44: Any criminal offence or enforcement power created by legislation in response to a public health threat should explicitly specify that (as a minimum) the rights protected by the European Convention on Human Rights would provide a defence against enforcement or conviction.

⁴¹⁸ Scottish Parliament Justice Sub-Committee on Policing, *Justice Sub-Committee on Policing Legacy Report*, Session 5 (2021, SP 990), paragraph 28

⁴¹⁹ [2022] EWHC 736 (Admin)

⁴²⁰ [2022] UKSC 32

GLOSSARY

Affirmative scrutiny procedure

Statutory instruments made under the affirmative procedure require active debate and approval by the relevant legislature (i.e. both Houses of the UK Parliament, the Scottish or Welsh Parliament, or the Northern Ireland Assembly).

Committee of the Whole Parliament (Scottish Parliament)

In the Scottish Parliament, legislative scrutiny of Bills is normally led by one of the Parliament's specialist committees. For example, the Criminal Justice Committee will take the lead on the scrutiny of Bills relating to the court system. However, where a Bill needs to be fast tracked, it will usually be scrutinised by a Committee of the Whole Parliament, of which all MSPs are members and the Presiding Officer is the convener.

Draft affirmative scrutiny procedure

Under the draft affirmative procedure, a statutory instrument must be laid in draft before the legislature and cannot be made into law until it is debated and approved by that legislature.

Emergency-responsive legislation

This report uses “emergency-responsive legislation” to refer to bespoke primary legislation enacted during a public health emergency in order to respond to the health threat.

Explanatory memoranda

Explanatory memoranda are documents that clearly explain, in non-technical terms, the legal changes that are made by a piece of legislation. They are therefore helpful in enabling individuals without technical legal training to understand regulations, and are a useful complement to Keeling Schedules, which are more technical and detailed.

Fixed Penalty Notice (“FPN”)

An FPN is a notice which offers the person to whom it is issued the chance to avoid prosecution for an offence by paying a financial penalty. It is commonly used for low-level motoring and other offences, such as driving without a seatbelt or littering. If an individual accepts the FPN and pays the fine then they will not receive a criminal conviction. If a fixed penalty notice is unpaid within 28 days, then the police can decide to prosecute.

Framework legislation

This report uses “framework legislation” to refer to primary legislation designed and enacted outside of an emergency period, and which empowers governments to respond to a variety of potential public health threats.

Impact assessment

Impact assessments are evaluative assessments of the costs, benefits and risks of a proposed government policy, including the likely direct or indirect impacts that the policy will have on individuals, society and/or businesses. Governments can use targeted impact assessments to consider the impact a policy will have on a particular group. For example, equality impact assessments are used to consider how individuals protected under the Equality Act 2010 will be affected by government decision-making. In some cases, governments are legally required to produce an impact assessment before a policy is introduced. For example, in Wales, a Health Impact Assessment must be carried out for certain policies.

Keeling Schedule

A Keeling Schedule is used to show how an existing statute or regulation will look if a proposed amendment is adopted. It is a document which highlights the proposed changes in a form similar to a “tracked changes” version of a Word Document.

Made affirmative scrutiny procedure (in Northern Ireland the “confirmatory procedure”)

In cases of urgency an affirmative statutory instrument can be made into law by a minister and come into force without parliamentary approval, but will expire within a specified period (usually 28 or 40 days) unless it is debated and approved by the legislature.

Made negative scrutiny procedure

Under the made negative procedure, a statutory instrument does not require active approval by the legislature: it comes into force and remains law unless the legislature rejects it within a specified period. If the legislature does not reject the instrument within that period, it is deemed to have consented.

Primary legislation

Law that is made by the legislature, comprising Acts of Parliament, Acts of the Scottish Parliament, Acts of the Northern Ireland Assembly, and Acts of the Welsh Parliament.

Regulations

Regulations are one category of secondary legislation enacted in statutory instruments.

Secondary legislation

Law made by ministers using powers granted to them by the legislature under primary legislation. It is also known as delegated or subordinate legislation.

Statutory instrument (in Northern Ireland “statutory rule”)

The most common form of secondary legislation.

Sunset clause

Sunset clauses set a time limit on the period for which legislation remains in force, and are a common feature of emergency legislation. Once sunsetted provisions in legislation pass their expiry date they cease to be law, but any actions taken under that legislation while it was in force remain valid.

EVIDENCE AND COMMENTS CITED IN THE REPORT

The following individuals or organisations provided evidence or comments which we have cited in the report.

Comments (mostly received on some or all draft recommendations)

Lord Bethell, Conservative Member of the House of Lords and formerly Parliamentary Under Secretary of State at the Department of Health and Social Care (2020-2021)

Children's Commissioner for Wales

Children and Young People's Commissioner for Scotland

Equality Commission for Northern Ireland

Equality and Human Rights Commission

Murdo Fraser MSP, Conservative Member of the Scottish Parliament and formerly Chair of the Scottish Parliament Covid-19 Committee (2020-2021)

Daniel Greenberg CB, Parliamentary Commissioner for Standards in the House of Commons and formerly Counsel for Domestic Legislation in the House of Commons (2016-2022)

Matt Hancock MP, Independent Member of Parliament for West Suffolk and formerly Secretary of State for Health and Social Care (2018-2021)

