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Public Health Law During the COVID-19 Pandemic in Ireland

Editors:

Alan Eustace, Sarah Hamill, Andrea Mulligan

A Public Policy Report of the

COVID-19 LEGAL OBSERVATORY

School of Law, Trinity College Dublin

<https://www.tcd.ie/law/tricon/covidobservatory/>

Harnessing Trinity's Collective Expertise for the Greater Good

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ABOUT THE COVID-19 LEGAL OBSERVATORY

Harnessing Trinity's Collective Expertise for the Greater Good

COVID-19 presents an unprecedented public health crisis. New laws were introduced at a rapid pace on the basis of compelling public health and economic concerns. Universities play a vital role in ensuring that laws are effective but also that rights and fundamental freedoms are protected insofar as possible, even in emergency circumstances.

To address this, the COVID-19 Law and Human Rights Observatory¹ of Trinity College Dublin engages in research across the full range of Ireland's legal response to COVID-19. Academics in the Observatory the work with research assistants to identify, aggregate, contextualise, explain, and analyse the legal components of Ireland's COVID-19 response. We aim both to inform the public and to provoke public debate.

The Observatory's Blog² publishes academic commentary on Ireland's legal response to COVID-19 as it evolves. The Observatory also provides an unofficial consolidated version of Ireland's regulatory response to COVID-19, as well as a range of official guidance documents. This is the fourth public policy report of the Observatory. The first report, *COVID-19: Public Policy Report on Supporting Individuals* examined how public policy could support individuals against the backdrop of COVID-19;³ the second report, *Ireland's Emergency Powers During COVID-19* was completed on behalf of the Irish Human Rights and Equality Commission and explored how Ireland deployed emergency powers during the pandemic;⁴ the third report, *A Right to Disconnect: Irish and European Legal Perspectives*, explored

¹ <https://www.tcd.ie/law/tricon/covidobservatory/index.php>.

² <https://tcdlaw.blogspot.com/>.

³ Deirdre Ahern and Suryapratim Roy, (eds), 'Law and Policy Responses to Covid-19 in Ireland: Supporting Individuals, Communities, Businesses, and the Economy' (Trinity Covid-19 Observatory, November 2020) <[Covid-19 Public Policy Report.pdf \(tcd.ie\)](#)> (accessed 19 April 2021)

⁴ Conor Casey, Oran Doyle, David Kenny and Donna Lyons, *Ireland's Emergency Powers During the Covid-19 Pandemic* (IHREC 2021) <<https://www.ihrec.ie/documents/irelands-emergency-powers-during-the-covid-19-pandemic/>> accessed 25 June 2021.



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the need for a right to disconnect against the backdrop of a rise in remote-working during the pandemic.⁵

The work of the Observatory is supported by the Trinity College Dublin COVID-19 Response Fund.

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⁵ Mark Bell, Marta Lasek-Markey, Alan Eustace and Thomas Pahlen, 'A Right to Disconnect: Irish and European Perspectives' (Trinity Covid-19 Observatory, May 2021) < <https://www.tcd.ie/law/2020.21/Final%20RTD%20report.pdf>>



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Contributors to this Report

Mark Bell

Regius Professor of Laws and Fellow, Trinity College Dublin and member of the Trinity Covid-19 Law and Human Rights Observatory.

Patricia Brazil

Averil Deverell Lecturer in Law, Trinity College Dublin, barrister and member of the Trinity Covid-19 Law and Human Rights Observatory.

Conor Casey

Lecturer in Law, University of Liverpool and member of the Trinity Covid-19 Law and Human Rights Observatory.

Heather Conway

Professor, School of Law, Queen's University Belfast.

Mel Cousins

Visiting research fellow, School of Social Work and Social Policy, Trinity College Dublin and member of the Trinity Covid-19 Law and Human Rights Observatory.

Sarah Curristan

PhD candidate, School of Law, Trinity College Dublin.

Oran Doyle

Professor in Law, Trinity College Dublin and director of the Trinity Covid-19 Law and Human Rights Observatory.

Niamh Egleston

Graduate of Trinity College Dublin and London School of Economics.

Alan Eustace

Scholar and PhD candidate, School of Law, Trinity College Dublin and member of the Trinity Covid-19 Law and Human Rights Observatory.



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Sarah Hamill

Assistant Professor in Law, Trinity College Dublin and member of the Trinity Covid-19 Law and Human Rights Observatory.

David Kenny

Associate Professor in Law, Trinity College Dublin and member of the Trinity Covid-19 Law and Human Rights Observatory.

Andrea Mulligan

Assistant Professor in Law, Trinity College Dublin, barrister and member of the Trinity Covid-19 Law and Human Rights Observatory.

Sara-Jane O'Brien

Adjunct Assistant Professor in Law, Trinity College Dublin and barrister.

David Prendergast

Assistant Professor in Comparative Law, Trinity College Dublin and member of the Trinity Covid-19 Law and Human Rights Observatory.

Mary Rogan

Associate Professor in Law, Trinity College Dublin and member of the Trinity Covid-19 Law and Human Rights Observatory.

Sophie van der Valk

PhD candidate, School of Law, Trinity College Dublin.

Conor White

Graduate of University College Dublin and University of Cambridge, and member of the Trinity Covid-19 Law and Human Rights Observatory.



ABOUT THE COVID-19 LEGAL OBSERVATORY	i
Contributors to this Report.....	iii
Executive Summary	7
Introduction	9
Chapter I: Public Health Governance: The Role of NPHET	11
NPHET’s Structure and Decision-making process.....	11
NPHET’s influence on public health decision making.....	13
Case Study: December 2020-January 2021	21
Criticisms of NPHET-government relationship in pandemic response	25
Conclusions.....	28
Chapter II: Restrictions to Control Spread of the Virus.....	29
Introduction.....	29
Criminal justice and public health approaches.....	30
Restrictions adopted during the Pandemic	31
Enforcement in practice	36
Minimal punishment, maximal compliance?.....	39
Conclusions.....	42
Chapter III: COVID-19, Public Health and Funerals in Ireland	43
Initial Restrictions on Funerals	43
‘COVID-Safe’ Funerals.....	45
Broader Public Health Impacts	46
Chapter IV: COVID-19 and the Prison System in Ireland.....	47
Introduction.....	47
Protecting Rights in Prison During the COVID-19 Pandemic	48
Changes to Prison Regimes.....	49
Changes to the execution of sentences.....	56
Vaccination	61
Oversight, transparency and information sharing.....	63
Conclusions.....	66
Chapter V: Direct Provision.....	68
Introduction.....	68
Direct provision and the pandemic	69
Pandemic Unemployment Payment.....	71
Reforming direct provision	72
Conclusions.....	74



Chapter VI: Income maintenance for those unable to work for health-related reasons	75
Overview of the Irish sickness benefit system.....	75
The response to the COVID crisis.....	76
Impact of COVID-19	80
Conclusions	80
Chapter VII: Remote Working Support as Public Health Policy Measures	83
Context	83
Financial support for PAYE workers.....	83
Financial support for the self-employed.....	85
Financial Supports for Third-Level Students	86
Infrastructure and public services	89
Indirect supports	92
Conclusions.....	93
Chapter VIII: Vaccines	96
Vaccine Prioritisation.....	96
Mandatory Vaccination	108
Vaccines Requirements and Employment	113
Chapter IX: Public/Private Healthcare in a Pandemic.....	119
Healthcare in Ireland	119
The First Wave of COVID-19	121
Subsequent waves of COVID-19	122
Analysis and Conclusions	125
Chapter X: Ireland’s Approach to Counting Deaths from COVID-19.....	129
The Importance of Death Tolls in a Pandemic.....	129
Death Notification and Registration in Ireland.....	131
Reporting and Counting COVID-19 Deaths.....	134
Proposed Reforms to the Deaths Registration Process.....	138
Conclusions.....	139
DISCLAIMER	141



Executive Summary

The COVID-19 pandemic represented and represents an unprecedented public health crisis. In Ireland, as in much of the world, this has resulted in the need to introduce significant and stringent public health measures in an attempt to control the pandemic. This report seeks to analyse the Irish public health law responses and public health governance during the pandemic.

In this report, contributors examine the role of the National Public Health Emergency Team (NPHE) and the government in decision-making during the pandemic, as well as the specific responses which the government introduced to minimise transmission including the limits which were imposed on funerals and the broader impacts of such restrictions. Special attention is given to the measures adopted to reduce transmission amongst persons in prison and in direct provision, and the social welfare supports which were introduced to encourage people to work from or stay at home. The report also examines the roll-out of COVID-19 vaccines and considers the likely legality of mandatory vaccination. The last two chapters deal with two aspects of managing the pandemic: the role that private hospitals played during the pandemic, and the legal regime for reporting deaths in Ireland.

Overall, one key finding of this report is a significant lack of transparency. From who actually made decisions during the pandemic, to whether certain public health measures were actually legally enforceable, to the sources and reliability of reported deaths from COVID-19, this report identifies multiple instances where transparency over both how decisions were made and the extent of particular measures was lacking. Transparency and clarity are key aspects of public health governance and one of the key recommendations of this report is the need for more transparency.

On the basis of the analysis in the report, we make the following recommendations:

1. We recommend that the government clarify the relationship between the government and NPHE and ensure democratic oversight of public health measures.
2. We recommend that when the government introduces public health measures they should, as far as possible, avoid relying on a criminal justice-based approach and the government should be clear about which measures attract or do not attract criminal sanctions and why.



Trinity College Dublin

Coláiste na Tríonóide, Baile Átha Cliath

The University of Dublin

3. We recommend that the government should make provision for professional support to be provided to bereaved families who lost loved ones during the pandemic.
4. We recommend that the prison service should make public, in a timely fashion, the measures adopted by the during the pandemic.
5. We recommend that the prison service should make sure that prisoners are provided with timely information about the pandemic and future public health crises.
6. We recommend that the government should end direct provision without delay.
7. We recommend that the government should introduce a statutory sick pay scheme.
8. We recommend that the government should allow for tax deductions for remote working to be offset against PAYE on an ongoing basis rather than offset at the end of each tax year
9. We recommend that the government should place moratoria on gas, electricity, phone and internet disconnections on a statutory footing for the duration of any public health crisis and strict price controls should also be adopted.
10. Given the relative weaknesses of Students' Unions, we recommend the government create a Higher Education Ombudsman to support third-level student welfare, especially around remote working issues but also to consider their safety, health, and welfare on campus.
11. We recommend that the government extend eligibility for the ICT scheme and the €250 direct payment to non-EEA students.
12. We recommend that the government should provide additional supports for childcare during the pandemic and, moving forward, should make childcare expenses tax deductible or subsidise them.
13. We recommend that the government should not make vaccinations mandatory unless there is clear evidence of the harm caused by individuals refusing vaccination.



14. We recommend that the government urgently address the lack of capacity in Irish public hospitals.
15. We recommend that where private hospitals are involved in providing public services, the HSE should be clear about the costs of such outsourcing.
16. We recommend that the proposed reforms to registering deaths should also, in order to ensure timely data, preclude a funeral or cremation from taking place until a death is registered.

Introduction

Since June 2020, the Trinity Covid-19 Law and Human Rights Observatory has provided commentary on the public health law and public health governance aspects of the pandemic.¹ The pandemic has seen marked increases in the scholarship on and about public health law and governance as academics and policymakers from around the world struggle to manage repeated waves of COVID-19. The pandemic has shed light on both strengths and shortcomings of public health in Ireland. Already reforms are being considered to the registration of deaths, direct provision, and remote working as a result of the experiences during the pandemic. Yet given the speed at which the pandemic spread around the world, some public health measures were perhaps heavy-handed. This is understandable but, as this policy report makes clear, lessons from the various waves of the pandemic were not always learned and applied to subsequent waves.

This policy report analyses the public health measures adopted in Ireland, as well as how existing public health measures were adapted to the pandemic. So too does it consider public health measures which may be needed in the future, such as mandatory vaccination, and advises on the best approach

¹ See, eg, Róisín Costello, 'Private Policy, Public Health and the Balance of Power during COVID-19' (Trinity Covid-19 Observatory blog, 17 July 2020) <https://tcclaw.blogspot.com/2020/07/private-policy-public-health-and.html>; Mark Bell, 'No Jab, No Job? Vaccine Requirement and Anti-Discrimination Law' (Trinity Covid-19 Observatory blog, 25 March 2021) <https://tcclaw.blogspot.com/2021/03/no-jab-no-job-vaccine-requirements-and.html>; Sophie van der Valk and Mary Rogan, 'Facemasks in Prison During Pandemic – How to Balance Safety, Security and Rights?' (Trinity Covid-19 Observatory blog, 17 March 2021) < <https://tcclaw.blogspot.com/2021/03/facemasks-in-prison-during-pandemic-how.html>>; Patricia Brazil, 'Direct provision and COVID19' (Trinity Covid-19 Observatory blog, 11 August 2020) < <https://tcclaw.blogspot.com/2020/08/direct-provision-and-covid19.html>>; Heather Conway, 'COVID-19 and the Funerals in Ireland: A Strange New Normal' (Trinity Covid-19 Observatory blog, 4 August 2020) < <https://tcclaw.blogspot.com/2020/08/covid-19-and-funerals-in-ireland.html>>.



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to adopt for ongoing and future measures to suppress the pandemic moving forward. A recurring theme in this report is the lack of transparency around how decisions are made and a lack of accountability, whether in worrying gaps over democratic oversight of public health guidance or in changes introduced in prisons to protect prisoners. Some of the recommendations in this report – such as ending direct provision, providing subsidised childcare, making remote working easier, and providing an adequate system of universal healthcare – were already being called for prior to the pandemic. The pandemic has given calls for these reforms fresh impetus as well as illustrating the need for other reforms as a matter of urgency.

As with previous reports, this Report deals with measures which have changed, often quickly, multiple times throughout the COVID-19 pandemic. The bulk of these chapters were submitted in early April 2021 and so the analysis here is complete up until that time.

We would like to thank our colleagues for contributing to this report, and we would also like to thank our research assistants Cian Henry and Kate Heffernan for their assistance.

Alan Eustace, Sarah Hamill, and Andrea Mulligan



Chapter I: Public Health Governance: The Role of NPHE

Conor Casey, David Kenny and Andrea Mulligan*

Before turning to substantive analysis of the public health decisions that were made in the course of the COVID-19 pandemic, we consider the way in which those decisions were made: the question of *how* the pandemic was governed. When the pandemic struck in spring 2020 a new pandemic decision-making structure was established, at the centre of which was the National Public Health Emergency Team for COVID-19 (NPHE). The importance of NPHE cannot be understated. It has, since the start of the pandemic, been one of the most visible aspects of the State's public health response to the pandemic. It is the primary means by which the State takes expert public health advice on pandemic response measures. It has also, on some accounts, become a *de facto* primary *decisionmaker*—rather than merely an advisor—in the pandemic response.

Public health literature and guidance is in agreement that transparency and accountability are central aspects of good pandemic governance.¹ Familiar aspects of the rule of law, these principles take on a special importance where a government is engaged in making complex, high-stakes decisions that must be informed by rapidly evolving scientific evidence, under extreme time pressure. The WHO comments in this context that transparency requires that decision-makers publicly explain the basis for decisions in accessible language, while acknowledging uncertainties where they arise. Accountability requires both that the public know who is responsible for making decisions, and how they can challenge decisions with which they disagree.²

NPHE's Structure and Decision-making process

It is a statutory requirement that the Minister for Health consults the Chief Medical Officer (CMO) in respect of the making of Regulations under the Health Act. The CMO leads NPHE, which was set up by the Minister for Health in January 2020. NPHE is composed of medical experts from a diverse

* One of the authors was a member of the Pandemic Ethics Advisory Group. All views expressed here are the views of the chapter authors and do not represent the former group or any of its other members.

1 World Health Organisation, *Guidance for Managing Ethical Issues in Infectious Disease Outbreaks* (WHO 2016); Nuffield Council on Bioethics Webinar, 'COVID-19 and Policy Making: the Role of Public Engagement and Deliberation' (15 May 2020); World Health Organisation, *Considerations for Quarantine of Individuals in the context of Containment for Coronavirus Disease (COVID-19)* (WHO 2020).

2 WHO, *Guidance for Managing Ethical Issues in Infectious Disease Outbreaks* (n 1) 16.



range of state bodies as well as others drawn from academia who have relevant experience in health and/or other matters.³ Many of its members are drawn from State health authorities such as the Department of Health, Health Service Executive, Health Protection Surveillance Centre, Health Information and Quality Authority, Health Products Regulatory Authority. There are, at the time of writing, 38 members. At the start of the Pandemic, there were various advisory subgroups to compliment the core Team, including an Expert Advisory Group and various subgroups including: an Acute Hospital Preparedness Subgroup, a Behavioural Change Subgroup, an Irish Epidemiological Modelling Advisory Group, a Pandemic Ethics Advisory Group, and a Vulnerable People Subgroup. In November 2020, it emerged that the Expert Advisory Group and almost all subgroups had been disbanded in the summer of 2020. The Department of Health apparently took on many functions of these groups. Only the Modelling Advisory group remains.⁴

NPHE's terms of reference provide that its core responsibilities are to:

- Oversee and provide direction, guidance, support and expert advice across the health service and the wider public service, for the overall national response to Coronavirus, including national and regional and other outbreak control arrangements;
- Consider the most up to date national and international risk assessments and consider any implications for the national response;
- Liaise with relevant organisations and stakeholders, to include other Government departments, statutory and voluntary agencies, international bodies and the relevant regulators;
- Direct and ensure an effective communications system at local, regional and national levels.⁵

It is, fundamentally, an advisory body: it has no juridical role in the making of laws or the issuing of *official* public health guidance. It operates by consensus, and makes its decisions/recommendations as

3 Martin Wall and Jennifer Bray, 'Questions raised over transparency of public health team' *The Irish Times* (25 April 2020) <<https://www.irishtimes.com/news/ireland/irish-news/questions-raised-over-transparency-of-public-health-team-1.4237581>> accessed 25 June 2021.

4 Paul Cullen, 'Covid Advisory Groups Shut as Work "Realigned" into Departments' *The Irish Times* (4 November 2020) <<https://www.irishtimes.com/news/health/covid-advisory-groups-shut-as-work-realigned-into-departments-1.439923>> accessed 25 June 2021.

5 Department of Health, 'National Public Health Emergency Team (NPHE) for COVID-19: Terms of Reference' (11 February 2020) <<https://www.gov.ie/en/collection/691330-national-public-health-emergency-team-covid-19-coronavirus/>> accessed 19 November 2020.



a Team, on a collective basis.⁶ Directly after its meetings, it sends its recommendations to the Minister for Health, generally by way of a letter, which the Minister then typically presents to Cabinet if executive or legislative action is needed on foot of these.⁷ NPHET states that it is committed to transparency and will communicate its decisions publicly and provide media briefings.

In September 2020, as a new wave of restrictions were being introduced, the Government announced a sort of filtering process for NPHET recommendations and advice.⁸ A new group of civil servants, chaired by the Secretary General to the Government, would meet following NPHET advice. According to reporting in *The Irish Times*, this group was designed to complement NPHET's epidemiological/medical expertise by providing 'advice to Government on the strategic economic and social policy responses to the management of the disease and to consider the NPHET advices'⁹ It was envisaged the group would add expertise and additional supervision to NPHET advice where it lacked particular knowledge, e.g. 'in areas such as sports'. It also served for these recommendations to 'be brought back within the political realm'.¹⁰ There has not been a great deal of reporting about the operation of this group in practice.

NPHET's influence on public health decision making

The influence of NPHET in shaping Ireland's public health response has been the subject of some scrutiny. The relationship between the government and NPHET—and the locus of power in that relationship—is not always entirely clear. Whatever the *precise* nature of that relationship, it is fair to say, however, that NPHET's influence is undoubtedly vast. While it is of course appropriate that the public health response be led by expert advice, there are accountability issues that arise the more *de facto* power is vested in technocratic public health advisors and away from the political executive democratically accountable to the Dáil and electorate.

6 Department of Health, 'National Public Health Emergency Team (NPHET) for COVID-19: Governance Structures' (26 June 2020) 5 <<https://www.gov.ie/en/publication/de1c30-national-public-health-emergency-team-nphet-for-covid-19-governance-/>> accessed 19 November 2020.

7 *ibid* 5.

8 Harry McGee, 'New Covid-19 oversight group to filter advice from NPHET to Cabinet' *The Irish Times* (15 September 2020) <<https://www.irishtimes.com/news/health/new-covid-19-oversight-group-to-filter-advice-from-nphet-to-cabinet-1.4355782>> accessed 25 June 2021.

