



A: Introduction

1. The Court of Protection team has been asked to advise on a number of occasions as to the legal position in relation to testing for COVID-19, especially as testing (a) starts to be more generally available; and (b) is increasingly being rolled out as mandatory in certain settings.
2. What follows is a general discussion, as opposed to legal advice on the facts of individual cases, which the team can provide. It primarily relates to the position in England in relation to those aged 18 and above; specific advice should be sought in respect of Wales and those under 18.

B: The context

3. Testing is seen as a key part of the Government's strategy to bring COVID-19 under control. There are a number of contexts in which testing¹ may be relevant:
 - a. For clinical purposes, to determine whether a patient has or does not have COVID-19, for purposes of deciding how to address their symptoms;
 - b. In the community, to determine whether a person has COVID-19 and hence whether they may be required to self-isolate, either within (for instance) a supported living placement, or within their own home.

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Disclaimer: This document is based upon the law as it stands as at May 2020; it is intended as a guide to good practice, and is not a substitute for legal advice upon the facts of any specific case. No liability is accepted for any adverse consequences of reliance upon it.

The picture at the top, "Colourful," is by Geoffrey Files, a young man with autism. We are very grateful to him and his family for permission to use his artwork.

¹ We do not address here testing of professionals who may have been exposed to COVID-19.

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- c. Prior to entry to an institution, to determine whether the person has COVID-19 and hence whether they may be required to go into isolation upon arrival. In particular:
- (i) Government policy is to test all residents prior to admission to care homes. As the COVID-19 Adult Social Care Plan³ stated on 16 April 2020 (paragraph 1.30): “[t]his will begin with all those being discharged from hospital and the NHS will have a responsibility for testing these specific patients, in advance of timely discharge. Where a test result is still awaited, the patient will be discharged and pending the result, isolated in the same way as a COVID-positive patient will be.”
 - (ii) In mental health, learning disability, autism, dementia and specialist inpatient facilities, NHS England’s policy is that “[f]ollowing the expansion of testing capacity, and to support the effective management of COVID-19 in healthcare settings, testing should be expanded to all individuals admitted to inpatient settings. This includes preparing to cohort patients as possible COVID-19 cases who need to be admitted while they await a test result.”⁴
- d. In an institution, whether that be a hospital or a care home, to determine whether a person has or does not have COVID-19 and hence whether they should be required to isolate themselves so as to secure against the risk that they transmit what is a highly contagious virus. The Government has confirmed that where an outbreak of COVID-19 has occurred in a care home, all symptomatic residents should be tested.⁵
4. In many cases, the person in question will actively want testing, and have capacity to consent to it. In supporting a person to make the decision whether or not to be tested, it may help to have reference to our [capacity assessment guide](#). As that guide makes clear, it is important to identify the information that it is relevant to the decision in question; it is clear – we suggest – that that information must include the consequences if the test is positive. Those consequences will vary from setting to setting, but will in all cases mean that the person will be required to self-isolate for a period of time (most likely 14 days). In terms of the test itself, it may also – in some circumstances⁶ – be useful to make use of this [easy-read guide](#) to having swabs taken.
5. However, what happens if the person (1) does not have capacity to consent to be tested; or (2) has capacity to consent to be tested but refuses to be? We address each in turn.

³ [DHSC: COVID-19: our action plan for adult social care](#) (16 April 2020).

⁴ [NHS England: Supporting patients of all ages who are unwell with coronavirus \(COVID-19\) in mental health, learning disability, autism, dementia and specialist inpatient facilities](#) (updated 30 April 2020).

⁵ [DHSC: COVID-19: our action plan for adult social care](#) (16 April 2020), paragraph 1.27.

⁶ Not least depending upon the type of test being used.

C: Lack of capacity to consent

6. If the person cannot consent, then, unless there is a health and welfare attorney or deputy who can consent on their behalf,⁷ the relevant professionals will have to decide whether they reasonably believe that to test the person is in their best interests.⁸
7. There cannot be a blanket decision that testing is in the best interests of a group of residents or patients, as this would be contrary to the requirement of the MCA 2005 that it is the best interests of that particular person at that particular time which are determinative.⁹ However, with one exception and bearing in mind that it really does depend on the circumstances, it is likely that a test would be in the person's best interests for the following reasons:
 - a. In many cases, it may be possible to identify that the person, were they able to, would consent to testing if they had capacity, in which case the decision is an easy one, as there would be an alignment between 'what P would have done' and the outcome that would be in their best interests;¹⁰
 - b. In other cases, it might well be clear that the person would wish to be tested so as to know whether they would have to be isolated upon arrival into a care home. More generally, testing positive or negative will determine which care arrangements are appropriate to meet an individual's needs which most people would want to know;
 - c. Also, very often, if the person does not have a test, there will be consequences for them in terms of their residence and care. For instance, perhaps it may make a difference as to where they can be accommodated, or perhaps their regular carers will refuse to work with them. Clearly such circumstances will need to be weighed in the best interests balance;
 - d. The best interests checklist provides for 'other factors that he would be likely to consider if he were able to do so' which might, depending on the person, include the effect the decision will have on those around them.¹¹ We suggest that, in asking whether the person would have

⁷ If the attorney or deputy refuses, then there will be a serious question mark as to whether they are acting – as they are required to – in the best interests of the person; at that point, unless they change their stance, an application to the Court of Protection will be required.