Dr Fu-Meng Khaw, National Director of Health Protection and Screening Services and Executive Medical Director at Public Health Wales

Eluned Morgan MS, Cabinet Secretary for Health & Social Care in the Welsh government

Northern Ireland Commissioner for Children and Young People

Northern Ireland Human Rights Commission

A Northern Ireland official working in Health Protection

Scottish Human Rights Commission

Senior officials in the Welsh government (provided comments in a personal capacity)

Senior members of the UK Health Security Agency

Oral evidence

Marie Anderson, Police Ombudsman for Northern Ireland

Lord Anderson, Crossbench Member of the House of Lords

Lord Bethell, Conservative Member of the House of Lords and formerly Parliamentary Under Secretary of State at the Department of Health and Social Care (2020-2021)

Lord Blencathra, Conservative Member of the House of Lords and formerly Chair of the House of Lords Delegated Powers and Regulatory Reform Committee (2017-2022)

Michael Clancy, Director of Law Reform at the Law Society of Scotland

Stephen Gibson, Chair of the Regulatory Policy Committee

Professors Hans Petter Graver, Professor of Law at the University of Oslo

Daniel Greenberg CB, Parliamentary Commissioner for Standards in the House of Commons and formerly Counsel for Domestic Legislation in the House of Commons (2016-2022)

Baroness Grey-Thompson, Crossbench Member of the House of Lords

Professor Aeyal Gross, Professor of Law in Tel Aviv University's Faculty of Law

Professor Eirik Holmøyvik, Professor of International, Constitutional and Human Rights Law at the University of Bergen

Sanchita Hosali, CEO of the British Institute of Human Rights

David Isaac CBE, Provost of Worcester College, Oxford and formerly Chair of the Equality and Human Rights Commission (2016-2020) (provided evidence in a personal capacity)

Lord Janvrin, Crossbench Member of the House of Lords and member of the Delegated Powers and Regulatory Reform Committee (provided evidence in a personal capacity)

Sir Bernard Jenkin MP, Conservative Member of Parliament and Chair of the House of Commons Liaison Committee

Sir Jonathan Jones, senior consultant in public and constitutional law at Linklaters LLP and formerly head of the UK Government Legal Department (2014-2020) (provided evidence in a personal capacity)

Professor Anna-Bettina Kaiser, Professor of Public Law and the Foundations of Law at Humboldt University Berlin

Dr Dean Knight, Associate Professor in Public and Government Law at Victoria University of Wellington

Professor Anna Katharina Mangold, Professor for European Law at the Europa-Universität Flensburg

Dr Brian McCloskey, Senior consulting fellow in the Global Health Programme at Chatham House and formerly Director of Global Health for Public Health England

Professor Susan McVie, Chair of Quantitative Criminology at Edinburgh Law School

David Melding, formerly Conservative Member of the Welsh Parliament (1999-2021)

Professor Peter Neyroud, Associate Professor in Evidence-based Policing at the University of Cambridge

Professor Johanne Poirier, Peter MacKell Chair in Federalism at McGill University

Dr Marco Rizzi, Associate Professor in health law and policy at the UWA Law School

Professor Emmanuel Slautsky, Professor of Public and Comparative Law at the Université libre de Bruxelles

Baroness Thornton, Labour Member of the House of Lords and formerly Shadow Spokesperson for Health (2018-2022)

Professor Adam Tomkins, John Millar Professor of Public Law at the University of Glasgow and formerly Conservative Member of the Scottish Parliament (2016-2021)

Written evidence

We have published all written evidence cited in the report, which can be viewed on the written evidence page of the Commission's [website](#).

The Committee on the Administration of Justice Northern Ireland (Appendix 1)

Dr Ronan Cormacain, Consultant Legislative Counsel (provided evidence in a personal capacity) (Appendix 2)

Crown Prosecution Service (Appendix 3)

Disability Action (Appendix 4)

Equality and Human Rights Commission (Appendix 5)

Sir Jonathan Jones senior consultant in public and constitutional law at Linklaters LLP and formerly head of the UK Government Legal Department (2014-2020) (provided evidence in a personal capacity) (Appendix 6)

Law Society of Scotland (Appendix 7)

Liam Laurence Smyth CB, Clerk of Legislation in the House of Commons (provided evidence in a personal capacity) (Appendix 8)

Professor Susan McVie, Chair of Quantitative Criminology at Edinburgh Law School (Appendix 9)

Professor Sir David Nabarro, Co-Director and Chair of Global Health at Imperial's Institute of Global Health Innovation and Special Envoy on Covid-19 for the World Health Organization (Appendix 10)

Northern Ireland Assembly (Appendix 11)

The Police Foundation (Appendix 12)

Scottish Police Federation (Appendix 13)

Secondary Legislation Scrutiny Committee (Appendix 14)

Dr Louise Thompson and Dr Alexandra Meakin, respectively Senior Lecturer at the University of Manchester and Lecturer in Politics at the University of Leeds (Appendix 15)

Professor Joe Tomlinson, Professor Simon Halliday and Dr Jed Meers, respectively Professor of Public Law, Professor of Socio-Legal Studies and Senior Lecturer in Law at the University of York (Appendix 16)

Welsh Parliament (Senedd Cymru) (Appendix 17)

The Women's Policy Group Northern Ireland (Appendix 18)



Independent Commission
on UK Public Health
Emergency Powers





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