9 *ibid*.

10 *ibid*.



Decisionmaker in practice?

It is important to stress again that the role of NPHE is to give public health advice; it has no role in the constitutional chain of official action around the State's public health response. Despite this, there have been repeated allegations that NPHE has agglomerated more power in practice than its formal place in the decision-making process would suggest and become, in practice, the real decisionmaker for much of the public health response. It is very difficult to know to what extent this is the case, because it is hard to distinguish agreement or due deference from *undue* deference in the form of an excessive ceding of decision-making responsibility. However, the government, particularly in the early stages of the pandemic, often presented NPHE advice as determinative of the question of what measures should be introduced or retained, when in fact this was a governmental decision that needed to factor in considerations beyond those that NPHE was charged to consider. Action, or inertia, could be explained by reference to NPHE advice, or lack of it. Examples of this include government comments on testing priorities,¹¹ facemask rules,¹² and nursing homes protection measures.¹³ The government has been accused of 'hiding behind'¹⁴ NPHE in respect of unpopular decisions, or even letting 'the tail wag the dog'¹⁵ and letting NPHE advice translate uncritically into government policy. It is possible that this influence went beyond what the government was happy with: some commentators suggested that the new intermediate group set up in September 2020, to stand between NPHE and government, was an attempt to channel and limit the influence of NPHE advice. It might have intended to do this either by consolidating more power in the civil service¹⁶ or making it easier for government to depart from or dilute NPHE recommendations by drawing on additional streams of advice.¹⁷

11 See the comments of Simon Harris in the Dáil that testing priorities would be 'decided by public health experts and NPHE' and that these would 'not be political decisions'. Dáil Deb 7 May 2020, vol 992, no 10 <<https://www.oireachtas.ie/en/debates/debate/dail/2020-05-07/6/>> accessed 25 June 2021.

12 See the comment of Leo Varadkar that 'we have to be guided by the CMO and NPHE on something that is purely a matter of public health advice.' Dáil Deb 21 May 2020, vol 993, no 4 <<https://www.oireachtas.ie/en/debates/debate/dail/2020-05-21/4/>> accessed 25 June 2021. Similarly, Shane Ross claimed he could not make masks mandatory on public transport in the absence of NPHE advice. Dáil Deb 3 June 2020, vol 993, no 7.

13 Dáil Deb 16 April 2020, vol 992, no 6 <<https://www.oireachtas.ie/en/debates/debate/dail/2020-04-16/3/>> accessed 25 June 2021.

14 Malachy Clerkin, 'Cowardly Government Hide behind Nphet as Fans Remain Locked Out' *The Irish Times* (7 September 2020) <<https://www.irishtimes.com/sport/gaelic-games/cowardly-government-hide-behind-nphet-as-fans-remain-locked-out-1.4347903>> accessed 25 June 2021.

15 Jack Quann, 'Alan Kelly: "The Tail is Wagging the Dog" When it Comes to NPHE and the Government' *Newstalk* (4 June 2020) <<https://www.irishtimes.com/sport/gaelic-games/cowardly-government-hide-behind-nphet-as-fans-remain-locked-out-1.4347903>> accessed 25 June 2021.

16 Philip Ryan, 'Power Being Stripped Away by Nphet and Ronan Glynn as Civil Servants Take Control of Covid-19 Crisis' *The Irish Independent* (16 September 2020) <<https://www.independent.ie/irish-news/power-being-stripped-away-by-nphet-and-ronan-glynn-as-civil-servants-take-control-of-covid-19-crisis-39535019.html>> accessed 25 June 2021.

17 Conor Lenihan, 'Covid-19 Oversight Group Could Add to Confusion over Health Advice' *The Irish Times* (16 September 2020) <<https://www.irishtimes.com/opinion/covid-19-oversight-group-could-add-to-confusion-over-health-advice->



Close collaborator?

Several instances evidence a fruitful back-and-forth between NPHET and government, where each sought to strike a second-order consensus against a backdrop of first-order disagreement over policy options. In April 2020 when government wished to allow child minders to enter the homes of healthcare workers providing essential services, the government was persuaded not to do this on the basis of NPHET intervention.¹⁸ In August 2020, the government—with some obvious reluctance—was persuaded by NPHET intervention against the reopening of pubs not serving food.¹⁹ But this back-and-forth has also worked the other way: in June 2020, Cabinet decided—with NPHET seemingly endorsing the decision—to substantially accelerate reopening plans, lifting travel restrictions more quickly and more extensively than NPHET’s recommended timeline, and allowing for the reopening of shopping centres, which NPHET had recommended against.²⁰ There is evidence here of each side being open to persuasion and discussion, and no evidence that these disagreements were in any way contentious.

NPHET advocated for a form of mandatory quarantine in designated facilities for international travellers from as early as May 2020, but government did not act on this recommendation until early 2021.²¹ Between February-April 2021 there was considerable debate and discussion between NPHET and government, and within government itself, over the introduction of mandatory hotel quarantine for passengers entering the State. NPHET minutes from 18th February 2021 recorded that ‘some members’ expressed the view that ‘travel restrictions should be extended to all inbound travellers to Ireland, regardless of the origin of their destination’.²² But there was ‘consensus’ that Ireland should

1.4355703> accessed 25 June 2021. “Departments of Finance and Public Expenditure and Reform, and Martin Fraser’s group, [had] been arming themselves with reams of statistical analysis to buttress their arguments this time”: Jack Horgan-Jones, ‘Stubborn Covid Figures Mean Further Tension between Nphet and Government Expected’, *The Irish Times* (19 November 2020) <<https://www.irishtimes.com/news/ireland/irish-news/stubborn-covid-figures-mean-further-tension-between-nphet-and-government-expected-1.4413756>> accessed 25 June 2021.

18 Michelle Hennessy, ‘Who’s Calling the Shots? - The Role of Ireland’s Public Health Emergency Team and its Key Players’ *The Journal* (25 April 2020) <<https://www.thejournal.ie/nphet-5083275-Apr2020/>> accessed 25 June 2021.

19 Cónal Thomas, ‘Decision to Delay Pubs Reopening Will Be Met with ‘Fury and Despair’, Publican Reps Say’ *The Journal* (4 August 2020) <https://www.thejournal.ie/decision-to-delay-pubs-reopening-will-be-met-with-fury-and-despair-by-industry-publican-reps-say-5167511-Aug2020/?utm_source=story> accessed 25 June 2021.

20 Fiach Kelly, ‘Ministers Happy To Be Part of Plan to Lift Restrictions’ *The Irish Times* (6 June 2020) <<https://www.irishtimes.com/news/politics/ministers-happy-to-be-part-of-plan-to-lift-restrictions-1.4272114>> accessed 25 June 2021.

21 Philip Ryan, ‘Nphet Experts Sought Hotel Quarantine for All Travellers Arriving in Ireland’ *The Irish Independent* (22 March 2021) <<https://www.independent.ie/world-news/coronavirus/nphet-experts-sought-hotel-quarantine-for-all-travellers-arriving-in-ireland-40223723.html>> accessed 25 June 2021.

22 Department of Health, ‘NPHET COVID-19 Meeting Minutes - 18 February 2021’ <<https://www.gov.ie/en/collection/691330-national-public-health-emergency-team-covid-19-coronavirus/#january-march-2021>> accessed 25 June 2021.



at a minimum ‘focus on implementing a robust strategy with a secure legal underpinning for travellers from high-risk countries in the first instance, before considering further extension of these measures, being cognisant of existing HSE resources.’²³

On 7th March 2021, the Oireachtas introduced the Health (Amendment) Act 2021 to provide the statutory underpinning for mandatory quarantine in a designated facility. The Act empowered the Minister for Health, having regard to advice of the Chief Medical Officer and having consulted with the Minister for Foreign Affairs, to designate the countries from which passengers would be subject to quarantine. The Chief Medical Officer was assisted in this task by the Expert Advisory Group on Travel – a NPHET sub-group established on 1 March 2021 to develop a method of risk assessing States and consider all concerns COVID-19 poses for travel.²⁴ The Advisory Group swiftly recommended that 43 countries be added to the list of designated states.²⁵ 26 countries were promptly added by the Minister for Health on foot of this advice, but a dispute erupted within government over the addition of many of the recommended countries – especially the United States of America and several EU member states.²⁶

It was reported that the recommendation of the Advisory Group caused a division within government, particularly between the Minister for Health, who wished to act on the advice, and the Minister for Foreign Affairs, who was reportedly worried about the possible impact on ‘Irish citizens living in these countries.’²⁷ It was reported some members of government were worried about ‘diplomatic issues’ and legal concerns about ‘EU freedom of movement rights’²⁸. There was also concern expressed that the Minister for Health had ‘blindsided’ the Minister for Foreign Affairs and not consulted with him as statutorily obligated to do under the Health (Amendment) Act 2021 before making any designation.²⁹ Such concerns were bolstered by a (unpublished) letter written by the Attorney-General to the

23 *ibid.*

24 Department of Health, ‘Minister for Health Announces Additions to List of Designated States’ (9 April 2021) <<https://www.gov.ie/en/press-release/c7f7d-minister-for-health-announces-additions-to-list-of-designated-states/>> accessed 25 June 2021.

25 Christina Finn and Daragh Brophy, ‘Government Advised to Add US, France, Germany and Italy to Hotel Quarantine List’ *The Journal* (30 March 2021) <<https://www.thejournal.ie/hotel-quarantine-list-ireland-more-countries-added-us-france-germany-italy-5395771-Mar2021/>> accessed 25 June 2021.

26 Hugh O’Connell, ‘6,000 People Flew in Last Week from Countries Health Experts Want on Hotel Quarantine List’ *The Irish Independent* (9 April 2021) <<https://www.independent.ie/world-news/coronavirus/6000-people-flew-in-last-week-from-countries-health-experts-want-on-hotel-quarantine-list-40294385.html>> accessed 25 June 2021.

27 *ibid.*

28 Finn and Brophy (n 24).

29 Christina Finn, ‘An Expansion that Will Cost Millions or a Necessity? Quarantine Clashes End with 16 Additions to Hotel Quarantine List’ *The Journal* (10 April 2021) <<https://www.thejournal.ie/mandatory-hotel-quarantine-clashes-fianna-fail-fine-gael-5403749-Apr2021/>> accessed 25 June 2021.



Minister for Health which reportedly expressed worry that health officials had ‘not followed the correct process or adhered to the legislation the Oireachtas passed on quarantine when formulating their advice.’³⁰ Several practical concerns were raised, including about the current capacity of quarantine facilities and the cost of expansion.³¹

On 9th April 2021 the government decided following a cabinet meeting that 16 additional countries recommended by NPHEt would be designated as subject to mandatory hotel quarantine, including the recommendations concerning the United States and EU member states France, Italy, Belgium that had sparked controversy.³² It was also reported that new members would be added to the Advisory Group to broaden its expertise; including specialists in the logistics of hotel quarantining, laws relating to international travel and foreign relations.³³

This complex episode is hard to characterise as a disagreement between NPHEt on the one hand and government on the other. It is better characterised as an intense dispute *within* the government over how best to respond to NPHEt’s advice and the process by which policy should be formed on foot of public health advice on travel. Some in government, especially the Minister for Health, were keen to press ahead and act promptly on the advice in its entirety, while others expressed caution and advocated delaying acting on advice so several practical and political concerns could be further discussed. In the end a compromise of sorts was reached—NPHEt’s advice was eventually acted on in respect of the United States and EU member states—but only after the concerns vocally expressed by some members of government were addressed through intensive intra-executive debate. It also resulted in an alteration to the composition of the Advisory Group to broaden its expertise in areas which clearly seemed reflective of concerns recently expressed by some members of government: including specialists in the logistics of hotel quarantining and laws relating to international travel and foreign relations. Thus, while NPHEt’s advice was substantively followed, it was not accepted in an uncritical way, but only after significant deliberation.

30 Jennifer Bray, Cliff Taylor, Jack Horgan-Jones, ‘Concern Plans to Extend Hotel Quarantine Could Breach EU Citizens’ Rights’ *The Irish Times* (31 March 2021) <<https://www.irishtimes.com/news/politics/concern-plans-to-extend-hotel-quarantine-could-breach-eu-citizens-rights-1.4525043>> accessed 25 June 2021.

31 *ibid.*

32 Jack Horgan-Jones, Jennifer Bray, Simon Carswell, ‘Government to Add US and Four EU Countries to Quarantine List’ *The Irish Times* (10 April 2021) <<https://www.irishtimes.com/news/politics/government-to-add-us-and-four-eu-countries-to-quarantine-list-1.4533451>> accessed 25 June 2021.

33 Mary Regan, ‘US, Canada and France Added to Hotel Quarantine List’ *RTE News* (10 April 2021) <<https://www.rte.ie/news/coronavirus/2021/0409/1208892-mandatory-hotel-quarantine/>> accessed 25 June 2021.



Mere advisor?

The status of mere advisor is the one that NPHET has *de jure*: as a matter of constitutional law all decisions are made by government or ministers who, nominally at least, are accountable to the Oireachtas and the people. At times, there has been evidence that NPHET does occupy the role of mere policy advisor and on several occasions, there has been clear disagreement and a government departure from, or dilution of, public health advice:

- In the summer of 2020, there was disagreement between NPHET and the government over the precise nature of what retail activity should resume. The CMO recommend keeping shopping centres closed, whereas the Government³⁴ proceeded to permit their reopening. The government said adherence to guidelines issued by another statutory body – the Health and Safety Authority – could ameliorate any risks which concerned NPHET.
- Another issue of apparent disagreement concerned mandatory quarantine for incoming travellers. NPHET had on several occasions recommended that such a measure be introduced.³⁵ The government pleaded that there were various issues – from the practical to the legal - that made this difficult or impossible.³⁶ Despite renting a hotel premises apparently for this purpose, the government did not introduce such a statutory regime for hotel quarantine until almost a year later.³⁷

There have several other issues where there appeared to be disagreement, but where evidence about the precise degree or nature of the disagreement is less clear:

34 Christina Finn, “‘It’s a Deviation’”: Government “Found a Way Around” NPHET Advice on Shopping Centres and 20km Rule’ *The Journal* (5 June 2020) <<https://www.thejournal.ie/nphet-advice-government-5116107-Jun2020/>> accessed 25 June 2021.

35 This was expressed in several letters from NPHET to government, and in press conferences. See Jack Power, ‘Mandatory Quarantine “Desirable” amid Concern over Flights from Abroad’ *The Irish Times* (13 July 2020) <<https://www.irishtimes.com/news/health/mandatory-quarantine-desirable-amid-concern-over-flights-from-abroad-1.4303456>> accessed 25 June 2021.

36 Jack Power and Simon Bracken, ‘Covid-19: Mandatory Quarantine for New Arrivals Would Not Be Effective, Minister Says’ *The Irish Times* (19 July 2020) <<https://www.irishtimes.com/news/health/covid-19-mandatory-quarantine-for-new-arrivals-would-not-be-effective-minister-says-1.4308350>> accessed 25 June 2021.

37 See the Health (Amendment) Act 2021, signed into law on March 7th 2021.



- the safety of reopening childcare facilities and schools in May of 2020, where there was apparent disagreement between the government and the CMO on how clear the evidence was on this point;³⁸
- the publication of guidelines on the wearing of facemasks;³⁹
- the continuation of cocooning for over 70s while other measures were being relaxed.⁴⁰

These above disagreements, however, paled in comparison to the disagreement around NPHEt's recommendations on a second lockdown in autumn 2020. The dispute began quietly in late August, with a private warning from NPHEt that it might be necessary to consider a second lockdown if the number of cases continued to increase. This was met with strong resistance from government figures, who said it would not be possible for social and economic reasons.⁴¹ In early October, NPHEt recommended a 'circuit break' four-week lockdown—a short period of severe Level-5 restrictions to attempt to curb virus spread—to halt rising case numbers.⁴² The government was surprised by this advice, as it represented a stark departure from NPHEt advice only three days before the Level 5 recommendation, advising that a move to less onerous Level 3 restrictions was necessary. There was also no notification of this advice to government before it was revealed in the media. The Government very openly refused to follow this advice. Instead, it went with a lower Level 3 response,⁴³ as it did not believe the data had changed sufficiently since the prior NPHEt recommendation of a Level 3 response. Minister for Health Stephen Donnelly noted the proper role of each actor: NPHEt's advised government on 'what they believe is required from a public health perspective to suppress this virus', but the government 'has a different job'⁴⁴

38 Laura Fletcher, 'Varadkar: Reopening schools, childcare facilities 'among safest things' to do' *RTE News*, May 14th, 2020 <<https://www.rte.ie/news/2020/0513/1138197-reopening-school-childcare/>> accessed 25 June 2021.

39 Philip Ryan and Anne-Marie Walsh, 'Government Cut Advice on Masks from its Roadmap' *The Irish Independent* (6 May 2020) <<https://www.independent.ie/world-news/coronavirus/government-cut-advice-on-masks-from-its-roadmap-39184465.html>> accessed 25 June 2021.

40 Philip Ryan and Gabija Gataveckaitė, 'Cabinet Overruled Health Officials on Advice that Over-70s Should Keep Cocooning until August' *The Irish Independent* (5 May 2020) <<https://www.independent.ie/world-news/coronavirus/cabinet-overruled-health-officials-on-advice-that-over-70s-should-keep-cocooning-until-august-39181325.html>> accessed 25 June 2021.

41 Pat Leahy, Jennifer Bray and Jack Horgan-Jones, 'Government Resists Calls from NPHEt for a Return to Full Lockdown' *The Irish Times* (20 August 2020) <<https://www.irishtimes.com/news/politics/government-resists-calls-from-nphet-for-a-return-to-full-lockdown-1.4334326>> accessed 25 June 2021.

42 Jack Horgan-Jones and Paul Cullen, 'Covid-19: NPHEt Recommends State Moves to Level 5 Restrictions for Four Weeks' *The Irish Times* (4 October 2020) <<https://www.irishtimes.com/news/ireland/irish-news/covid-19-nphet-recommends-state-moves-to-level-5-restrictions-for-four-weeks-1.4371810>> accessed 25 June 2021.

43 Órla Ryan, 'NPHEt Members Believe Level 5 Advice "Should Have Been Communicated More Carefully to Government"' *The Journal* (6 October 2020) <<https://www.thejournal.ie/nphet-level-5-recommendation-5225094-Oct2020/>> accessed 25 June 2021.

44 Órla Ryan, 'Tánaiste Stands Over NPHEt Criticisms while Taoiseach's Spokesperson Says Varadkar is "Entitled to His Opinion"' *The Journal* (6 October 2020) <<https://www.thejournal.ie/stephen-donnelly-ireland-level-3-5224900-Oct2020/>> accessed 25 June 2021.



which was to take policy decisions factoring in not only public health but the broader ‘context of the entire country, in the context of our society, our communities, jobs, and our economy’.⁴⁵

Tánaiste Leo Varadkar, in an appearance on RTE’s *Claire Byrne Live*, harshly criticised NPHET, saying that their recommendation had come out of the blue and had not been ‘thought through’. He said the government had to consider wider social and economic impacts such as the effect of stringent lockdowns on jobs and people’s livelihoods; that the sudden move from level 2 to 5 nationally was not in line with the graduated plan that had been agreed; and that NPHET concerns about ICU capacity were not shared by the HSE. He also noted NPHET had not given the government a plan for what would happen after the 4 week lockdown that was proposed, and that the ‘circuit break’ approach proposed by NPHET was not a strategy that had been shown to be effective.⁴⁶ He also criticised a lack of ‘prior consultation’ with the government.⁴⁷ Reports suggested government felt that it was being ‘bounced into’ this move by NPHET.⁴⁸ Two weeks later, as case numbers continued to climb, NPHET recommended a six-week Level 5 lockdown, and the government agreed to follow this recommendation.⁴⁹ Government was criticised in some quarters for ignoring the earlier advice when it became necessary only weeks later to implement it.⁵⁰

Some commentators noted that these events marked a shift in the relationship between the government and NPHET from collaborative to something ‘more wary’.⁵¹ But it served to bring into sharp relief the reality of the relationship. According to a report in *The Irish Times*, Taoiseach Micheál Martin had informally told NPHET not to ask for restrictions that the Government would not

45 *ibid.*

46 Patsy McGarry and Harry McGee, ‘Varadkar Criticises Holohan: Says Level 5 Advice “Not Thought Through”’ *The Irish Times* (5 October 2020) <<https://www.irishtimes.com/news/politics/varadkar-criticises-holohan-says-level-5-advice-not-thought-through-1.4372925>> accessed 25 June 2021.