⁸ We do not consider that the question of advance decisions will be relevant here. It is difficult to see that a test for COVID-19 would fall to be considered a 'medical treatment' for purposes of s.24 MCA 2005. In any event, even if a person did purport to make an advance decision to refuse a COVID-19 test, then they would be in the same position, legally, as a capacitous individual refusing to undergo a test: as discussed in the next section, such capacitous refusal is not a bar to testing.

⁹ See *Aintree v James* [2013] UKSC 67 at paragraph 39 (all case references here are hyperlinked to case-law summaries).

¹⁰ See *Briggs v Briggs (No. 2)* [2016] EWCOP 63.

¹¹ Best interests might include "*altruistic sentiments and concern for others*": see Report on Mental Incapacity (1995) Law Com No 231 at para 3.31; see also *Aintree v James* [2013] UKSC 67 at [24].

consented, it will frequently be relevant to consider whether they would see themselves as a 'responsible citizen'¹² more broadly, and hence would wish to ensure that it was known whether or not they had COVID-19 so as to enable others to be protected.

8. Even if it is clear that the person would **not** wish to be tested, the best interests test is – ultimately – not a pure 'substituted judgment' test, and it is legitimate to take into account other factors, including the potential that the person might cause a risk of harm to others,¹³ in deciding whether to override the person's known wishes. On the basis that it is rarely sensible to say 'never,' we cannot rule out that there may be a situation where there is simply no realistic prospect that the individual will come into contact with anyone (or least no-one not properly equipped with PPE), such that their risk of transmission of COVID-19 is non-existent. However, in general, we suggest that it is legitimate for the relevant professionals to take into account the public health risks in play in determining best interests even in the face of a known desire not to undertake the test.
9. Although the test may be uncomfortable and invasive, in many cases it will be possible to carry out the test in such a way that it cannot sensibly be said that any restraint of the individual will be required. If restraint – which would not necessarily need to involve physical force – is required, then consideration will have to be given as to whether the conditions in s.6 MCA 2005 are met. We note that the conditions include a specific focus upon whether the act in question is necessary to prevent harm to the person¹⁴ (as opposed to others). On one view, this would mean that it would be improper to restrain the person if the primary reason to test them were for the protection of others. In most cases, we consider that it will be possible to advance sufficient reasons related to the person's own interests to satisfy the s.6 test. However, if it is clear that (1) the person will resist requiring the use of force necessary to bring about the test; and (2) the primary reason for testing is for the protection of others (which would be extremely rare), we suggest that consideration should be given either:
 - a. To invoking the public health powers set out in the next section; or
 - b. To making an application to the Court of Protection.
10. The one caveat to the position set out at paragraph 7 above is where there is proper reason to consider that the process of carrying out the test, itself, would cause the person serious distress or other harm – for instance if they cannot tolerate a swab being taken. In such a case, and if there is no other way of securing testing in an acceptable fashion, we **strongly** advise seeking legal

¹² See, for the idea of being a responsible citizen, *SSHD v Sergei Skripal; SSHD v Yulia Skripal* [2018] EWCOP 8 and the MCA Code of Practice at paragraphs 5.47-48.

¹³ See e.g. *Birmingham CC v SR* [2019] EWCOP 28 at paragraph 41.

¹⁴ Section 6(2).

advice, as this is a situation in which – at a minimum – an approach to the Court of Protection is required.¹⁵