47 Marie O’Halloran and Vivienne Clarke, ‘Donnelly Says He Told Taoiseach about Possible Level 4 before Nphet Meeting’ *The Irish Times* (9 October 2020) <<https://www.irishtimes.com/news/politics/donnelly-says-he-told-taoiseach-about-possible-level-4-before-nphet-meeting-1.4376506>> accessed 25 June 2021.

48 Pat Leahy, ‘Collaboration between Public Health Experts and Government Appears Over’ *The Irish Times* (6 October 2020) <<https://www.irishtimes.com/news/politics/collaboration-between-public-health-experts-and-government-appears-over-1.4372869?mode=amp>> accessed 25 June 2021.

49 Daniel McConnell and Paul Hosford, ‘How We Got to Where We Are: The Moves that Lead Us to Level 5’ *The Irish Examiner* (22 October 2020) <<https://www.irishexaminer.com/news/spotlight/arid-40068992.html>> accessed 25 June 2021.

50 Stephen Collins, ‘Nphet Now in Control of the Country’s Economic and Social Policy’ *The Irish Times* (23 October 2020) <<https://www.irishtimes.com/opinion/nphet-now-in-control-of-the-country-s-economic-and-social-policy-1.4388405>> accessed 25 June 2021; Pat Leahy, ‘Anatomy of a Lockdown U-turn: Holding Out against Nphet a Gamble Politicians Unwilling to Take’ *The Irish Times* (23 October 2020) <<https://www.irishtimes.com/news/politics/anatomy-of-a-lockdown-u-turn-holding-out-against-nphet-a-gamble-politicians-unwilling-to-take-1.4389592>> accessed 25 June 2021.

51 Leahy (n 47).



sanction.⁵² If this was done, it occluded the relationship between government and NPHET. This high-profile disagreement made it clear that NPHET merely *recommends*, and the government *acts*.

Case Study: December 2020-January 2021

It is instructive to examine in detail the disagreements between the government and NPHET in late 2020 to help to map this relationship.

Advice on opening

During a meeting on the 18th November 2020, on the subject of managing the pandemic over the Christmas period, senior Government officials and members of NPHET clashed. *The Irish Times* reported that, 'senior officials emphasised to Dr Holohan that the Government—not NPHET—would make decisions about easing the lockdown and what restrictions would be in place over Christmas.'⁵³ There were suggestions that the government was attempting to frame the debate in a manner that would enable it to depart from NPHET advice.⁵⁴ The Irish Times reported that during this late November period, the Secretary General to the Government had become fond of reminding politicians: 'Youse are the Government'.⁵⁵

NPHET met on the 25th November to discuss recommendations for the Christmas period. In a letter of advice sent to the Minister for Health the next day, the CMO wrote: 'if restrictions are eased now, to a similar extent but more rapidly than in the summer, from a higher baseline force of infection, in winter and over the Christmas period a third wave of disease will ensure much more quickly and with greater mortality than the second'.⁵⁶

The letter also set out NPHET's recommendation that the 'hospitality sector remain closed (with the exception of take-away and delivery) over the eight-week period'. It was further stated that 'if some

52 *ibid*.

53 Pat Leahy, Jack Horgan-Jones, Martin Wall and Jennifer Bray, 'Holohan Urges People to 'Work Together' as Senior Officials Clash with Nphet' *The Irish Times* (19 November 2020) <<https://www.irishtimes.com/news/health/holohan-urges-people-to-work-together-as-senior-officials-clash-with-nphet-1.4413035>> accessed 25 June 2021.

54 Jack Horgan-Jones, 'Stubborn Covid Figures Mean Further Tension between Nphet and Government Expected', *The Irish Times* (19 November 2020) <<https://www.irishtimes.com/news/ireland/irish-news/stubborn-covid-figures-mean-further-tension-between-nphet-and-government-expected-1.4413756>> accessed 25 June 2021.

55 *ibid*.

56 Department of Health, 'Letter from CMO to Minister for Health re COVID-19 (Coronavirus) - 26 November 2020' 7 <<https://www.gov.ie/en/collection/ba4aa0-letters-from-the-cmo-to-the-minister-for-health/#august-december-2020>> accessed 25 June 2021.



element of hospitality is retained, the NPHET is of the view that the recommended easing of measures with regard to household mixing over the two-week festive period... could not also take place'.⁵⁷

That same day, the Cabinet Covid-19 sub-committee met and proposed that the hospitality sector be allowed to reopen from December 7th. A senior source said the Government would seek to 're-balance' the aspect of NPHET's advice which stated that a choice had to be made between relaxing restrictions on household visits and allowing the hospitality sector to reopen. One Government source said that a 'polite showdown' with NPHET was expected.⁵⁸

On 27th November, the Taoiseach announced that restaurants and pubs serving a substantial meal could reopen from the 4th December 2020 (with additional restrictions imposed on them). Going against NPHET advice to not allow household mixing if the hospitality sector was to re-open, the Government also announced that from 18th December, up to three households would be allowed to gather.⁵⁹ One commentator stated that '[t]he most significant thing that happened this week is that the Government, quite deliberately and carefully, exerted its authority over public health experts'.⁶⁰

Advice to reintroduce restrictions

The CMO wrote to the Minister for Health on the 17th December following a NPHET meeting that day. The letter stated:

'NPHET is especially concerned at how rapidly the case numbers have increased over recent days and notes that the epidemiological situation is considerably more concerning now than had been projected at the end of November. [...] there are significant indications that we are now experiencing the early stages of a third wave of infection'.⁶¹

57 *ibid* 11.

58 Jennifer Bray, Harry McGee and Pat Leahy, 'Restaurants and Gastropubs to Reopen in December under Government Plan' *The Irish Times* (26 November 2020) <<https://www.irishtimes.com/news/health/restaurants-and-gastropubs-to-reopen-in-december-under-government-plan-1.4420274>> accessed 25 June 2021.

59 David Murphy, 'Shops, Hairdressers, Gyms to Reopen as Country Moves to Level 3 on Tuesday' *RTE News* (27 November 2020) <<https://www.rte.ie/news/coronavirus/2020/1127/1180803-coronavirus-ireland/>> accessed 25 June 2021.

60 Pat Leahy, 'Government Right to Exert Its Authority over Nphet' *The Irish Times* (28 November 2020) <<https://www.irishtimes.com/opinion/pat-leahy-government-right-to-exert-its-authority-over-nphet-1.4421593>> accessed 25 June 2021.

61 Department of Health, 'Letter from CMO to Minister for Health re COVID-19 (Coronavirus) – 17 December 2020' <<https://www.gov.ie/en/collection/ba4aa0-letters-from-the-cmo-to-the-minister-for-health/#august-december-2020>> accessed 25 June 2021.



On foot of this, NPHET advised that the duration of the ‘Christmas period’ of reduced restrictive measures should end at midnight on the 28th December. It advised that enhanced Level 3 measures should be introduced from midnight on the 28th December, and that from that point on hospitality should open for take-away and delivery services only, and visits to private homes should be allowed only from one other household. In another letter on 21st December, the CMO stated that the situation regarding Covid had ‘deteriorated very substantially’ since the 17th December and there were clear signs of ‘exponential growth’. The CMO stated that it was his ‘considered view as Chair’ that Level 5 measures would be necessary.⁶²

The coalition party leaders met on the evening of the 21st December to discuss the growing concerns over the rise in cases.⁶³ The Cabinet Covid-19 sub-committee was also convened that evening and it was reported that they agreed that restaurants and gastro pubs should close from mid-afternoon on Christmas Eve.⁶⁴ Following a Cabinet meeting on 22nd December, the Taoiseach announced that the country would move to Level 5, with some modifications from the 24th December 2020 and were to last until at least 12th January 2021 (i.e., just under 3 weeks).⁶⁵ NPHET met on the 23rd December and the CMO wrote to the Minister for Health on the same day, recommending that ‘the full suite of Level 5 measures are introduced with effect from midnight on the night of 26th December for a period of six weeks’.⁶⁶ This recommendation was repeated in a letter on December 30th,⁶⁷ and an unscheduled Cabinet meeting then took place at 4pm that day, following which the Taoiseach announced that the Country would move to full Level 5 restrictions for ‘at least’ one month.⁶⁸ In January, Ireland recorded more than 100,000 cases and 1,000 deaths, dwarfing the peaks in previous waves.

62 Department of Health, ‘Letter from CMO to Minister for Health re COVID-19 (Coronavirus) – 21 December 2020’ <<https://www.gov.ie/en/collection/ba4aa0-letters-from-the-cmo-to-the-minister-for-health/#august-december-2020>> accessed 25 June 2021.

63 ‘As it Happened: A Return to Level 5 – with Modifications – from Christmas Eve’ *The Journal* (22 December 2020) <<https://www.thejournal.ie/liveblog-cabinet-restrictions-christmas-5308393-Dec2020/>> accessed 25 June 2021.

64 Christina Finn, ‘Cabinet Covid Committee Agrees Hospitality Should Shut on Christmas Eve’ *The Journal* (21 December 2020) <<https://www.thejournal.ie/post-christmas-restrictions-5307923-Dec2020/>> accessed 25 June 2021.

65 As it happened: A return to Level 5 – with modifications – from Christmas Eve, *thejournal.ie* (22 December 2020).

66 Department of Health, ‘Letter from CMO to Minister for Health re COVID-19 (Coronavirus) – 23 December 2020’ 5 <<https://www.gov.ie/en/collection/ba4aa0-letters-from-the-cmo-to-the-minister-for-health/#august-december-2020>> accessed 25 June 2021.

67 Department of Health, ‘Letter from CMO to Minister for Health re COVID-19 (Coronavirus) – 30 December 2020’ 6 <<https://www.gov.ie/en/collection/ba4aa0-letters-from-the-cmo-to-the-minister-for-health/#august-december-2020>> accessed 25 June 2021.

68 Mary Regan, ‘Country to move to full Level 5 restrictions for “at least” one month’ *RTE News* (30 December 2020) <<https://www.rte.ie/news/2020/1230/1186931-cabinet-meeting/>> accessed 25 June 2021.



Government response to criticisms on departure from NPHET advice

The Government faced backlash in January 2021 for going against NPHET's advice in the lead up to Christmas. Minister for Health Stephen Donnelly was criticised for the way in which he characterised the Government's response to NPHET advice during an interview which took place on January 11th 2021. In response to a question as to whether the Government accepted responsibility for how things 'went wrong' over the Christmas period, Donnelly stated: 'the Government has been following public health advice from Day 1.' When it was put to him that the Government 'went against public health advice', he stated 'no, no it didn't.' The interviewer then asked, 'in what way did it follow health advice if NPHET said don't open pubs and restaurants at the same time as allowing household visits and the Government did it anyway?' In the course of a long reply, Donnelly said 'to be honest there is no way of knowing which of those would have led to more or less spread. In the main areas around Level 5, Level 3, going back to Level 5, going beyond Level 5, Government and NPHET and Government and the CMO have been very, very closely aligned and we will remain so.'⁶⁹

In a similar vein, Tánaiste Leo Varadkar said in an interview on RTÉ's This Week

The NPHET advice that we should not open hospitality. And we did. On the other hand, NPHET did advise that we should allow and could allow household visits to occur and household gatherings to occur from 2 December. ... And we decided against that. We didn't allow that until the 18th of December. So if we followed that advice to the letter, yes we would not have had groups of six gathering in thousands of restaurants around the country. But we would have had groups of six and more gathering in two million kitchens and two million living rooms around the country so would we be in a better or worse situation now? I can't answer that definitively. No one can.⁷⁰

On the 21st January 2021, the Finance Minister, Paschal Donohoe admitted on Newstalk radio that the Government did not fully follow NPHET advice at the beginning of the Christmas period and said he accepted the Government's deviation from public health advice at Christmas 'had a clear' effect on the number of cases.⁷¹ Mr Donohoe said the Government would reflect on its mistakes.

69 Sean Murray, 'Factfind: Did the Government Actually Follow NPHET's Advice Heading into December?' *The Journal* (14 January 2021) <<https://www.thejournal.ie/factfind-stephen-donnelly-nphet-5323575-Jan2021/>> accessed 25 June 2021.

70 *ibid.*

71 Aoife Moore, 'Paschal Donohoe: Deviation from Nphet Advice Had 'Clear' Impact on Covid-19 Numbers' *The Irish Examiner* (21 January 2021) <<https://www.irishexaminer.com/news/politics/arid-40211474.html>> accessed 25 June 2021.



Since this period, there has been no reported divergence from NPHET advice, including, at the time of writing (late June 2021), the delay of the opening of indoor hospitality in early July. It is possible that the government simply agreed with all of NPHET recent recommendations. But it is also possible that the experience of the December/January wave has created a severe reticence to depart at all from NPHET recommendations.

Criticisms of NPHET-government relationship in pandemic response

There have been several major criticisms levelled at the NPHET-government relationship and its effects on pandemic response.

Criticism of composition

There are three major criticisms that have been levelled at NPHET's composition. First, some have alleged that NPHET lacks diversity of scientific and health viewpoints, and could constitute an echo chamber for certain viewpoints.⁷² Secondly, some have criticised its failure to represent certain groups and stakeholders acutely affected by their advice, such as those representing autistic children, and the operators of nursing homes.⁷³ The Government has responded to this criticism saying that NPHET is not by design a representative body.⁷⁴ Thirdly, the Trinity College Dublin COVID-19 Legal Observatory, in a Report prepared for the Irish Human Rights and Equality Commission, criticised NPHET for having no experts in human rights or equality concerns amongst its members while purporting to take these considerations into account.⁷⁵ The winding down of the subgroups and Advisory Group, with no obvious rationale, is also troubling, as was the fact that this was done largely without comment or scrutiny. The IHREC Report recommended: the re-establishment of a NPHET sub-group with the

72 Diarmaid Ferriter, 'We Must Consider NPHET May Be Wrong' *The Irish Times* (11 September 2020) <<https://www.irishtimes.com/opinion/diarmaid-ferriter-we-must-consider-nphet-may-be-wrong-1.4351749?mode=amp>> accessed 25 June 2021.

73 See the comments of Catherine Connolly at Dáil Deb 6 May 2020, vol 992, no 9 <<https://www.oireachtas.ie/en/debates/debate/dail/2020-05-06/7/>> accessed 25 June 2021; Dáil Deb 21 May 2020, vol 993, no 4 <<https://www.oireachtas.ie/en/debates/debate/dail/2020-05-21/4/>> accessed 25 June 2021; Dáil Deb 10 June 2020, vol 993, no 9 <<https://www.oireachtas.ie/en/debates/debate/dail/2020-06-10/6/>> accessed 25 June 2021; Dáil Deb 8 July 2020, vol 994, no 6 <<https://www.oireachtas.ie/en/debates/debate/dail/2020-07-08/9/>> accessed 25 June 2021.

74 Leo Varadkar, Dáil Deb 7 May 2020, vol 992, no 10 <<https://www.oireachtas.ie/en/debates/debate/dail/2020-05-07/2/>> accessed 25 June 2021.

75 Conor Casey, Oran Doyle, David Kenny and Donna Lyons, *Ireland's Emergency Powers During the Covid-19 Pandemic* (IHREC 2021) <<https://www.ihrec.ie/documents/irelands-emergency-powers-during-the-covid-19-pandemic/>> accessed 25 June 2021.



relevant expertise to address ethical, human rights, and equality concerns; and that NPHET itself should have members with expertise on ethical, human rights, and equality concerns.⁷⁶

NPHET use of media

There has been criticism, especially from government, about NPHET's public communications. While it is obviously appropriate for NPHET to be transparent, there are grounds for arguing that NPHET's approach has gone beyond this. The seemingly routine leaking of NPHET recommendations immediately after meetings came to a head when government 'railed against NPHET' for 'a leak which effectively bypassed agreed reporting structures' in respect of the October 2020 lockdown recommendation.⁷⁷ The CMO condemned the leaking of this information.⁷⁸

While this might at some points have seemed inadvertent, it eventually came to be seen as NPHET attempting to indirectly influence government decision-making. Senior civil servants reported that they believed NPHET used media appearances to put political pressure on the Government to accept NPHET advice.⁷⁹ According to Pat Leahy, NPHET's November 'media campaign – and that's how it was seen – was raising hackles in Government Buildings' as it was seen as 'a careful and deliberate strategy by the public health experts to push the Government towards a more restrictive and cautious reopening.'⁸⁰

While NPHET engaging in public communication is very important and entirely proper, if the government's suspicions are correct, and NPHET (or certain members) attempted to force the hand of government by way of the media, this would not be appropriate. It would be an overreach of its advisory role to attempt to use its technocratic status and clout to dictate public policy whose formulation is constitutionally reserved to the executive.

76 *ibid* 102.

77 Jennifer Bray, Jack Horgan-Jones and Pat Leahy, 'Nphet's Shock Recommendation Caused Disbelief and Anger within Government' *The Irish Times* (7 October 2020) <<https://www.irishtimes.com/news/politics/nphet-s-shock-recommendation-caused-disbelief-and-anger-within-government-1.4373965>> accessed 25 June 2021.

78 RTE News, 'Confidentiality over NPHET Discussion "Didn't Happen"' *RTE News* (7 October 2020) <<https://www.rte.ie/news/coronavirus/2020/1007/1170091-chief-medical-officer-tanaiste/>> accessed 25 June 2021.

79 Leahy, Horgan-Jones, Wall and Bray (n 52).

80 Pat Leahy, 'Health Experts Favour Tighter Covid Restrictions, the Politicians Less' *The Irish Times* (21 November 2020) <<https://www.irishtimes.com/news/politics/health-experts-favour-tighter-covid-restrictions-the-politicians-less-1.4415096>> accessed 25 June 2021.



Accountability

A major concern about the NPHET government relationship is accountability. In a report for IHREC, the Observatory previously described the risk of an accountability trap, that we can fall into in one of two ways:⁸¹ either NPHET—a body that is not accountable—is *de facto* decisionmaker; or the government—the group actually empowered to decide and accountable to the people’s representatives—can suggest technocratic actors made unpopular decisions to avoid taking responsibility. The latter concern was perhaps more of a concern in the early days of the pandemic, where there was little challenge to NPHET advice, and heavy reliance in public communications on the importance of listening to experts. In the middle period, some open conflict over the best policy choices suggested a functional balance, with government and NPHET each occupying their proper role. However, concerns in that period over NPHET using the media to try to force government’s hand, and a possible reticence to challenge NPHET after the failures of December 2020, raised the concern that NPHET—an unaccountable body—is decisionmaker in practice. From an accountability perspective, this is highly problematic.

Public Engagement – Challenging Unpopular Decisions

Returning to the WHO formulation of accountability, it requires both that the public knows who is making decisions and how they can challenge decisions with which they disagree. Good governance should incorporate an openness to diverse perspectives and communication efforts on the part of government should be ‘designed to facilitate a genuine two-way dialogue, rather than as merely a means to announce decisions that have already been made.’⁸² Decision makers should be willing to recognise and debate alternatives to the approach they have adopted, and should actively engage with stakeholders who disagree with the policies in place. Throughout the pandemic response there was an absence of any structured mechanism whereby the views of the public or stakeholders could be solicited or taken on board, either by NPHET or government. This was perhaps excusable in the early phase of the pandemic, where governance mechanisms evolved under conditions of true emergency, but it is harder to justify in later phases, especially after the relative calm of the summer months when cases were low and measures could have been taken to establish better governance structures for the second and third waves. The approach of government/NPHET often recalled a

81 Conor Casey, Oran Doyle, David Kenny and Donna Lyons, *Ireland’s Emergency Powers During the Covid-19 Pandemic* (Irish Human Rights and Equality Commission, 2021) <<https://www.ihrec.ie/documents/irelands-emergency-powers-during-the-covid-19-pandemic/>> accessed 25 June 2021.

82 World Health Organisation (n 1) 15



“Decide-Announce-Defend” (DAD)⁸³ model of public decision-making, whereby decisions are made without stakeholder involvement and robustly defended against even valid criticisms. Undoubtedly, public engagement is challenging in a pandemic. Some commentators have described the situation as paradoxical: pandemic decision-making must take place very rapidly to be effective, thereby making public engagement highly impractical, yet public engagement is more important than ever during a pandemic.⁸⁴

The only method whereby concerns could be raised was through print, broadcast, and social media. On occasion, this was effective in securing a change to policy as, for example, in the case of the amending of the retail restrictions to permit children’s shoes to be sold.⁸⁵ Useful as the media are in scrutinising policy, effective change depends on persons within the media taking on a particular issue as a ‘cause’ and no guarantee exists that unpopular but worthy policy criticisms will gain any traction.⁸⁶ As such, reliance on the media alone cannot guarantee this aspect of public accountability.

Conclusions

The foregoing picture raises the concern that, after sweeping statutory powers were delegated to the Government by the Oireachtas, the government has—unofficially, but *de facto*—in many cases re-delegated these powers to unelected, technocratic public health experts. If we do not have clear lines of decision-making and accountability, and a clear sense of the power resting with the government, then the idea that we can have even notional democratic oversight for these powers seems very remote.⁸⁷ This is undoubtedly a cause for concern.

83 Nadejda Komendantova and Antonella Battaglini, ‘Beyond Decide-Announce-Defend (DAD) and Not-in-My-Backyard (NIMBY) Models? Addressing the Social and Public Acceptance of Electric Transmission Lines in Germany’ (2016) 22 *Energy Research & Social Science* 224.

84 Reema Patel discussing the pandemic public-engagement paradox: Nuffield Council on Bioethics Webinar (n 1).

85 Ellen O’Riordan et al, “Shoe Shops Will Be Allowed Sell for Children by Appointment, Says Martin” *The Irish Times* (31 March 2021) <<https://www.irishtimes.com/news/ireland/irish-news/shoe-shops-will-be-allowed-sell-for-children-by-appointment-says-martin-1.4525066>> accessed 25 June 2021.

86 In the case of the children’s shoes issue a number of media actors created pressure on the government to change the policy. See, for example, segment devoted to this issue: RTE Radio 1, ‘Drivetime’ (30 March 2020) <<https://www.rte.ie/radio1/drivetime/programmes/2021/0330/1207079-drivetime-tuesday-30-march-2021/>> accessed 25 June 2021.

87 Conor Casey and David Kenny, ‘Ireland—COVID-19 response raises some rule of law concerns’ (2021) 3 *Public Law* 480, 481.



Chapter II: Restrictions to Control Spread of the Virus

Oran Doyle, David Prendergast and Conor White

Introduction

In this chapter, we analyse the ways in which the Government has sought to control people's behaviour in an attempt to limit spread of the virus. Although the criminal law has featured heavily in this effort, it is better characterised as a 'public health' approach than a 'criminal justice' approach. The Government has relied on criminal sanctions as a supplement to a range of other measures – legal and non-legal – that seek to coordinate behaviour in a way that reduces spread of the virus, rather than to criminalise people for blameworthy behaviour. While there is much to recommend this strategy, the Government has allowed for considerable vagueness both about what is required and whether criminal sanctions apply. This raises very significant rule of law concerns, articulated in the Observatory's earlier report with Irish Human Rights and Equality Commission.¹ In this chapter, we explore whether such vagueness could serve a valid public health objective by encouraging people to behave in a way that will reduce virus-spread more than would be achieved by merely strict legal compliance. We conclude that while such a strategy may have been successful in the early days of the pandemic, it has a limited shelf life. As people begin to perceive the dissonance between government communications and legal requirements, the strategy loses effectiveness. Moreover, the strategy becomes harder to justify as criminal enforcement increases.

This chapter will begin by distinguishing between criminal justice and public health approaches, before identifying a potential rationalisation for the state leading people to believe that the law is more onerous than is in fact the case. It then analyses the various restrictions employed during the pandemic, as enacted in law and as enforced in practice. It will highlight the move to use fixed-penalty fines and the apparent uneven enforcement. It then concludes with an analysis of the effectiveness and justification of the Government's approach.

¹ Conor Casey, Oran Doyle, David Kenny and Donna Lyons, *Ireland's Emergency Powers During the Covid-19 Pandemic* (IHREC 2021) 65 <<https://www.ihrec.ie/app/uploads/2021/02/Irelands-Emergency-Powers-During-the-Covid-19-Pandemic-25022021.pdf>> accessed 24 June 2021.



Criminal justice and public health approaches

There are two main ways in which criminal law is engaged in addressing disease and contagion. A criminal justice or punitive approach uses general criminal offences (e.g. assault) to deter and punish people who spread contagion. Conduct that spreads contagion, or otherwise endangers public health, may satisfy the definition of a general offence. A deliberate spread of a virus may amount to the culpable infliction of bodily harm and, in England and Wales and in Canada, non-disclosure of HIV positivity for sexual relations has been held capable of amounting to grievous bodily harm and other offences.² These offences can be explained in traditional criminal justice terms or retributivism and, to an extent, deterrence in respect of causing harm to others. This approach elevates criminal law's general concerns over any specific public health goals. It may indeed elevate retributivism over deterrence; it is backward-looking in its operation, concerned to apply punishment as just deserts for harmful conduct rather than to engineer minimal future damage to public health.

A second way, the public health approach, seeks to make selective use of criminal law. Certain offences are used as adjuncts to public health measures and only as a last resort to secure necessary compliance with such measures, which are aimed to be primarily voluntary.³ To criminalise those who spread the virus may be unwise from a public health perspective as it would discourage people from getting tested or sharing details of close contacts. Conversely, conduct that is not traditionally prohibited, including conduct that principles of legality and autonomy recommend against criminalising, may be prohibited in pursuit of public health goals. This approach is forward-looking; it is not about formally marking out wrongs and doing justice in individual cases, but about engineering the best public health outcomes for the future.

One type of offence arguably straddles the two approaches, that of criminalising specifically the omission to take precautions against the spread of infectious disease, as in section 30 of the Health Act 1947. It is an offence for a person 'who knows that he is a probable source of infection with an infectious disease' to omit to take 'reasonable precaution to prevent his infecting others with such disease by his presence or conduct or by means of any article with which he has been in contact' or, for a 'person having the care of another person and knowing that such other person is a probable

² *R v Dica* [2004] EWCA Crim 1103; *R v Cuerrier* [1998] 2 SCR 371.

³ Edward M Mathews, 'Pathogens, Punishment and Public Health: Some jurisdictions have not yet prosecuted exposure to, or transmission of, a pathogen during sexual activities – should they do so now?' (PhD Thesis, Trinity College Dublin 2017) Ch 4.2 and 4.4 <<http://www.tara.tcd.ie/handle/2262/85226>> accessed 24 June 2021.



source of infection with an infectious disease shall ...take every other reasonable precaution to prevent such other person from infecting others with such disease by his presence or conduct or by means of any article with which he has been in contact'. This offence was enacted to help tackle tuberculosis, and it was left in force after that threat ended and can be seen as a non-fatal analogue of gross negligence manslaughter.

The legal response to the COVID-19 pandemic in Ireland matches the public health approach, not the criminal justice approach. There has been little or no use of traditional criminal offences. There were reports of spitting incidents, accompanied by shouts of 'coronavirus', in the first lockdown;⁴ but this conduct straightforwardly matches the definition of basic assault in any event, its seriousness amplified by concern about the virus. Specifically, there has been no effort to prosecute people after the fact for spreading the virus even where their behaviour was in clear breach of special legal measures and public health guidance and many others seemingly contracted the virus through contact with them. The offence in section 30 of the Health Act 1947 was not used. Instead, criminal law has been used predominantly in the mode of enforcing restrictions on movements, gatherings, and events. In short, the criminal law has been engaged in service of public health goals rather than to pursue the general logic of criminal justice.

Restrictions adopted during the Pandemic

Forms of restriction on behaviour

During the pandemic, the Government has relied on four different mechanisms, with increasing bite, to control people's behaviour:

- Public health advice;
- Legal prohibitions without sanction (dubbed 'civil offences' by Leo Varadkar);
- Criminal offences with a reasonable excuse clause;
- Criminal offences without any reasonable excuse clause.

⁴ For example, see Barry Roche, 'Man Who Spat at Garda Saying He Had Covid-19 Given Community Service' *The Irish Times* (25 June 2020) <<https://www.irishtimes.com/news/ireland/irish-news/man-who-spat-at-garda-saying-he-had-covid-19-given-community-service-1.4288194>> accessed 24 June 2021.



Each of these plays a legitimate role in a public health strategy to reduce the spread of the virus. Some issues have only been controlled by advice (e.g. hand hygiene) while others have been controlled by different mechanisms at different times. Legal prohibitions without sanction assist the conscientious citizen to conform her behaviour to a standard that – if reliably followed by enough other people – will be sufficient to control spread of the pandemic.

The lack of sanction, however, may undermine coordination over time if the conscientious citizen feels that others are not complying: why should I not leave my county if I know that my neighbours are leaving the county? The introduction of sanctions can help to address this free-rider problem. But it can be difficult to calibrate restrictions appropriately and there is a risk, when the restrictions are so extensive and intrusive into ordinary life, that the state might over-criminalise behaviour. To provide some flexibility, prohibitions have frequently included a general reasonable excuse clause. But desirable flexibility entails potentially problematic uncertainty. Most strictly of all, regulations can provide for straightforward criminal offences without reasonable excuse clauses.

The theory of Ireland’s approach to enforcing COVID-19 restrictions was quite accurately described by the Minister for Health in October 2020 while introducing the legislation to enable him to put in place so-called on-the-spot fines: ‘So while solidarity, personal and collective responsibility are at the core of our national response to Covid-19, enforcement must also be available as a last resort.’⁵

Enforcement mechanisms

When the Minister makes regulations under the Health Act 1947, as amended in March 2020, he or she may deem particular provisions to be ‘penal provisions.’⁶ These provisions can then be criminally enforced in several different ways. Breach of a penal provision is a criminal offence, punishable by a fine of up to €5,000 and/or up to six months’ imprisonment.⁷ A Garda may direct a person to take steps to comply with a penal provision; failure to do so is a criminal offence for which a person may be arrested.

⁵ Dáil Deb 23 October 2020, vol 999, no 8 <https://www.oireachtas.ie/en/debates/debate/dail/2020-10-23/2/#spk_2> accessed 24 June 2021.

⁶ Health Act 1947, s 31A(6).

⁷ Health Act 1947, s 31A(12) as amended by the Health (Amendment) Act 2021, s 3. Prior to March 2021, the maximum fine had been €2,500.



In September 2020, a wide range of enforcement powers was introduced in respect of premises where intoxicating liquor is sold or supplied for consumption on the premises.⁸ These powers essentially allow the Gardaí to inspect such premises without a warrant, issue immediate closure orders, and/or seek closure orders from the District Court.

In November 2020, the Minister started to exercise a new statutory power to designate some penal provisions as fixed penalty provisions (sometimes referred to as on-the-spot fines).⁹ If a Garda has reasonable grounds for believing that a person has contravened a fixed penalty provision, he or she may serve a fixed payment notice on the person. If the person pays the penalty within 28 days, no prosecution will proceed. The Act initially restricted the Minister to fixing penalties of no greater than €500. Since March 2021, the Minister has had the power to set fines at up to €2,000. The Health (Amendment) Act 2021 also introduced a parallel set of penalties for breaches related to mandatory quarantine, with fines up to €2,000 and imprisonment up to one month.

Since November 2020, Gardaí have had specific powers to deal with offences that may be taking place in dwellings. First, if a Garda has reasonable grounds for believing that a person is in a public place with an intent to, or is about to, or is attempting to enter a dwelling in contravention of a dwelling provision, he or she can issue a direction to the person to leave the place and vicinity. Second, if a Garda has reasonable grounds for believing that an event is taking place in contravention of a dwelling provision, he or she can direct the occupier to cause everyone attending the event to leave the dwelling and the vicinity, other than those who live there. The Garda is permitted to attend at the main entrance to the dwelling and to require the occupier to provide his or her name. It is an offence to fail to comply with a direction of a Garda, without reasonable excuse. This criminal offence is punishable by a fine of up to €1,000 and/or imprisonment of up to one month.

Restrictions on leaving home

During the strictest lockdowns—April-May 2020, October-November 2020, January-April 2021—there were criminal prohibitions on leaving one's home without a reasonable excuse. Since November 2020, this was liable to a fixed penalty of €100. The provision enumerates a number of specific excuses that will constitute a reasonable excuse. These specific excuses are non-exhaustive of what may a

⁸ Health Act 1947, [section 31A\(6A\)](#).

⁹ *ibid* [s 31C](#).



reasonable excuse, which is open ended. This criminal prohibition was also a means of controlling other activities outside the home, and movement in general. If you were outside your home without a reasonable excuse, you would be committing a criminal offence and liable to conform to Garda directions.

Restrictions on movement

When there has not been a restriction on leaving your home, there have frequently been some restrictions on movement, limiting people to travel within their county, or to a particular geographic radius if the travel is for particular purposes. These provisions have generally taken the form of sanctionless legal prohibitions.

Restrictions on events in the home

Particularly since Autumn 2020, there has been increasing awareness of how the virus spreads through informal contact in the home. Over the course of September and October 2020, there were increasingly strict limits on the number of people one could invite into one's home: from people from three households, to people from one household only, to no guests from other households. Also, these restrictions went from sanctionless prohibitions to criminal offences, without any reasonable excuse clause. Finally, increased enforcement powers were introduced: the dwelling offence provisions (described above) and fixed payment notices: the offence of organising such an event is liable to a fixed payment notice of €500; the offence of attending such an event is liable to a fixed payment notice of €150.

Restrictions on international travel

For much of the pandemic, the restrictions on international travel largely consisted of guidance. There were minimal obligations to register contact details and a proposed residence for after you arrived in the country, but thereafter the obligation to remain in the residence was only a matter of advice. Since January 2021, the obligations have been steadily increased. An obligation to take a PCR test with a 'not detected' result prior to arriving in Ireland was introduced and applied to a widening range of countries, then all countries. This was a criminal offence (without a reasonable excuse clause) but not an immigration condition for entering the state. Mandatory home quarantine was introduced for all



passengers, with passengers from high risk states being obliged to do so for 14 days while those from other states could obtain a not-detected PCR test five days after arrival in order to leave home quarantine. These were again criminal offences without a reasonable excuse clause. These restrictions were further increased with the introduction of mandatory hotel quarantine to apply to people arriving from certain states in March 2021.

For much of the pandemic, no restrictions applied to people arriving into the State from Northern Ireland and indeed they were not subject to the same movement restrictions as applied to other people. This was changed in February 2021 to ensure that people arriving from Northern Ireland were subject to the same movement restrictions as anyone else. This meant, in effect, that they could not cross the border unless they had the same sort of reasonable excuse for movement as required of someone resident in the State. Again, this was a criminal provision, but with a reasonable excuse clause.

In February 2021, it was made a criminal offence to travel to an airport or port for the purposes of leaving the country without reasonable excuse. This is a penal provision, liable to a fixed payment notice of €2,000—the only instance in which the Minister has made use of the power under the 2021 Act to stipulate such a high penalty.

Face coverings

Requirements to wear face coverings on public transport were introduced in July 2020 with an obligation in respect of certain indoor public places being introduced in August 2020, with additional places added periodically until December 2020. Both are currently extended to November 2021. The obligations to wear face coverings are governed by a criminal offence with a reasonable excuse clause. Since last November, these have been the subject of fixed penalty provisions, with a stipulated penalty of €80. The definition of a face covering was amended with effect from January 2021 to ensure a face covering did not leave a visible gap.



Enforcement in practice

Groups responsible for enforcement

The Health Act 1947, which has been amended four times since March 2020, envisages that certain health officials are involved in enforcing public health law. However, the vast majority of enforcement has fallen to the Garda Síochána.¹⁰ The Gardaí are likely the only organisation equipped to deal with large-scale and consistent enforcement. A by-product of Garda-led enforcement is that compliance with public health measures is associated with the ordinary enforcement of criminal law.

There have been four primary Garda operations through the pandemic:

- Operation Fanacht: the primary Garda operation to enforce travel restrictions;
- Operation Treoraím: checks of retail premises across Ireland to ensure compliance with regulations;
- Operation Navigation: checks of licensed premises across Ireland to ensure compliance with regulations; and
- Operation Faoiseamh: enhanced support for victims of domestic violence.

The Gardaí have been further deployed to police self-quarantine and incidents related to mandatory quarantine. Members of the Defence Forces are involved with mandatory quarantine too but in an organisational, rather than enforcement capacity.

Forms of penalty

For a short initial period, there was no criminal law enforcement. Announcing the 27 March 2020 lockdown, Taoiseach Leo Varadkar said that, with certain exceptions, ‘everybody must stay at home in all circumstances’ and used phrases such as ‘prohibition’ and ‘restrictions’.¹¹ These measures did not have the force of law until 8 April 2020.¹² In that intervening period, a Garda campaign was

¹⁰ The Garda Síochána works with the Director of Public Prosecutions in bringing prosecutions.

¹¹ ‘Speech of Taoiseach Leo Varadkar 27 March 2020’ (27 March 2020) <https://merrionstreet.ie/en/news-room/news/speech_of_taoiseach_leo_varadkar_27_march_2020.html> accessed 24 June 2021.

¹² [Health Act 1947 \(Section 31A -Temporary Restrictions\) \(Covid-19\) Regulations 2020 \(S.I. No. 121/2020\)](#)



launched to achieve compliance by persuasion achieved through widespread deployment.¹³ The first report of a person charged under the legislation occurred on 15 April 2021.¹⁴ From 8 April to 28 June 2020, 363 offences were recorded by the Gardaí.¹⁵ There have been laws in place continuously since 8 April 2020 which have required police enforcement.

Payment notices / on-the-spot fines

The October 2020 introduction of on-the-spot fines simplified enforcement. This has relied on pre-existing Garda infrastructure, using an internal phone app and the Fixed Charge Processing Office to generate fines. The Minister for Health said this transition was to address the ‘small number of people who make conscious decisions not to follow the measures everyone else is following.’¹⁶ The Minister for Justice said that the government hoped that ‘the fixed-charge system being proposed will help to change behaviour’.¹⁷ The theory follows that people would avoid non-compliance with the threat of an almost immediate financial hit.

Throughout 2021, the Garda Press Office has published weekly statistics on the number of these fines used, breaking them down by offence, gender, age group, Garda regions and divisions, day of issuance and the current status of fines.¹⁸ These fines have largely been issued to men (74% male, 26% female), 18-25 year-olds (53% of fines) and at weekends (45% of fines).

These on-the-spot fines were created in part to provide potential offenders with the opportunity to have lower penalties and to avoid court and a criminal conviction.¹⁹ Perhaps surprisingly, a significant number of those issued with these fines have not availed of the on-the-spot fines issued to them; the latest statistics on all fines to date indicate 7% are within the payment period, 46% are paid and 47%

¹³ RTE News, ‘Garda Operation Takes Place amid New Covid-19 Restrictions’ *RTE News* (28 March 2020) <<https://www.rte.ie/news/2020/0328/1126935-covid19-measures-policing/>> accessed 24 June 2021.

¹⁴ RTE News, ‘First Person Charged with Violating Virus Restrictions’ *RTE News* (15 March 2020) <<https://www.rte.ie/news/2020/0415/1130713-covid-charged-break-restrictions/>> accessed 24 June 2021.

¹⁵ An Garda Síochána, ‘COVID-19 Statistics’ <<https://www.garda.ie/en/about-us/our-departments/office-of-corporate-communications/news-media/coronavirus-covid-19-.html>> accessed 24 June 2021.

¹⁶ Dáil Deb 23 October 2020, vol 999, no 8 <https://www.oireachtas.ie/en/debates/debate/dail/2020-10-23/2/#spk_2> accessed 24 June 2021.

¹⁷ *ibid.*

¹⁸ An Garda Síochána (n 15).

¹⁹ Conor White, ‘Higher Fines for Travelling Abroad: Legal Imperfections’ (*COVID-19 Law and Human Rights Observatory*, 12 February 2021) <<https://tcdlaw.blogspot.com/2021/02/higher-fines-for-travelling-abroad.html>> accessed 24 June 2021.



are unpaid, with non-paying individuals due to receive a court date. Further research would be necessary to determine whether non-payment is due to refusal to pay, inability to pay or lack of knowledge of the consequences of not paying within 28 days.

As of 13 May 2021, 21,417 fines have been issued, meaning potentially over 10,000 offences are due to be brought to court, in addition to prosecutions that are not designated as fixed penalty provisions. As a point of comparison, 226,692 separate offences came before the District Court in 2019 related to road traffic offences.²⁰

Uneven enforcement?

The pandemic experience thus far appears to show a level of unevenness present in enforcing public health measures, in part due to difficulties in how to investigate some kinds of breaches.