11. We have been asked whether testing for COVID-19 constitutes serious medical treatment for purposes of s.37 MCA 2005, which would mean that it would be necessary for any NHS body carrying out the test¹⁶ to instruct an IMCA if the person is ‘unbefriended.’ It is not immediately obvious that a test in fact constitutes ‘medical treatment,’ but if it does then, ordinarily, it is not obvious that it would fall within the definition of **serious** medical treatment for the purposes of the MCA and the associated regulations. However, if there is a specific reason to consider that the very process of carrying out the test (for instance to overcome any resistance on the part of the person) would be likely to “involve serious consequences for the patient” or “there is a fine balance between its benefits to the patient and the burdens and risks it is likely to entail”, then it may be that an IMCA should be instructed. In any event, however, and as set out above, this is a situation in which it is suggested that an approach to the Court of Protection is likely.
12. We should note that everything that we have said above could apply in any setting – including the inpatient psychiatric setting where the person is detained under the MHA 1983.
13. There is a very important corollary to our suggestion that – in the majority of cases – it can be said that testing for COVID-19 is in the best interests of the person – ‘P’. That is, that if the test is **positive**, then the steps that are then taken to isolate P are taken in such a way that reflects the principle of least restriction and minimises the impact of any restrictions upon him or her.
14. In some cases, these steps may amount to a deprivation of their liberty and, if they do, lawful authority must be obtained if it is not already in place. The DHSC’s Emergency MCA and DoLS guidance (9 April 2020) addresses this,¹⁷ and, importantly, emphasises (at paragraph 30) that: “(d) *If the reasons for the isolation are purely to prevent harm to others or the maintenance of public health, then [Public Health Officers] powers should be used.*” In other words, the DHSC is making clear, a DoLS authorisation could not be used in such a situation, and the powers under the Coronavirus Act 2020 would have to be used to bring about the lawful deprivation of the person’s liberty arising from their isolation.

¹⁵ See the Serious Medical Treatment Guidance issued by the Vice-President in January 2020 ([2020] EWCOP 2).

¹⁶ Not every test will be carried out by NHS bodies. There is therefore a gap in the law in relation to a situation where the test is to be carried out by someone else as the duty to instruct an IMCA would not arise.

¹⁷ But does not address in terms the question of whether, if a person is already lawfully deprived of their liberty (under a DoLS authorisation or under the Mental Health Act 1983), the additional restrictions upon them will amount to an **additional** deprivation of their liberty requiring separate consideration. Alex has discussed this here; note that if the person is already subject to the MHA 1983, they could not be subject to a separate DoLS authorisation providing for their isolation (by operation of Sch 1A to the MCA 2005).

D: Capacitous refusal

15. We start this section with two caveats:

- a. At the time of writing, no guidance has been made publicly available as to how those discharging functions under the Coronavirus Act 2020 are to do so. We are aware that guidance has been produced (presumably under paragraph 21 of Schedule 21 to the Act) for Public Health Officers, but this is not in the public domain.
- b. We have been unable to find any guidance from either the Government or NHS-England as to whether they consider that the powers under the Coronavirus Act 2020 extend to compelling an individual to undergo testing. In [guidance](#) most recently updated on 30 April 2020 relating (essentially) to psychiatric facilities, NHS England provides that

“Case-by-case reviews will be required where any patient is unable to follow advice on containment, isolation and testing. Providers should decide the appropriate use of the relevant legal framework for each case, with support from medicolegal colleagues as required. Non-concordance with isolation represents a clear and obvious risk to other people. This should, in the first instance, be conveyed to the patient, helping them to understand the clinical reasons for self-isolation and testing.”

The guidance then suggests: “[f]or further detail, see legal guidance,” but [the legal guidance](#) does not, in fact, address the question of how to manage a capacitous patient who refuses to be tested.

16. The position is therefore – and unhelpfully – not as clear as it could be.

17. Schedule 21 provides public health officers, constables and (in some circumstances) immigration officers with the means to enforce public health restrictions, including returning people to places that they have been required to stay. Where necessary and proportionate, constables and immigration officers can direct individuals to attend, remove them to, or keep them at suitable locations for screening and assessment. If a person is at a place suitable for screening and assessment, paragraph 10 of Schedule 21 provides that a public health officer¹⁸ may (a) require the person to be screened and assessed, and (b) impose other requirements on the person in connection with their screening and assessment.

¹⁸ Defined in paragraph 3(2) of Schedule 21.

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18. Those requirements may (in particular) include requirements to provide a biological sample or to allow a healthcare professional to take a biological sample by appropriate means.¹⁹ Failure to comply with such a direction without reasonable excuse constitutes a criminal offence.²⁰
19. In most cases, being directed (and, as required,²¹ being informed of the potential consequences of not doing so) will be sufficient to bring about compliance. But what about the position where the person **refuses** to comply?
20. We suggest that it is likely to be unlawful to use force to bring about testing in most situations absent recourse to court. The Coronavirus Act 2020 specifically envisages the use of reasonable force in relation to the operation of powers under Schedule 21, but only by a constable or immigration officer in the exercise of a power conferred by the Schedule²² and a constable or immigration officer cannot carry out testing or obtain a biological sample. Whilst a constable or immigration officer could be present at or outside the testing room to ensure the individual does not abscond from the room, it is difficult to see how they could themselves lawfully deploy reasonable force to bring about the testing itself.
21. We further suggest that it would be challenging to bring the situation within the "*general power* [which exists at common law] *to take such steps as are reasonably necessary and proportionate to protect others from the immediate risk of significant harm.*"²³ Whilst COVID-19 undoubtedly has the potential to cause significant harm, it is not immediately obvious that a failure to consent to a test by a person would give rise to an immediate risk to others in the same way (say) as restraining an individual about to assault another.²⁴ It would certainly be difficult to see how the common law powers could be relied upon if the person is not in close proximity to others and there is no likelihood of them being in such proximity.
22. There may, but we note only may, be a difference if the person is detained under the MHA 1983:
- a. If the person has capacity to, and does, refuse to be tested,²⁵ we note that it would be difficult, in general, to see the basis upon which testing for COVID-19 could be said to be medical

¹⁹ Paragraph 10(2).