The most common on-the-spot fine has been for leaving one's home without a reasonable excuse (69% of fines), colloquially, though incorrectly, stated as 'leaving your 5 km'.²¹ This should be expected as it may simply involve, for instance, a police checkpoint and being asked whether or not you have a reasonable excuse for your travel. Corresponding with the removal of the '5 km limit' and replacement with restrictions reduced to just inter-county travel, the volume of fines quite dramatically reduced (2,747 fines in April, versus 7,092 in February and 6,762 in March). While checkpoints were a very visible way to demonstrate enforcement, research by the Policing Authority in April 2021 found that checkpoints were not a major source for fines.²² At the other end of enforcement via on-the-spot fines, 391 fines were issued up to 13 May 2021 for not wearing a mask.

There are statistics available too for offences outside the fixed penalty provision system. Since the introduction of legislation to require arriving passengers to produce a negative PCR test, 265 offences

²⁰ Courts Service, 'Annual Report 2019' 83 <<https://www.courts.ie/acc/alfresco/9bd89c8a-3187-44c3-a2e9-ff0855e69cb5/CourtsServiceAnnualReport2019.pdf/pdf#view=fitH>> accessed 24 June 2021.

²¹ The restriction was most recently removed on 12 April 2021 by the Health Act 1947 (Section 31A - Temporary Restrictions) (Covid-19) Regulations 2021.

²² Policing Authority, 'Report on Policing Performance by the Garda Síochána during COVID-19' (19 April 2021) <https://www.policingauthority.ie/assets/uploads/documents/2021_04_19_Report_13_on_policing_performance_during_Covid-19_Final.pdf> accessed 24 June 2021.



were detected up to 8 May 2021, but only one of those has had proceedings commenced. Between 3 July 2020 and 8 May 2021, 445 breaches were recorded at licensed premises and between 25 October 2020 and 8 May 2021, 227 breaches were detected at retail premises. These numbers, while not insignificant, are substantially lower than the enforcement of unexcused individual travel. No statistics are available directly identifying breaches in public places other than licensed and retail premises.²³

These statistics capture the ability to fine or prosecute where there are recognised offences. Key measures to restrict transmission, such as social distancing and having sufficient ventilation were never formulated into offences. Conversely, the enforcement of ‘leaving your 5 km’ was only indirectly connected to the spread of the virus and acted as a substitute means of curbing the spread of COVID-19.

Is it the case that enforcement is always a ‘last resort’? The Policing Authority’s report in April 2021 indicates that the ‘4Es’ system – ‘Engage, Explain, Encourage and as a last resort Enforce’ – continues to be policy, though it features accounts of some stakeholders who feel some of the first steps are bypassed. There are no statistics released on the prevalence and efficacy of the first three Es. The discretionary elements of the system of enforcement will naturally lead to variations depending on context.

Minimal punishment, maximal compliance?

This analysis shows how the criminal law has been deployed as part of a public health strategy, supplementing and reinforcing other norms, rather than according to a criminal justice logic. This is, in our view, appropriate. Of more concern, however, is the divergence between the true content of the enacted legal measures during the COVID-19 crisis and the official descriptions or statements of what citizens can and cannot do, whether these statements were offered in formal settings, such as the HSE webpages,²⁴ or in informal settings, such as a Minister being interviewed in the media.²⁵ This

²³ Between 29 June 2020 and 8 May 2021, 581 offences were identified for ‘Breaches of Health Act 1947’ which exclude offences identified regarding ‘Licensed Premises, Retail Premises, Face Coverings and International Travel Regulations’.

²⁴ Conor Casey et al (n 1).

²⁵ Conor Lally, ‘People Can Travel more than 5km to Collect Takeaway Food, says Minister for Justice’ *The Irish Times* (15 January 2021) <<https://www.irishtimes.com/news/crime-and-law/people-can-travel-more-than-5km-to-collect-takeaway-food-says-minister-for-justice-1.4459370>> accessed 24 June 2021.



has been identified as constituting a legality concern.²⁶ It could, however, reflect a deliberate strategy to imply that the rules are stricter than they really are, or that they will be applied in a stricter way than what is officially intended to be the case. Can a strategy of minimal enforcement, maximal compliance be defended?

Under-enforcement and uneven enforcement of criminal law is commonplace. One explanation is that, notwithstanding rule of law principles, the pursuit of legitimate political goals may be aided on occasion by artful divergence between the rules as announced and the rules as applied.²⁷ For example, in criminal law, if the defence of duress²⁸ (which exculpates those who committed a crime only because coerced by threats) was not known, or little known by the public, but still applied in court, it could have exculpating effect for those who committed crimes because coerced by threats, while also being less open to unmeritorious invocation. Anybody who qualifies for a duress defence they didn't know about at the time of the offence tends to be a morally apt candidate for it, whereas a person influenced by their awareness of the duress defence at the time may be a dubious candidate. The use of standards in criminal law definition is another device that makes it difficult to know or predict the exact application of law in court. Vague criminal law standards, such as in a test that turns on what is reasonable in the circumstances,²⁹ may chill undesirable behaviour beyond that actually criminalised, and leave moral elbow room for just applications of criminal liability in difficult cases.

One could project a design on to the phenomenon of the divergence between the COVID-19 rules as enacted and as described in communications from official sources. Elderly people were discouraged from leaving their homes for any reason whatsoever in the first lockdown. The HSE website's lists of Dos and Don'ts in the first lockdown told elderly people not to leave their house, presented in the same stark terms as the actual legal proscriptions at the time, even though there was no legal norm specifically addressed to elderly people.³⁰ Here, the law had not taken the drastic step of applying an age discrimination in a criminal prohibition of a basic freedom. Yet it may have been helpful for public health at the time if many elderly people – and younger people who would have to support them – believed elderly people were under a legal obligation, and not merely advised, to 'cocoon'. The 4Es approach to policing, noted above, reveals clearly an aim to not apply the law as announced. However, the public announcement and recognition of the 4Es approach from early on would tend to reduce

²⁶ Casey et al (n 23) 67-68.

²⁷ Dan-Cohen (n 27).

²⁸ *ibid* 633.

²⁹ As for the lawful use of force in Non-Fatal Offences Against the Person Act 1997, s 18-19.

³⁰ Casey et al (n 1) 65.



the efficacy of a design whereby the public are allowed think the law is stricter than how it will be really applied.

The combination of a standard-based test for liability – a ‘reasonable excuse’ for leaving one’s residence – with rule-like enumerated examples that will satisfy that standard may serve to selectively transmit to the public the content of the law as it will be applied. A possible explanation of this design is that it contemplates minimal prosecution of its offence, as there often can be found in the circumstances some ‘reasonable excuse’ for a person being out of their residence despite their reason not being explicitly anticipated in the legislation. Yet the public messaging, the media, and common understanding would tend not to (and did not in fact) generally understand and describe this law as turning on a contestable, open-ended *standard* but rather understood it by reference to the listed acceptable reasons for leaving one’s home to exercise, to shop for groceries, collect a take-away, and so on. The overuse in public discourse of the ‘5 km limit’ in particular may show this, especially in the third lockdown. This was a specific radial distance limit for one’s zone of exercise only, but was talked about as a 5 km limit on one’s travel or movements generally.³¹ Generally speaking, the public focused on the rule-like norms, not the standard.

Even if minimal punishment, maximal compliance was the initial strategy, its effectiveness and appropriateness diminished over time. Divergences between what the law requires and what the government communicates become all too obvious. Golfgate in August 2020 marked an inflection point: people appeared more questioning of the government’s message once they realised that what they had thought were legal restrictions were known by powerful people to be merely advice and guidance. This in turn may have contributed to compliance fatigue and the need for stricter enforcement mechanisms. The very large number of fines issued since January 2021 suggests that

³¹ Minister McEntee corrected this misconception in a media interview in January 2021 (see n25). She noted that the 5km limit in legislation applied to exercise and that people were permitted to travel beyond 5km for shopping and takeaways. However, the Minister, as reported (n25), then went on to give a misleading description of where people stood in legal terms:

‘She added that sanctioning people driving to collect takeaways “might seem harsh” but people are asked to travel for food “within their vicinity, to travel to maybe the closest shop or the nearest takeaway ... [a]s rural as you might be, 80km is certainly not the closest (takeaway),” she said.’

The relevant legislation (SI No 701/2020 - Health Act 1947 (Section 31A - Temporary Restrictions) (Covid-19) (No. 10) Regulations 2020, Regulation 4(2)(t)) said nothing about shops or takeaways that one could permissibly visit being in one’s ‘vicinity’ or being the ‘nearest’ or ‘closest’. The Minister’s words were clearly a fudge between what was a legal restriction and what was desired, or what was asked for, from a public health perspective. Critically, at this point, the fudge was being used to rationalise and stand over an on the spot penalty for behaviour (driving 80km to collect a takeaway) that was not actually prohibited since the collecting a takeaway excuse for travel did not include a limit on the distance one could travel. In any event, the Minister’s clarification seemed to have no impact on the widespread references to 5km as a general travel limit rather than simply an exercise zone limit.



enforcement—albeit uneven and sometimes without any legal basis—is now a staple aspect of the public health strategy. A legal regime that was, on one view, never meant to be widely or strictly enforced was called on to be enforced. What looks like benign fudging of the rules in the context of minimal enforcement begins to look like a problematic exercise of state authority in the context of stricter enforcement.

Conclusions

For the remainder of the pandemic and any future emergency this analysis suggests three general recommendations:

- A public health approach is preferable to a criminal justice approach;
- Public health guidance and criminal law enforcement both play an important role in the public health approach;
- Blurring the boundary between public health guidance and criminal law enforcement, apart from raising rule of law concerns, can only be an effective strategy in the short-term and should not be followed in future.



Chapter III: COVID-19, Public Health and Funerals in Ireland

Heather Conway

The law's treatment of human remains has always been based on two things: respect for the dead and public health.¹ These core values are self-explanatory. The first is a universal standard that speaks to basic notions of human dignity. The second acknowledges the risk of disease as unattended bodies decompose; to guard against this, the dead must be physically separated from the living. Both values usually carry equal weight. However, in pandemics and other emergency situations (*eg* natural disasters) the balance inevitably shifts to public health.

Dealing with the dead involves the initial removal, storage and preparation of the body followed by some sort of final dispositive ritual- what have been described as the 'practical and emotional tasks associated with death.'² Managing a sharp increase in death rates is part of every pandemic, and plans for temporary morgues and enhanced burial capacity were part of the government's preparedness strategy back in the spring of 2020, to ensure that local systems were not overwhelmed as COVID-19 rates started to climb.³ Within both the medical profession and deathcare industry, concerns around the infectious properties of corpses and possible virus transmission through respiratory droplets and bodily fluids triggered protocols for handling human remains in suspected or confirmed COVID-19 deaths and the wearing of PPE. However, the greater danger was of the dead becoming highly localised sites for person-to-person transmission, as large numbers of people came together at wakes and/or funerals. This public health risk is what drove the restrictions imposed on *all* funerals in late March 2020, for both COVID-19 and non-virus deaths.

Initial Restrictions on Funerals

Funerals do more than remove the threat of disease posed by decaying corpses. They are important social rituals that mark the life of the deceased; and in Ireland, in particular, they allow family and friends to come together to mourn their loss, while drawing support from members of the community

¹ Heather Conway, *The Law and the Dead* (Routledge 2016) 59-60.

² Geri M Bosley and Alicia Skinner Cook, 'Therapeutic Aspects of Funeral Ritual' (1994) 4 *Journal of Family Psychotherapy* 69.

³ <[Coronavirus: Temporary morgue planned for Kilmainham \(irishtimes.com\)](https://www.irishtimes.com/news/coronavirus/coronavirus-temporary-morgue-planned-for-kilmainham-2020-03-26)> (*The Irish Times*, 26 March 2020).



who gather to pay their respects to the living and the dead. It has been said that Irish people have a ‘particular reverence’ for funerals, and attendance is viewed as a ‘social obligation’.⁴

Funerals could still go ahead when the first strict lockdown was introduced in March 2020. The government wisely stopped short of banning mourners, no doubt mindful of the public outcry that greeted a suggestion to this effect by the Irish Association of Funeral Directors⁵ and the potential for a rights-based challenge to any such edict.⁶ Basic legal restrictions were set out in the Health Act 1947 (Section 31A- Temporary Restrictions) (Covid-19) Regulations 2020.⁷ Passed in response to the ‘immediate, exceptional and manifest risk posed to human life and public health by the spread of Covid-19’, curbs on freedom of movement and prohibitions on gatherings ended the traditional Irish wake. The regulations listed funerals as a ‘reasonable excuse’ for individuals to leave their place of residence but only where the deceased was ‘(i) another person who resided in the relevant residence before his or her death, or (ii) a close family member.’⁸ While the regulations did not impose a numbers limit, government guidance stated a maximum of 10 people in attendance (excluding funeral directors, and people officiating at the service). Mourners from different households would have to travel separately to and from the funeral, wear the obligatory face-coverings, and maintain a safe physical distance from each other throughout the ceremony itself.

The intent behind these combined legal restrictions and official guidance was to make social distancing easier and curb transmission of the virus, protecting not only the small numbers of mourners but also funeral directors and other key personnel (*eg* crematoria and cemetery staff, funeral celebrants) with vital roles to play in such challenging times.

⁴ Maria Ronan, “Funerals in the Time of Coronavirus” (2020) *Irish Journal of Sociology*, available at <<https://doi.org/10.1177/0791603520967617>> accessed May 2021.

⁵ <[Coronavirus: Funerals to be held under controlled conditions \(irishtimes.com\)](https://www.irishtimes.com/news/coronavirus/coronavirus-funerals-to-be-held-under-controlled-conditions-1.4411111)> (*The Irish Times*, 13 March 2020) accessed 16 June 2021.

⁶ The European Court of Human Rights has included the execution of funeral rites within the right to private and family life under Article 8(1) of the Convention. For example, *Pannullo and Forte v France* (application no 37794/97) and *Girard v France* (application no 22590/04) both suggest a legitimate family interest in what happens to the remains of a deceased loved one. In *Solska and Rybicka v Poland* [2018] ECHR 730 (applications nos 30491/17 and 31083/17), the court accepted that Article 8(1) was more about relations between the living, but agreed that it extended to certain situations after death (including the way in which the body of a dead relative was treated, and issues regarding the ability to attend the funeral).

⁷ These regulations were passed pursuant to the Health (Preservation and Protection and other Emergency Measures in the Public Interest) Act 2020 - one of a series of measures passed by the Oireachtas in response to the pandemic.

⁸ Regulation 2(k). One of the non-exhaustive exceptions to the general restriction imposed by Regulation 4(1). Funeral and burial services were classed as ‘essential services’ under Sch 2.



‘COVID-Safe’ Funerals

As restrictions were eased and re-introduced in line with shifting infection levels, the rules around funerals adjusted slightly as Ireland moved through different ‘Levels of Alert’. However, restrictions on movement, prohibitions on gatherings and social distancing- all core elements of lockdown strategies that have been replicated worldwide- continued to dominate funerals.⁹

Numbers caps have remained in place, rising from 10 to 25, and with an increase to 50 taking effect in May 2021¹⁰ (though smaller venues may hold less for social distancing reasons). Funeral directors have reported a sense of relief that larger funerals are becoming possible.¹¹ A limit of 10 made it difficult for families to decide who could be physically present at the deceased’s funeral¹²- and the original statutory rules (or subsequent versions) did not define who was a ‘close family member’. The rationale seems obvious: individual families take many different forms, and attempting a ‘one-size-fits-all’ definition would have been problematic. However, all sorts of situations and family dynamics can complicate decisions on who can and who cannot attend,¹³ and it is easy to envisage the anguish (and potential conflict) that this has created during the pandemic. Restrictions on travel - both to and within the State - have also impacted on funerals; and while domestic travel is resuming, the advice against non-essential travel and mandatory self-isolation for people arriving in Ireland from countries that are not on the current COVID-19 green list will continue to impact.

Intended as time-limited measures, government advice is that social distancing and some level of restrictions will be with us for the foreseeable future - despite the success of the vaccination programme - with stricter controls being (re)introduced if infection rates increase. Funerals (and wakes) are still gatherings that pose some public health risk with documented outbreaks of COVID-19

⁹ This discussion makes no assumptions about the legality of otherwise of these measures. The human rights issues raised by the restrictions on fundamental freedoms are discussed at length by Oran Doyle, David Kenny, Donna Lyons and Conor Casey, *Ireland’s Emergency Powers During the Pandemic*, available at <www.ihrec.ie/app/uploads/2021/02/Irelands-Emergency-Powers-During-the-Covid-19-Pandemic-25022021.pdf> accessed May 2021.

¹⁰ <[Death and bereavement during COVID-19 \(citizensinformation.ie\)](http://citizensinformation.ie)> accessed May 2021.

¹¹ <[Covid-19: Funeral directors adapt after surviving pandemic anger \(irishtimes.com\)](http://irishtimes.com)> accessed 4 May 2021.

¹² The pandemic has increased live-streaming of funerals, enabling those who cannot be physically present to be virtually present.

¹³ Disputes, within families, over funeral arrangements can often occur at such emotionally charged time (see *eg* Heather Conway, “‘First Among Equals’: Breaking the Deadlock in Family Funeral Disputes’ (2018) 39 *Liverpool Law Review* 151) and COVID-19 restrictions are likely to have caused further aggravation.



having occurred as result.¹⁴ With this in mind, it may be some time before they return to any semblance of pre-pandemic normality.

Broader Public Health Impacts

Major changes have been imposed on funerals, in a country where the ritualistic and community elements of this last act for the dead are ingrained in our socio-cultural psyche. As public health measures designed to limit and control the spread of COVID-19, these have been reluctantly accepted by most Irish citizens. However, when governments talk about protecting public health in pandemics, the primary focus is on *physical health*; *mental health* is a secondary issue- though this is something that is short-sighted, and damaging to those who have lost loved ones since the start of the pandemic.

Allowing funerals to go ahead with a small number of mourners recognises how vital this is for the mental health and wellbeing of the bereaved. That said, the emotional impact of altered funeral formats is significant and has already been highlighted by the bereavement sector.¹⁵ Closed coffins prevent families from seeing a loved one who may have died alone in hospital or in a care home, and who is now isolated in death as well; and the role that funerals play in bringing families, friends and communities together to pay their last respects to the dead and provide vital support to the bereaved is irretrievably lost when funerals are restricted to such small numbers. There is no wake, no viewing of the deceased, no comforting hugs or handshakes at funerals, no post-funeral gathering- all such ingrained parts of our socio-cultural fabric in Ireland, with key roles to play in the grieving process. For those who have been denied the basic right to say a 'proper' goodbye to their dead since March 2020, the longer-term mental health impact of combined legal restrictions and public health guidance on funerals is becoming apparent. Ensuring that adequate professional support is available must be a government priority, as vital lessons are learned for the remainder of the pandemic and for any similar future events.

¹⁴ <[Covid-19: Small gatherings and behaviour at funerals risking progress, warns Holohan \(irishtimes.com\)](#)> (*The Irish Times*, 15 November 2020); <[Covid-19: Donegal wake linked to 84-case cluster - BBC News](#)> BBC, 6 May 2021.

¹⁵ See eg <[The Irish Childhood Bereavement Network](#)> and <[Coronavirus: grieving and isolation | Cruse Bereavement Care](#)> (links accessed May 2021).



Chapter IV: COVID-19 and the Prison System in Ireland

Sarah Curristan, Sophie van der Valk and Mary Rogan

Introduction

COVID-19 can have an outsize effect in places of detention. Prisons are by their nature shared spaces, where people live in close confines. 48% of prisoners in Ireland share cells.¹ The Irish Prison Service's own figures show that 45% of prisoners must use the toilet in the presence of another.² The material realities and often poor physical infrastructure of our prisons make infection control protocols challenging to implement. The backgrounds of many people in prison are also characterised by physical and mental health problems,³ which have been linked with a higher risk of severe COVID-19. Ireland has a significant number of older prisoners in custody, with 15% of the sentenced prison population over the age of 50.⁴ In general, there is also higher prevalence of poorer health among the prison population,⁵ with a much higher levels of drug, alcohol, and tobacco dependency.⁶ The use of isolation and separation can exacerbate mental health problems. Prisons are therefore especially vulnerable to the spread of infectious disease, and are places where the effects of disease can be particularly intense.

This chapter examines the response of Ireland's prisons to the COVID-19 pandemic. Overall, Ireland's approach to managing COVID-19 in prisons has been quite successful, with far fewer cases than some prison systems in other parts of the world. This success has, however, come at a price, involving significant restrictions on visits and regimes. There have also been concerns about the transparency afforded to key changes in how prisons are run.

¹ Irish Penal Reform Trust, 'Doubling Up In Cells Is An Ineffective And Short-Term Response To Overcrowding' (*iprt.ie*, 2019) <<https://www.iprt.ie/latest-news/doubling-up-in-cells-is-an-ineffective-and-short-term-response-to-overcrowding/>> accessed 24 April 2021.

² Irish Prison Service, 'Census Prison Population October 2020 – Cell Occupancy – In-Cell Sanitation' (*Irishprisons.ie*, 2021) <https://www.irishprisons.ie/wp-content/uploads/documents_pdf/October-2020-In-Cell.pdf> accessed 24 April 2021.

³ Catherine MacNamara, Lorraine Varley, Patricia Mannix McNamara, 'Improving Prison Conditions by Strengthening the Monitoring of HIV, HCV, TB and Harm Reduction' (Irish Penal Reform Trust, 2016) <<https://www.iprt.ie/iprt-publications/monitoring-of-hiv-hcv-tb-in-prison-national-report-on-ireland/>> accessed 31 March 2021.

⁴ Irish Prison Service, 'Irish Prison Service Monthly Information Note – January 2020' (*Irishprisons.ie*, 2020) <https://www.irishprisons.ie/wp-content/uploads/documents_pdf/January-2020.pdf> accessed 31 March 2021.

⁵ Catherine MacNamara, Lorraine Varley, Patricia Mannix McNamara, 'Improving Prison Conditions by Strengthening the Monitoring of HIV, HCV, TB and Harm Reduction' (Irish Penal Reform Trust, 2016) <<https://www.iprt.ie/iprt-publications/monitoring-of-hiv-hcv-tb-in-prison-national-report-on-ireland/>> accessed 31 March 2021.

⁶ Joe M Barry and others, 'Primary Medical Care In Irish Prisons' (2010) 10 BMC Health Services Research.



Protecting Rights in Prison During the COVID-19 Pandemic

Ireland has been relatively successful in mitigating the transmission of COVID-19 within its prisons; until August 2020, there were no reported cases of COVID-19 within the prison system, with 97 confirmed cases among the prisoner population and 312 reported cases among prison staff since then.⁷ The Irish Prison Service (IPS) has developed a Prison Framework for Restrictive Measures governing changes to prison regime and activities which is aligned to the government's National Framework for Living with COVID.⁸ The management of COVID-19 within the Irish prison system comes at a steep cost in terms of the restrictions placed on the prison regime and, in turn, how these restrictions are experienced by people in custody, which have implications for the protections of the rights of those who are deprived of their liberty.

Human rights protections must not be dispensed with even in the extreme circumstances created by the pandemic. The World Health Organisation (WHO) has emphasised the role human rights must play in the management of COVID-19 in places of detention, stating that 'people in prisons and other places of detention are not only likely to be more vulnerable to infection with COVID-19, they are also especially vulnerable to human rights violations'.⁹ While the use of exceptional measures may be necessary to hinder the spread of the virus, their implementation must be just. Additionally, as prison regimes temporarily adopt these restrictive measures, the WHO advocates that there is a need to place human rights-informed decision making to the forefront.¹⁰ The European Committee for the Prevention of Torture and Inhuman and Degrading Treatment (CPT), the Council of Europe's international monitoring body for places of detention, has also added that decisions should be informed by a thorough assessment of the implications for the human rights of those affected.¹¹ The CPT advocates that any restrictive measures imposed should have a legal basis and be necessary, proportionate, time-bounded, and respectful of human dignity.¹² Further guidance issued by the CPT

⁷ *Dáil Debates* (2021) 1004(7), 3 March 2021, question 669.

⁸ *Dáil Debates* (2020) 999(5), 20 October 2020, questions 527, 528.

⁹ World Health Organisation, 'Preparedness, Prevention and Control of COVID-19 in Prisons and Other Places of Detention: Interim Guidance, 15 March 2020' (2020) 3 <<https://apps.who.int/iris/bitstream/handle/10665/336525/WHO-EURO-2020-1405-41155-55954-eng.pdf?sequence=1&isAllowed=y>> accessed 8 April 2021.

¹⁰ *ibid.*

¹¹ Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 'Follow-Up Statement Regarding The Situation Of Persons Deprived Of Their Liberty In The Context Of The Ongoing Covid-19 Pandemic' (2020) <<https://rm.coe.int/16809ef566>> accessed 8 April 2021.

¹² Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), 'Statement of Principles Relating to the Treatment of Persons Deprived of Their Liberty in the Context of the Coronavirus Disease (Covid-19) Pandemic' (2020) <<https://rm.coe.int/16809cfa4b>> accessed 8 April 2021.



states that temporary restrictions implemented in places of detention should be lifted as soon as it is possible to safely do so; they note that this is particularly exigent where such restrictions affect detained persons' contact with the outside world and the activities available to them under the prison regime.¹³

Changes to Prison Regimes

Prison regimes in Ireland have undergone several changes arising out of the need for infection control measures, many of which pose challenges for the protection of multiple rights. A key change has involved the use of isolation and restricted regimes. The Prison Rules 2007¹⁴ permit the separation of prisoners from the general population on the grounds of order,¹⁵ a threat of harm to the person,¹⁶ or for the purposes of special observation.¹⁷ Under Rule 11 of the 2007 Rules, a prisoner is examined by a doctor on admission for, amongst other things, their isolation on medical grounds where the prisoner is suspected of having a contagious condition. No new rule has been introduced to permit separation for reasons related to COVID-19. All those newly committed to prison must now, however, enter quarantine for 14 days, during which they may leave their cell only for exercise outdoors for a maximum of one hour per day,¹⁸ which is a minimum requirement under Rule 32, though, as noted below, there is a power to suspend exercise.¹⁹ The Irish Prison Service describes separation arising out of COVID-19 as being under Rule 103. Under Rule 103, a prison governor may not refuse to implement a direction that a prisoner who is suffering from, or suspected of suffering from, a contagious or infectious disease or condition that threatens the health or well-being of others, be segregated in order to prevent the spread of the disease or condition. While this rule mandates governors to follow a medical recommendation, it cannot be seen as a basis for isolation. The Irish Prison Service also introduced a policy of requiring prisoners over the age of 70 to 'cocoon', or separate from the rest of the prison population. This policy ended in July 2020, though prisoners can continue to request to cocoon. Such prisoners are considered to be separated under Rule 63, using an expansive interpretation of preventing 'harm'.

¹³ Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 'Follow-Up Statement Regarding The Situation Of Persons Deprived Of Their Liberty In The Context Of The Ongoing Covid-19 Pandemic' (2020) <<https://rm.coe.int/16809ef566>> accessed 8 April 2021.

¹⁴ Prison Rules 2007, SI no 252/2007.

¹⁵ Ibid, r 62.

¹⁶ Ibid, r 63.

¹⁷ Ibid, r 64.

¹⁸ Personal communication from the Press Office, Irish Prison Service to Mary Rogan (19 April 2021).

¹⁹ Prison Rules 2007, SI no 252/2007, part 3.



More generally, amendments to the Prison Rules 2007 in July 2020 grant the IPS Director General and prison governors the ability to restrict or suspend the entitlement to physical recreation and exercise in line with public health advice and the Infectious Diseases Regulations 1981.²⁰ There is no specified time limitation for these changes to the regime, a matter of concern to the NGO the Irish Penal Reform Trust.²¹ The legislation represents a significant change in Irish law, especially as the Prison (Amendment) Rules²² required, with caveats, all prisoners to be given the opportunity to spend a minimum period of two hours out of cell time with an opportunity for meaningful human contact, including, at the discretion of the governor, contact with other prisoners.

It is also notable that, unlike many emergency measures introduced during this period, there is no time limit on the legislation itself, which is concerning. Reportedly, prison gyms have continued to operate on a reduced basis to allow for social distancing.²³ The importance of outdoor exercise was recognised by people in custody during in a recent research study of prisoners' experiences of cocooning. The study also highlights that, owing to COVID-19 restrictions, access to the prison yard could be sporadic.²⁴

Another considerable impact of the pandemic has been restrictions on showers. Under Rule 25(2) of the Prison Rules 2007 a prisoner is permitted to take a hot shower or bath at least once a week. Due to infection control concerns, those prisoners who do not have an in-cell shower (the vast majority) cannot access a communal shower and must instead use the hot and cold water in the sink in their cell, a matter kept under review.²⁵

Another significant change has been to prison visits. Under Rule 35 of the Prison Rules 2007, people in custody are entitled to at least one half-hour visit per week. Visits are critically important for the purposes of maintaining relationships, in addition to contributing to prisoners' well-being.²⁶ As a result

²⁰ Prison (Amendment) Rules 2020, SI no 250/2020.

²¹ Irish Penal Reform Trust, 'Progress In The Penal System 2020: Assessing Progress During A Pandemic' (2021) <https://www.iprt.ie/site/assets/files/6845/progress_in_the_penal_system_2020.pdf> accessed 31 March 2021.

²² Prison (Amendment) Rules 2017, SI no 276/2017.

²³ Irish Prison Service, 'Family Information Booklet For People In Our Custody' (2020) <https://www.irishprisons.ie/wp-content/uploads/documents_pdf/Family-Information-Booklet-September-2020.pdf> accessed 8 April 2021; Personal communication from the Press Officer, Irish Prison Service to Mary Rogan (19 April 2021).

²⁴ Patricia Gilheaney, Joe Garrihy and Ian Marder, 'Ameliorating The Impact Of Cocooning On People In Custody – A Briefing' (Office of the Inspector of Prisons 2020) <<https://www.oip.ie/wp-content/uploads/2020/07/Ameliorating-the-impact-of-cocooning-on-people-in-custody-a-briefing.pdf>> accessed 8 April 2021.

²⁵ Personal communication from the Press Office to Mary Rogan (16 April 2021).

²⁶ Karen De Claire and Louise Dixon, 'The Effects of Prison Visits From Family Members on Prisoners' Well-Being, Prison Rule Breaking, and Recidivism: A Review of Research Since 1991' (2017) 18(2) Trauma, Violence, & Abuse 185.



of COVID-19 restrictions, visits have been significantly curtailed in prisons since March 2020. The Prison Rules (Amendment) 2020 granted the IPS Director General and prison Governors the ability to suspend or restrict prisoners' entitlement to visits in line with advice provided by the Department of Health or Health Service Executive and the Infectious Diseases Regulations 1981.²⁷ Modifications to the nature of visits can extend to their frequency, duration, and visitation arrangements including the age and number of visitors permitted. Restriction and suspension of visits may be implemented for 'a specified period or periods', but there is no time limit on the duration of this restriction.

Physical visits were initially suspended in March 2020, resumed briefly from late July 2020 onwards, before being suspended again in October 2020. Physical visits were reinstated temporarily over the Christmas period, albeit with visiting times limited to 15 minutes and no physical contact permitted.²⁸ At present, visits continue to be suspended and are set to be reintroduced when national restrictions return to level 3 under the National Framework for Living with COVID-19, as guided by public health advice.²⁹ The European Court of Human Rights has emphasised the importance of having an individualised risk assessment before placing restrictions on visits, though this has been in the context of security concerns;³⁰ it seems unlikely that the current restrictions could be successfully litigated.

Some positive developments have been observed in Irish prisons in order to facilitate family contact. For example, additional and extended phone calls have been permitted.³¹ Furthermore, the introduction of technology in all prisons to support video calls with family members has been praised.³² Feedback from prisoners and their families has been positive, particularly as the technology allows prisoners to see family members in their own home setting.³³ However, the duration of the calls is limited to 15 minutes after which the call automatically disconnects.³⁴ It is positive to note that the use of video calls will be maintained when physical visits are resumed,³⁵ they are particularly

²⁷ Prison (Amendment) Rules 2020, SI no 250/2020.

²⁸ *Dáil Debates* (2020) 994(4), 30 June 2020, question 333; *Dáil Debates* (2020) 1002(3), 9 Dec 2020, question 181.

²⁹ *Dáil Debates* (2021) 1005(1), 10 March 2021, question 718.

³⁰ *Khoroshenko v Russia* (application no 41418/04).

³¹ Caron McCaffrey, 'Ask An Expert: Managing Prisons During The COVID-19 Pandemic, Special Guest Blog With Caron McCaffrey, Director General Of The Irish Prison Service' (PRILA, 7 July 2020) <<https://prilatcd.wordpress.com/2020/07/07/ask-an-expert-managing-prisons-during-the-covid-19-pandemic-special-guest-blog-with-caron-mccaffrey-director-general-of-the-irish-prison-service/>> accessed 8 April 2021.

³² *Dáil Debates* (2020) 1002(3), 9 Dec 2020, question 181.

³³ Caron McCaffrey, 'Ask An Expert: Managing Prisons During The COVID-19 Pandemic, Special Guest Blog With Caron McCaffrey, Director General Of The Irish Prison Service' (PRILA, 7 July 2020) <<https://prilatcd.wordpress.com/2020/07/07/ask-an-expert-managing-prisons-during-the-covid-19-pandemic-special-guest-blog-with-caron-mccaffrey-director-general-of-the-irish-prison-service/>> accessed 8 April 2021.

³⁴ Irish Prison Service, 'Family Information Booklet For People In Our Custody' (2020) <https://www.irishprisons.ie/wp-content/uploads/documents_pdf/Family-Information-Booklet-September-2020.pdf> accessed 8 April 2021.

³⁵ *Dáil Debates* (2021) 1005(1), 10 March 2021, question 718.



valuable for prisoners' families who would otherwise be required to travel long distances or who have been advised to isolate during the pandemic. However, as a form of social contact they cannot be deemed equivalent to physical visits.

Additionally, in-class educational services for prisoners ceased in March 2020 in line with the public health guidance. According to the Irish Prison Service, teachers have supplied resources to prisoners to allow them to continue educational work, in some form, from their cells; this included the provision of books, printouts, and art supplies.³⁶ IPRT have highlighted that there are opportunities for the use of in-cell digital technologies to support education that could be further explored.³⁷ Some prisoners who partake in work within the prison have continued working in essential areas such as the kitchen, waste management, laundries, and industrial cleaning. However, workshops have been affected by social distancing protocols meaning that many work training programmes have been either significantly reduced in terms of placement numbers or suspended.³⁸

In their report on monitoring progress in the Irish prison system during 2020, the Irish Penal Reform Trust have commented that, "the punitive nature of prison has been intensified during the pandemic while its rehabilitative purpose has been significantly eroded by virtue of the imposition of COVID-19 restrictions".³⁹ Similarly, this point has been raised in research by Edgar *et al* which has collated prisoners' accounts of their experiences under COVID-19 restrictions in England and Wales. With prisoners confined to their cells for 23-hours a day and with the regime and services significantly curtailed, the authors query the extent to which prisons can fulfil a rehabilitative function.⁴⁰

Mental Health

Mental health is long established as a critical facet of public health.⁴¹ The introduction of public health measures and restrictions to curtail the transmission of COVID-19 has been recognised as a source of

³⁶ Irish Prison Service, 'Family Information Booklet For People In Our Custody' (2020) <https://www.irishprisons.ie/wp-content/uploads/documents_pdf/Family-Information-Booklet-September-2020.pdf> accessed 8 April 2021; Personal communication from the Press Office, Irish Prison Service to Mary Rogan (19 April 2021).

³⁷ Irish Penal Reform Trust, 'Progress In The Penal System 2020: Assessing Progress During A Pandemic' (2021) <https://www.iprt.ie/site/assets/files/6845/progress_in_the_penal_system_2020.pdf> accessed 31 March 2021.

³⁸ Irish Prison Service, 'Family Information Booklet For People In Our Custody' (2020) <https://www.irishprisons.ie/wp-content/uploads/documents_pdf/Family-Information-Booklet-September-2020.pdf> accessed 8 April 2021.

³⁹ Irish Penal Reform Trust, 'Progress In The Penal System 2020: Assessing Progress During A Pandemic' (2021) <https://www.iprt.ie/site/assets/files/6845/progress_in_the_penal_system_2020.pdf> accessed 31 March 2021.

⁴⁰ Kimmitt Edgar, Mia Harris, David Maguire and Claudia Vince, 'A CAPTIVE Snapshot of Life Under Covid' (2021) 253 Prison Service Journal 16.

⁴¹ World Health Organisation, 'Mental Health: Facing the Challenges, Building Solutions' (2005) <https://www.euro.who.int/_data/assets/pdf_file/0008/96452/E87301.pdf> accessed 8 April 2021.



substantial psychological strain,⁴² the extent of which is not yet fully understood. A key review paper by Brooks *et al* has examined the profoundly negative psychological effects associated with quarantine measures. These effects include exhaustion, detachment, anxiety, irritability, insomnia, stress, and depression.⁴³ While this paper draws upon studies conducted with the general population, the WHO emphasises that the effects of COVID restrictions may be even more acutely felt by those in custody.⁴⁴ Prison is an environment in which the deprivation of liberty and autonomy already poses profoundly detrimental psychological effects.⁴⁵ Consequently, the WHO advocate for the increased provision of emotional and psychological supports for people in prison.⁴⁶

As access to Irish prisons is restricted, at present, it is difficult to ascertain the impact of COVID-19 on the mental health of people in custody. A recent research study undertaken by the Office of the Inspector of Prisons (OIP) and Maynooth University has explored the experience of cocooning measures in Irish prisons.⁴⁷ The study examines the experiences of prisoners who are over-70 or who have an underlying condition and were required to cocoon during the first lockdown, a practice that ceased on 29 June 2020. The prisoners were supplied with journals to record their experiences over 14 days. The study provides a rare insight into what life in Irish prisons is currently like during the pandemic. One key finding is that prisoners likened cocooning to solitary confinement, being essentially restricted to their cells for the vast majority of the day with minimal interaction with other people. Additionally, cocooning prisoners felt as though they were being doubly punished as a result of being classed as a vulnerable group. Through the journals, prisoners expressed the significant toll of this practice on their mental well-being.

⁴² Konstantinos Kontoangelos, Marina Economou and Charalambos Papageorgiou, 'Mental Health Effects of COVID-19 Pandemic: A Review of Clinical And Psychological Traits' (2020) 17 (6) *Psychiatry Investigation* 491; Mohammad S Razai and others, 'Mitigating The Psychological Effects of Social Isolation During the Covid-19 Pandemic' (2020) 369 *British Medical Journal*.

⁴³ Samantha K Brooks et al, 'The Psychological Impact of Quarantine And How To Reduce It: Rapid Review of the Evidence' (2020) 395 *The Lancet* 912.

⁴⁴ World Health Organisation, 'Preparedness, Prevention and Control of COVID-19 in Prisons and Other Places of Detention: Interim Guidance, 15 March 2020' (2020) 3 <<https://apps.who.int/iris/bitstream/handle/10665/336525/WHO-EURO-2020-1405-41155-55954-eng.pdf?sequence=1&isAllowed=y>> accessed 8 April 2021.

⁴⁵ Ben Crewe, *The Prisoner Society* (Oxford University Press 2012); Gresham Sykes, *The Society of Captives* (Princeton University Press 1958).

⁴⁶ World Health Organisation, 'Preparedness, Prevention and Control of COVID-19 in Prisons and Other Places of Detention: Interim Guidance, 15 March 2020' (2020) 3 <<https://apps.who.int/iris/bitstream/handle/10665/336525/WHO-EURO-2020-1405-41155-55954-eng.pdf?sequence=1&isAllowed=y>> accessed 8 April 2021.

⁴⁷ Patricia Gilheaney, Joe Garrihy and Ian Marder, 'Ameliorating The Impact Of Cocooning On People In Custody – A Briefing' (Office of the Inspector of Prisons 2020) <<https://www.oip.ie/wp-content/uploads/2020/07/Ameliorating-the-impact-of-cocooning-on-people-in-custody-a-briefing.pdf>> accessed 8 April 2021.