²⁰ Paragraph 23(1)(a).

²¹ Paragraph 11(2)(b).

²² Paragraph 20(4).

²³ *Munjaz v Mersey Care National Health Service Trust & Ors* [2003] EWCA Civ 1036 at paragraph 46 per Lady Justice Hale.

²⁴ It might be easier to make this argument if the person was symptomatic, but given that, at that point, the person should be being isolated on the basis of their symptoms alone, it is still a stretch to argue that the failure to consent to the test, itself, is causing the immediate risk.

²⁵ The mere fact of detention under the MHA 1983 does not mean that they have, or lack, capacity to consent – this must be assessed individually.

treatment for a mental disorder so as to bring it within the scope of s.63 MHA 1983²⁶ (which, in turn, would give the power to use reasonable force to enable its administration);

- b. However, powers of detention bring with them powers of control.²⁷ These might – potentially – be seen as stretching to the use of reasonable force to bring about testing for COVID-19, especially if the alternative is requiring the patient be isolated from others to a degree that could be seen as more restrictive than the short-term act of bringing about the test.

23. The position, however, is not straightforward, and we suggest that legal advice is sought wherever the negotiating skills of the professionals involved (including, where relevant, the Public Health Officer) are not able to bring about an agreement to undergo the test. There are, at that point, two potential routes open:

- a. An application could be made to the magistrates' court under s.45G Public Health (Control of Diseases) Act 1984 for an order that the person "submit to medical examination."²⁸ Breach of that order is an offence.²⁹ There is, however, no ability for the magistrates to empower a person to enforce that order by force, so this would not necessarily add much save for the added weight of a court order;
- b. An application could be made to the High Court for an order under its inherent jurisdiction specifically to bring about the use of force to test the individual, there being no statutory provision governing this situation. It seems to us that, in principle, and especially given the expansive approach that has been adopted by the High Court to this jurisdiction recently,³⁰ such an order could be made even in respect of a capacitous adult refusing to undergo a test.³¹ It is very likely that the measures taken to enforce the test would amount to a deprivation of liberty,³² but such could be justified by reference to Article 5(1)(e) ECHR which enables detention for the prevention of the spreading of infectious diseases.

²⁶ We are well aware of the sometimes heroically broad interpretation of s.63. We could – just – envisage a situation in which, if the person were to receive a different treatment for their mental disorder dependent upon the outcome of the COVID-19 test, and if their refusal to undergo the test was a manifestation of their mental disorder, it could be brought within the scope of s.63, but we think that this is a distinct stretch.

²⁷ See *Munjaz* at paragraph 40.

²⁸ Section 45G(2)(a). The evidential requirements are set out in s.45G(3) and amplified in Regulation 4 of the [Health Protection \(Part 2A Orders\) Regulations \(SI 2010/658\)](#).

²⁹ Section 45O.

³⁰ As to which, see our [guidance note](#).

³¹ And we anticipate that the High Court would describe that the adult's refusal was in some way infected by irrationality so as to render it – if not incapacitous – open to doubt. As a matter of practical reality, and even if it should not be the case, we anticipate that this is more likely to be the case where the person is detained under the MHA 1983.

³² See the Commission decision in *X v Austria* (8278/78, decision of 13 December 1979) in which the Commission held that "enforcing a blood test on a person is a deprivation of liberty even if this deprivation is of very short length" (paragraph 2).

F: Useful resources

24. Useful free websites include:

- www.39essex.com/resources-and-training/mental-capacity-law – database of guidance notes (including as to capacity assessment) case summaries and case comments from the monthly 39 Essex Chambers Mental Capacity Law Report, to which a free subscription can be obtained by emailing marketing@39essex.com.
- www.mclap.org.uk – website set up by Alex with forums, papers and other resources with a view to enabling professionals of all hues to ‘do’ the MCA 2005 better. It has a specific [page](#) of resources relating to COVID-19 and the MCA 2005.
- www.mentalhealthlawonline.co.uk – extensive site containing legislation, case transcripts and other useful material relating to both the Mental Capacity Act 2005 and Mental Health Act 1983. It has transcripts for more Court of Protection cases than any other site (including subscription-only sites), as well as an extremely useful discussion list.
- www.scie.org.uk/mca-directory/ - the Social Care Institute of Excellence database of materials relating to the MCA.

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