As described previously, prison regimes have been significantly affected by restrictions implemented to curtail the spread of the virus. A small-scale survey study by the IPRT, conducted with family members of prisoners, found that concern for the mental health of their relative in prison was the number one worry expressed by participants.⁴⁸ Our understanding of the mental well-being of people in custody in Irish prisons at this time is significantly underdeveloped in comparison to other jurisdictions, though it seems most reasonable to state that the restrictions pose significant detriment to the well-being of people in custody. The state has a duty to protect the psychological well-being of people in prison, as a facet of their bodily integrity,⁴⁹ and caselaw has recognised that the prolonged use of isolation can call into question the protection of this right.⁵⁰ In *Connolly v. Governor of Wheatfield Prison*, Hogan J (as he then was) held that isolation for extended periods of months must be regarded as an exceptional measure which might in some instances ‘at least compromise the substance of the detainee’s right to the protection of the person and safeguarding of human dignity’.⁵¹ The indefinite detention of a person in isolation for a period of years would violate Article 40.3.3° in the court’s view. Under Irish law, the intention of the authorities is also highly relevant to considerations of whether a person’s rights are being breached in such circumstances, or at least to questions of remedy.⁵² As such, in light of the ending of the policy of requiring cocooning after several months, the exceptional nature of the pandemic and the efforts taken to mitigate the effects of isolation, it would seem that the bar to argue a breach of the right to the person would be very high.

While this is so, the effects of isolation cannot be underestimated. A paper by Edgar *et al* documents the accounts of prisoners in England and Wales of their experiences of prison during the pandemic from March to September 2020. For a substantial portion of this period, regimes were reduced to the barest of provision, with only services such as meals, phone calls, showering, open air access, and medical care being offered. The experiences of prisoners gathered through this project highlight acute feelings of isolation, painful feelings of separation from families, and a sense of purposelessness and inactivity.⁵³ Similarly, a thematic report conducted by Her Majesty’s Inspectorate of Prisons (HMIP)

⁴⁸ Irish Penal Reform Trust “‘I Am Worried About The Lasting Effect This Will Have’: The Experiences of People With A Family Member in Prison During COVID-19’ (2020) <https://www.iprt.ie/site/assets/files/6775/results_of_families_of_prisoners_survey_final_web-1.pdf> accessed 8 April 2021.

⁴⁹ *Kinsella v Governor of Mountjoy Prison* [2011] IEHC 235.

⁵⁰ *Connolly v Governor of Wheatfield Prison* [2013] IEHC 334.

⁵¹ *Connolly v Governor of Wheatfield Prison* [2013] IEHC 334, [18].

⁵² *Kinsella v Governor of Mountjoy Prison* [2011] IEHC 235; *Connolly v Governor of Wheatfield Prison* [2013] IEHC 334; *Mulligan v Governor of Portlaoise Prison* [2010] IEHC 269.

⁵³ Kimmett Edgar, Mia Harris, David Maguire and Claudia Vince, ‘A CAPTIVE Snapshot of Life Under Covid’ (2021) 253 *Prison Service Journal* 16.



has detailed the experiences of prisoners through in-depth qualitative interviews conducted in six prisons between autumn and November 2020. Prisoners were found to be spending, on average, 22.5 hours a day locked in their cells. On a day-to-day level, the report emphasises the monotony and boredom of being confined to one's cell. But more profoundly, the report captures high anxiety among prisoners, feelings of despair and loneliness, frustration at the lack of mental health supports, and the use of unhealthy coping strategies such as self-harm and drug use.⁵⁴ Commenting on the impact of COVID-19 in prisons in England and Wales, former Chief Inspector, Peter Clarke has stated, "*what we are seeing now is a decline in mental health quite broadly*".⁵⁵

Gulati *et al* recommend that mental health care in prison needs to be robustly maintained while precautionary measures and restrictions are in place.⁵⁶ Recent parliamentary questions concerning the provisions for mental health have revealed that there are substantial waiting lists for psychological and addiction services in the Irish prison system. Adapting to COVID measures has resulted in these services being delivered through telephone, video link, and where necessary, in person one-to-one appointments prisoners. With this said, the process of service delivery that was already overburdened has been further curtailed. Data supplied to the Dáil by the Irish Prison Service reports that 1,206 individuals are currently on the waiting list for psychological services.⁵⁷ To put this figure in context, the prison population on 9 March 2021, the date on which these waiting list figures were captured, stood at 3,814.⁵⁸

Critically, the successful management of COVID-19 does not just amount to management of the virus and its transmission, but also the management of its deleterious consequences;⁵⁹ this includes the impact of COVID measures on mental health and well-being. In this respect, people in custody are an extremely vulnerable group.

⁵⁴ Her Majesty's Inspectorate of Prisons, 'What Happens to Prisoners in a Pandemic? A Thematic Review' (2021) <<https://www.justiceinspectors.gov.uk/hmiprisoners/wp-content/uploads/sites/4/2021/02/What-happens-to-prisoners-in-a-pandemic.pdf>> accessed 8 April 2021.

⁵⁵ Peter Clarke, 'Inspecting Prisons During a Pandemic' (2021) 253 *Prison Service Journal* 11, 13.

⁵⁶ Gautam Gulati, Colum P Dunne and Brendan D Kelly, 'Correspondence: Prisons and the COVID-19 Pandemic' (2020) *Irish Journal of Psychological Medicine* 1.

⁵⁷ *Dáil Debates* (2021) 1005(2), 11 March 2021, question 181.

⁵⁸ Irish Prison Service, 'Prisoner Population on Tuesday 9th March 2021' (*Irishprisons.ie*, 2021) <https://www.irishprisons.ie/wp-content/uploads/documents_pdf/09-March-2021.pdf> accessed 8 April 2021.

⁵⁹ Samantha K Brooks *et al*, 'The Psychological Impact of Quarantine And How To Reduce It: Rapid Review of the Evidence' (2020) 395 *The Lancet* 912.



Changes to the execution of sentences

A key feature of Irish penal practice since the start of the pandemic has been a reduction in numbers in the prison system. As can be seen from Figure 1 below, the general prison population has remained below that of the previous year since the pandemic started in Ireland in March of 2020.

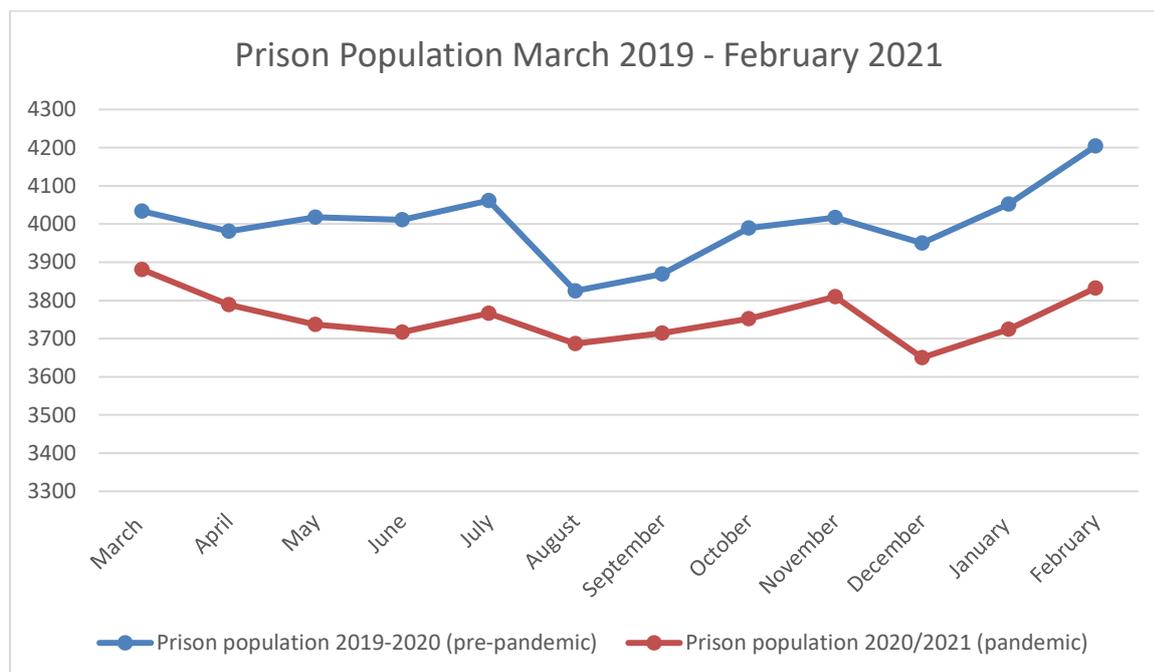


Figure 1: Snapshot of the number of people in custody on the last day of the month from 31st March 2019 to 28th February 2021. These figures are averages for the month. Source: Irish Prison Service.

One of the measures employed by the Irish Prison Service to deal with the Covid-19 pandemic was to reduce the prisoner population held in Irish prisons through a more expansive use of temporary release.⁶⁰ Temporary release is governed by section 2 of the Criminal Justice Act 1960, as amended by the Criminal Justice (Temporary Release of Prisoners) Act 2003. The legislation permits the Minister for Justice to release a person from prison; in reality this power is delegated to the Irish Prison Service. There is very broad discretion under the Act to release prisoners, including on humanitarian grounds or in preparation for release. A further ground permits the release of a person where the Minister is

⁶⁰ Department of Justice, 'Information regarding the Justice Sector COVID-19 plans' ([justice.ie](http://www.justice.ie/en/JELR/Pages/Information_regarding_the_Justice_Sector_COVID-19_plans), 13 November 2020) <http://www.justice.ie/en/JELR/Pages/Information_regarding_the_Justice_Sector_COVID-19_plans> accessed 31 March 2021.



of the opinion that it is needed to maintain good order in and humane and just management of the prison concerned. This flexible approach has meant that specific legislative change to take account of the need to reduce overcrowding during the pandemic has not been necessary, despite calls to introduce a specific health ground. Reports suggest that temporary release has been granted on a case-by-case basis, with a focus on those serving less than 12 months for a non-violent offence and, later, those with less than six months left on their sentence.⁶¹ Certain groups of prisoners are barred from availing of temporary release, including those serving sentences for sexual offences and those convicted of certain drugs offences.⁶²

Temporary release is subject to conditions, including a requirement to sign on at the prison from which the person was released on a regular basis. This has been amended from a weekly obligation to a monthly one to reduce traffic into and out of the prisons and free up administrative staff.⁶³

This expanded use of temporary release resulted in a decrease in the prison population from 4,235 on 11 March 2020 to 3,772 on 22 October 2020, a reduction of approximately 463 people in custody, or 11%.⁶⁴ This number has remained relatively stable since then, with 3,774 in custody as of the 16th March 2021.⁶⁵ As can be seen from Figure 2 below, temporary release was used for a considerable number of people in custody for the first few months of pandemic, but since July 2020 the average number of people on temporary release per month is slightly lower than the average observed for the corresponding month in the previous year. This may be due to fewer eligible prisoners within the prison population or, as highlighted above by Table 1, an overall decrease in the prison population.

⁶¹ *Dáil Debates* (2020) 994(2), 23 June 2020, questions 317-320.

⁶² Misuse of Drugs Act 1977 (as amended), section 15A.

⁶³ Department of Justice, 'Information regarding the Justice Sector COVID-19 plans' (*justice.ie*, 13 November 2020) <http://www.justice.ie/en/JELR/Pages/Information_regarding_the_Justice_Sector_COVID-19_plans> accessed 31 March 2021.

⁶⁴ *Ibid.*

⁶⁵ Irish Prison Service, 'Prisoner Population on Tuesday 16th March 2021' (*Irishprisons.ie*, 2021) <https://www.irishprisons.ie/wp-content/uploads/documents_pdf/16-March-2021.pdf> accessed 31 March 2021.

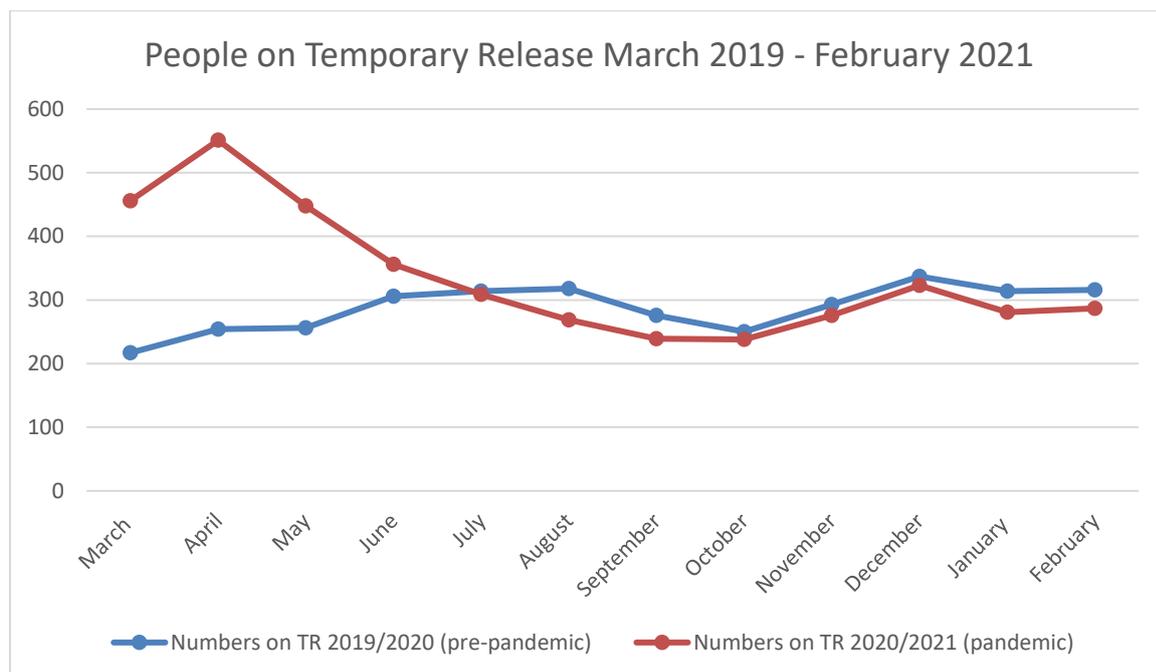


Figure 2: Daily average per month of the number of people on temporary release, March 2019 to February 2021. Source: Irish Prison Service.

As of 23 June 2020, 55 of 852 prisoners released from custody on full or reviewable temporary release since 2 March 2020 have been returned to custody. In 37 of these cases, this was a result of the person committing a criminal offence and their subsequent re-arrest, while in the remaining 18 cases this was due to a breach of one of other conditions of temporary release.⁶⁶ Fewer prisoners than normal however, sought release for Christmas.⁶⁷

Notably, there is also evidence that the numbers of people being sent to prison have declined during the pandemic. The number of committals for all reasons, pre-trial, under sentence, immigration-related matters and contempt of court instances appears to be down when compared to the same period pre-COVID-19 as can be seen in Figure 3.

⁶⁶ *Dáil Debates* (2020) 994(2), 23 June 2020, questions 317-320.

⁶⁷ Conor Gallagher, 'Prisoners Decline Christmas Temporary Release Due to Covid Fears' (*The Irish Times*, 23 December 2020) <<https://www.irishtimes.com/news/crime-and-law/prisoners-decline-christmas-temporary-release-due-to-covid-fears-1.4444827>> accessed 31 March 2021.

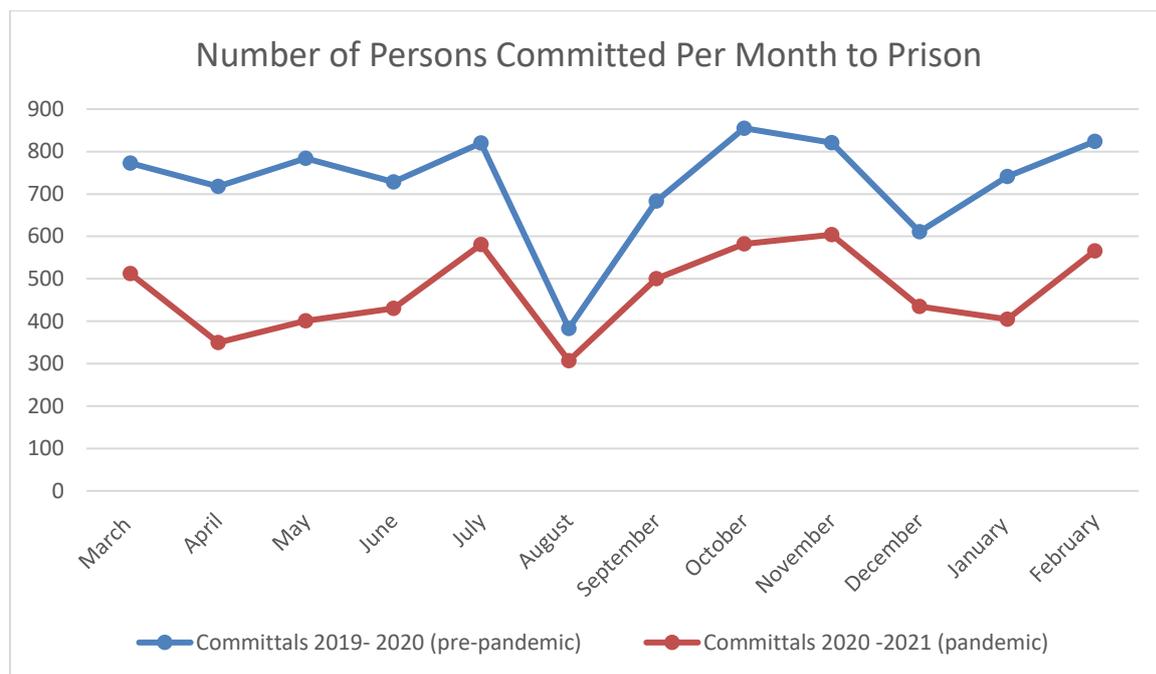


Figure 3: Daily average number of people committed to prison per month, March 2019 to February 2021. Source: Irish Prison Service

Remand and pre-trial detention

The criminal courts have remained operational during the pandemic, but trials requiring juries have been adjourned, often for many months or even years. One concern arising from this is the potential for an increase in the length of time people must spend on remand waiting for their trial.

In general, the average number of people on remand has remained relatively stable during the pandemic, as shown in Figure 4. This is unlike the overall picture for prison numbers, which have been decreasing.

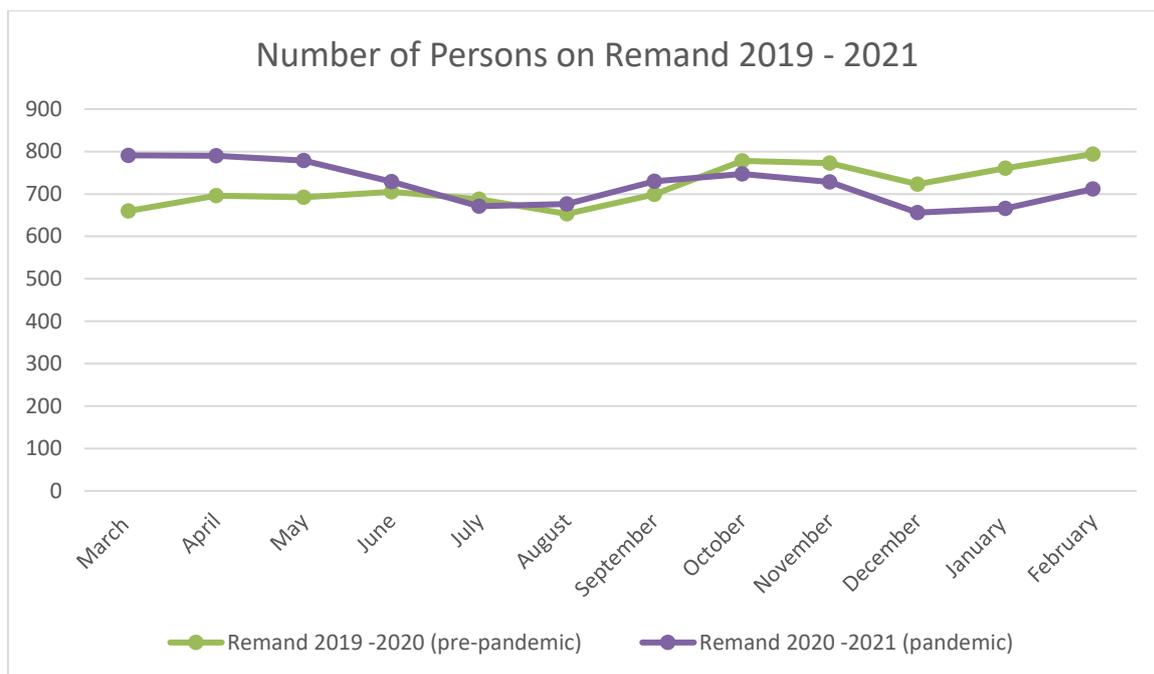


Figure 4: Daily average per month of the number of people on remand, March 2019 to February 2021.

Source: Irish Prison Service.

It also seems to be the case that the numbers of people in pre-trial detention for periods over one year seems to have increased during the pandemic, as can be seen in Figure 5. While these figures should be interpreted with caution, the delays occasioned to trials should be monitored carefully to ensure people are not spending unduly long periods in custody awaiting trial. The long-term implications of Covid-19 and the response to it should be carefully monitored to ensure that extended periods on remand are avoided as much as possible. Pre-trial detention has significant effects on the presumption of innocence, the right to liberty, the right of access to a lawyer, as well as family rights.⁶⁸

⁶⁸ *O'Callaghan v Attorney General* [1966] IR 501; Detour, 'Detour: Towards Pre-Trial Detention as Ultima Ratio' <<https://www.irks.at/detour/>> accessed 20 April 2021.

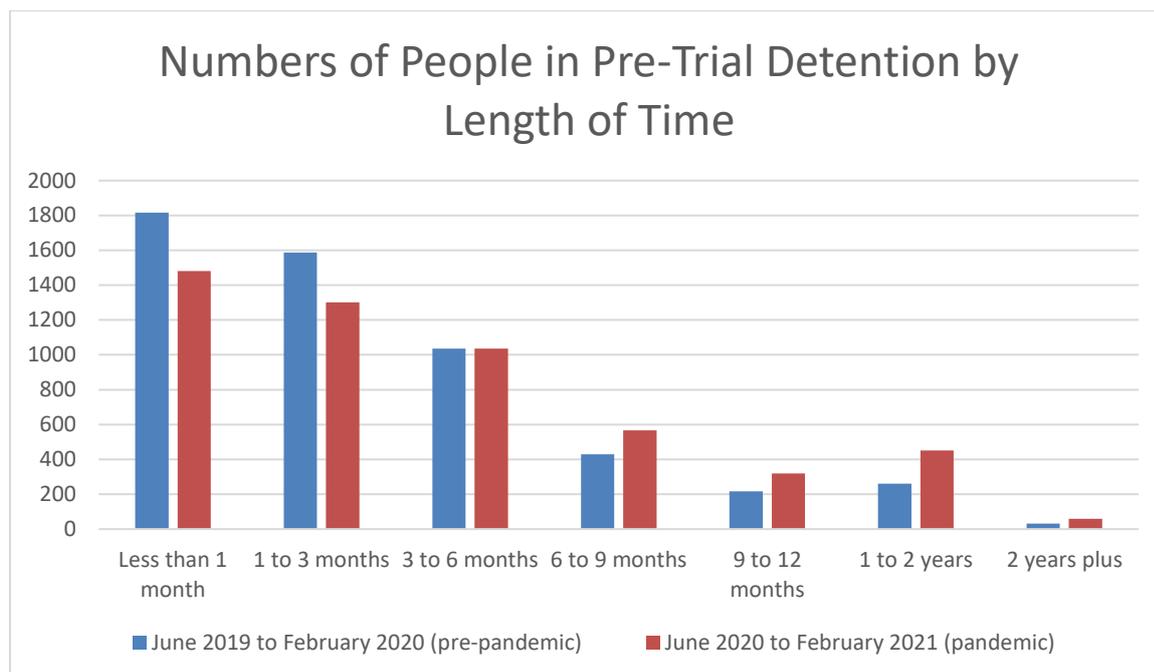


Figure 5: Number of people held in pre-trial detention by length of time. Source: Irish Prison Service.

Vaccination

People in prison are entitled to an equivalent level of healthcare to those in the community under international human rights standards and domestic law. Article 24(1) of the UN Mandela Rules⁶⁹ state that '[t]he provision of healthcare is a state responsibility. Prisoners should enjoy the same standards of care that are available in the community, and should have access to necessary healthcare services free of charge without discrimination on the grounds of their legal status'. The European Prison Rules, revised in 2020, state: 'Prison authorities shall safeguard the health of all prisoners in their care' and '[p]risoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation'.⁷⁰ The WHO states that: '[t]he provision of health care for people in prisons and other places of detention is a state responsibility' and additionally notes that 'experience shows that prisons, jails and similar settings where people are gathered in proximity may act as a source of infection, amplification and spread of infectious diseases within and beyond

⁶⁹ UNGA Res 70/175, 'United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)' (17 December 2015) UN Doc A/RES/70/175.

⁷⁰ Council of Europe: Committee of Ministers, 'Recommendation Rec(2006)2 of the Committee of Ministers to Member States on the European Prison Rules' (11 January 2006) <https://search.coe.int/cm/Pages/result_details.aspx?ObjectId=09000016809ee581> accessed 25 April 2021.



prisons.⁷¹ The European Committee for the Prevention of Torture has also indicated that '[a] prison health care service should be able to provide medical treatment and nursing care, as well as appropriate diets, physiotherapy, rehabilitation or any other necessary special facility, in conditions comparable to those enjoyed by patients in the outside community'.⁷² Domestically, this has been interpreted to mean that those in prison are entitled to the care which someone outside of prison in receipt of a medical card would receive, Rule 33 Prison Rules 2007. It is also clear from these standards that decisions of healthcare staff about people in prison should not be overridden on operational grounds.

In the initial phases of the vaccination roll-out strategy there was limited information on when people in prison would be vaccinated. Reports then suggested that people in prison would be vaccinated as a single priority group, as part of group 9 which comprised people between 18 and 64 living in crowded accommodation.⁷³ With the move to an age-based vaccination programme, it seems that people in prison will be vaccinated according to their age. This raises concerns about whether this approach represents truly equivalent care, given that the particular living circumstances of people in prison mean they are at much higher risk of contracting COVID-19 than those in the community, and the consequences of spread in a prison setting can be much more severe. It is also notable that it seems prison staff are also to be vaccinated according to age rather than their occupation, despite the additional risks they face. This is very disappointing and clarity should be provided for those working in difficult environments where there is an increased risk of contracting Covid-19. Due to the lack of clarity around the inclusion of prison staff for vaccination in a priority group, the Prison Officers' Association has directed all members to adhere strictly to their duties in the prisons in what is effectively a withdrawal of goodwill by prison staff.⁷⁴ This has resulted in disruptions across the service, notably affecting court due to a lack of staff to carry out prison escorts.

⁷¹ World Health Organisation, 'Preparedness, Prevention and Control of COVID-19 in Prisons and Other Places of Detention: Interim Guidance, 15 March 2020' (2020) 1 <<https://apps.who.int/iris/bitstream/handle/10665/336525/WHO-EURO-2020-1405-41155-55954-eng.pdf?sequence=1&isAllowed=y>> accessed 8 April 2021.

⁷² Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 'Healthcare Services in Prisons' (1993) <<https://rm.coe.int/16806ce943>> accessed 25 April 2021.

⁷³ Vivienne Clarke and Conor Gallagher, 'Garda Group Queries Vaccination Priority List for Prisoners And Gardaí' (*The Irish Times*, 9 March 2021) <<https://www.irishtimes.com/news/crime-and-law/garda-group-queries-vaccination-priority-list-for-prisoners-and-garda%C3%AD-1.4504716?localLinksEnabled=false>> accessed 25 April 2021.

⁷⁴ Isabel Hayes, 'Indicative Sentences to be Handed Down Amid Ongoing Prison Officers' Industrial Action' (*The Journal.ie*, 20 April 2021) <<https://www.thejournal.ie/indicative-sentences-prison-officers-strike-5415412-Apr2021/>> accessed 25 April 2021; Paul Reynolds, 'Withdrawal of Goodwill by Prison Officers Over Vaccine' (*RTE*, 16 April 2021) <<https://www.rte.ie/news/2021/0416/1210255-prison-officers-covid-vaccines/>> accessed 25 April 2021.



Oversight, transparency and information sharing

Prison inspection and monitoring can provide an important safeguard and support for the promotion of human rights in prisons. These practices have, however, been impacted by COVID-19. In its first interim report providing guidance for the management of COVID-19 in places of detention, the WHO advised that inspection and monitoring activities should not be discontinued as a consequence of COVID-19 measures and that the outbreak ‘must not be used as a justification for objecting to external inspection of prisons and other places of detention’.⁷⁵ The WHO adds that inspection bodies should retain access to all people held in places of detention, including those who are held in isolation, for the purposes of carrying out their work. Similarly, Penal Reform International (PRI), a non-governmental organisation that works to promote human rights within criminal justice systems, has underscored the importance of prison oversight during the pandemic, stating, ‘In times of emergency, the ability of independent bodies to monitor developments in detention facilities is essential to prevent excessive use of quarantine, abuse of power, use of torture or ill-treatment’.⁷⁶

The WHO’s position has been reiterated in their latest interim guidance document for the management of COVID-19 in places of detention.⁷⁷ However, they propose that inspection and monitoring bodies must conduct their work during the pandemic with cognisance of the principle of ‘do no harm’ – the obligation to be aware of, and mitigate, one’s own potentially negative effects in applying an intervention. This approach has also been advised by the Committee for the Prevention of Torture and Inhuman and Degrading Treatment (CPT), the Council of Europe’s international monitoring body for places of detention.⁷⁸ As such, the importance of oversight must be balanced alongside a duty of care in undertaking these activities.

At a national level, prison oversight in Ireland is provided through the prison Visiting Committees (VCs) and the prison inspectorate, the Office of the Inspector of Prisons (OIP). The Visiting Committees have been in operation in Ireland since 1925, when they were formally established under the Prisons

⁷⁵ World Health Organisation, ‘Preparedness, Prevention and Control of COVID-19 in Prisons and Other Places of Detention: Interim Guidance, 15 March 2020’ (2020) 5 <<https://apps.who.int/iris/bitstream/handle/10665/336525/WHO-EURO-2020-1405-41155-55954-eng.pdf?sequence=1&isAllowed=y>> accessed 8 April 2021.

⁷⁶ Penal Reform International, ‘Coronavirus: Healthcare and Human Rights of People in Prison’ (2020) 9 <<https://cdn.penalreform.org/wp-content/uploads/2020/03/FINAL-Briefing-Coronavirus.pdf>> accessed 8 April 2021.

⁷⁷ World Health Organisation, ‘Preparedness, Prevention and Control of COVID-19 in Prisons and Other Places of Detention: Interim Guidance, 15 March 2020’ (2020) <<https://apps.who.int/iris/bitstream/handle/10665/336525/WHO-EURO-2020-1405-41155-55954-eng.pdf?sequence=1&isAllowed=y>> accessed 8 April 2021.

⁷⁸ Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), ‘Statement of Principles Relating to the Treatment of Persons Deprived of Their Liberty in the Context of the Coronavirus Disease (Covid-19) Pandemic’ (2020) <<https://rm.coe.int/16809cfa4b>> accessed 8 April 2021.



(Visiting Committees) Act 1925.⁷⁹ Each prison has its own VC, which is comprised of voluntary members who conduct regular monitoring visits. The primary role of the VCs is to listen prisoners' complaints and to seek informal resolution of issues where possible. While, arguably, they provide important insight into prison issues, the VCs have been continually criticised for anodyne reporting of prison conditions, as well as the frequently late production of their reports.⁸⁰ As noted by the Irish Penal Reform Trust (IPRT) in their 2020 report *Progress in the Penal System: Assessing Progress During a Pandemic*, there has been no public record of the duties undertaken by the VCs during the pandemic,⁸¹ though, according to the Irish Prison Service, they have not been prevented from entering the prisons by the Irish Prison Service.⁸²

The OIP was established in 2002 and placed on statutory footing in through the Prisons Act 2007.⁸³ The OIP has unfettered access to all places of detention within the Irish prison system, and can conduct announced or unannounced visits at any time. The inspection team may speak with both prisoners and staff, and request any documentation or materials necessary for the conduct of their work.⁸⁴ During the first lockdown of the pandemic, the OIP conducted a series of one-day visits to each prison, with recognition of the principle of 'do no harm'.⁸⁵ These visits were conducted to monitor and assess the effects of the pandemic on prisons, with particular attention to matters of regime management, out of cell time, and meaningful human contact. However, these visits have also faced some criticism from the IPRT, which pointed out that the findings were not made public at a time in which there is great cause for concern for the well-being of people in custody and yet little insight into the current realities of prison life during the pandemic.⁸⁶

In other jurisdictions, inspection activities have been more comprehensively maintained. For example, in England and Wales, Her Majesty's Inspectorate of Prisons (HMIP) is responsible for prison inspections. Its former Chief Inspector, Peter Clarke, described the work of the inspectorate during

⁷⁹ Prisons (Visiting Committees) Act 1925.

⁸⁰ Mary Rogan, 'Visiting Committees and Accountability in the Irish Prison System: Some Proposals for Reform' (2009) 31 Dublin University Law Journal 298.

⁸¹ Irish Penal Reform Trust, 'Progress In The Penal System 2020: Assessing Progress During A Pandemic' (2021) <https://www.iprt.ie/site/assets/files/6845/progress_in_the_penal_system_2020.pdf> accessed 31 March 2021.

⁸² Personal communication from the Press Office, Irish Prison Service to Mary Rogan (19 April 2021).

⁸³ Prisons Act 2007.

⁸⁴ Agnieszka Martynowicz, 'Oversight of Prison Conditions and Investigations of Deaths in Custody: International Human Rights Standards and the Practice in Ireland' (2011) 91(1) The Prison Journal 81.

⁸⁵ Patricia Gilheaney 'Ask An Expert: Monitoring of Prisons During the Covid-19 Pandemic, With Patricia Gilheaney, Inspector of Prisons, Ireland' (PRILA, 10 June 2020) <<https://prilatcd.wordpress.com/2020/06/10/ask-an-expert-monitoring-of-prisons-during-the-covid-19-pandemic-with-patricia-gilheaney-inspector-of-prisons-ireland/>> accessed 8 April 2021.

⁸⁶ Irish Penal Reform Trust, 'Progress In The Penal System 2020: Assessing Progress During A Pandemic' (2021) <https://www.iprt.ie/site/assets/files/6845/progress_in_the_penal_system_2020.pdf> accessed 31 March 2021.



the pandemic. Clarke details how HMIP began with a series of 'short scrutiny visits' (SSVs) in April 2020. These consisted of one-day visits to prisons conducted with small inspection teams; the focus of the visits was to observe the essential issues of, *inter alia*: care for vulnerable prisoners, supports for prisoners at risk of self-harm and suicide; meaningful human contact; family contact; hygiene; healthcare; access to fresh air; and legal rights. In August 2020, as restrictions eased and public health advice allowed, the SSVs were replaced with 'scrutiny visits' (SVs). These visits are still shorter than the HMIP's full inspection process, but involve more substantial visits to the prison and the inclusion of staff and prisoner survey measures to assess the current climate of the prison system.⁸⁷

As a further example, the Prisons and Probation Ombudsman (PPO) which acts as the review body for complaints submitted by prisoners in England and Wales, has created a channel for the receipt and recognition of COVID-19 related complaints.⁸⁸ These complaints may relate to matters regarding the temporary measures or policies put into place by the prison, access to cleaning and hygiene supplies or PPE, or the effects of staffing shortages due to COVID-19.

The Minister for Justice and Equality, Helen McEntee, has confirmed that the OIP's planned general inspection programme for 2021 will be suspended until the inspection teams can safely undertake more protracted visits to the prison. Instead, the OIP will undertake a series of focused thematic inspections across each prison in the state, concentrating on COVID-19 issues; a survey will also be issued to prison staff to examine their experiences of pandemic measures in the prison environment.⁸⁹ These thematic inspections are currently underway, with visits already completed at Mountjoy and Cloverhill prisons at time of writing. The reports will be submitted to the Minister for approval before publication. This is a welcome and important undertaking, and will provide much necessary insight into the effects of the pandemic within Irish prisons. However, it requires the timely publication of these reports so that findings can be informative and acted upon while still relevant.

While prison oversight has been subject to limitations arising out of the pandemic, a further concern has been the extent and depth of publicly available information on what is happening in prisons during this time. Importantly, much of our knowledge as to how restrictions are operating has been obtained from the record of parliamentary questions - there is little by way of public reporting on the actual

⁸⁷ Peter Clarke, 'Inspecting Prisons During A Pandemic' (2021) 253 Prison Service Journal 11, 13.

⁸⁸ Prisons and Probation Ombudsman, 'Learning Lessons Bulletin: Complaints Investigations' (2020) <https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkjhkimgw/uploads/2020/12/6.7091_PPO_Learning-Lessons-Bulletin_Covid-Complaints_Draft_v7_WEB.pdf> accessed 8 April 2020

⁸⁹ *Dáil Debates* (2021) 1005(1), 10 March 2021, question 711.



lived experience of prisoners and the effects of these restrictions. There are also concerns about the provision of information to prisoners. The WHO advises that prison authorities should ensure that prisoners have access to accurate and up-to-date information regarding the pandemic.⁹⁰ This has also been emphasised by the CPT, who have similarly stated that prisoners need to be comprehensively informed of any restrictions or changes to the regime in a language they understand.⁹¹ Gulati *et al* describe that COVID-19 information is essential for people in prison in order to reduce feelings of anxiety and uncertainty regarding the virus within prison and also in the wider community.⁹² In prisons, the Irish Red Cross prisoners, in particular, have been praised for their role in developing and distributing prisoner newsletters with details of the risk of the virus and actions taken within the prison.⁹³ In a study exploring the experiences of cocooning prisoners, one prisoner commented, 'communication is very good, explaining why normal prison routine has been so drastically changed.'⁹⁴

One notable feature of the regulatory framework concerning prisons during the pandemic in Ireland has been the slowness with which legal change has followed changes in practice. For example, changes to prison regimes occurred very early on in the pandemic, but specific amendments to the Prison Rules were not introduced until July 2020, through the Prison (Amendment) Rules 2020. More generally, relatively limited change was needed to the law as the Prison Rules already provide governors with a large amount of discretion, with most entitlements being couched in language such as 'in as far as is practicable'.

Conclusions

The efforts involved on the part of prison staff and people in prison to keep COVID-19 cases as low as they have been in Irish prisons and to avoid any deaths from the virus have been very significant and praiseworthy. The challenges involved in preventing infectious disease in a prison environment are immense and multifarious. While this is so, the effects of the restrictions cannot be overlooked and

⁹⁰ World Health Organisation, 'Preparedness, Prevention and Control of COVID-19 in Prisons and Other Places of Detention: Interim Guidance, 15 March 2020' (2020) <<https://apps.who.int/iris/bitstream/handle/10665/336525/WHO-EURO-2020-1405-41155-55954-eng.pdf?sequence=1&isAllowed=y>> accessed 8 April 2021.

⁹¹ Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 'Follow-Up Statement Regarding The Situation Of Persons Deprived Of Their Liberty In The Context Of The Ongoing Covid-19 Pandemic' (2020) <<https://rm.coe.int/16809ef566>> accessed 8 April 2021.

⁹² Gautam Gulati, Colum P Dunne & Brendan D Kelly, 'Correspondence: Prisons and the COVID-19 Pandemic' (2020) Irish Journal of Psychological Medicine 1.

⁹³ *Dáil Debates* (2020) 993(5), 27 May 2020, question 371.

⁹⁴ Patricia Gilheaney 'Ask An Expert: Monitoring of Prisons During the Covid-19 Pandemic, With Patricia Gilheaney, Inspector of Prisons, Ireland' (PRILA, 10 June 2020) <<https://prilatcd.wordpress.com/2020/06/10/ask-an-expert-monitoring-of-prisons-during-the-covid-19-pandemic-with-patricia-gilheaney-inspector-of-prisons-ireland/>> accessed 8 April 2021.



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must be carefully monitored. A particular concern is the open-ended nature of the laws permitting reductions in regimes, such as the use of visits and exercise. When public health advice permits, these changes in the law should be reversed. It is also to be hoped that timely and comprehensive information on what is happening in prisons will be more available. A key concern now is vaccination. The particular position of people in prison, and indeed prison staff, means that treating them in the same way as the general population is unfair. Overall, prisons are places where rights are vulnerable outside of a pandemic, and very careful attention must be given to ensure that this situation is not exacerbated unduly, or for an unnecessary duration.



Chapter V: Direct Provision

Patricia Brazil

Introduction

Direct provision was introduced in April 2000 as a system for meeting the basic welfare needs of asylum seekers by providing full bed and board in designated accommodation units and a weekly financial payment of €19.10 per adult and €9.60 per child.¹ Since its introduction, the system of direct provision has been the subject of criticism in respect of a range of issues, including conditions in some direct provision centres,² the length of time spent by some people living in direct provision and the impact on both the mental and physical health of those people.³ The McMahon Report in 2015 made a number of recommendations for reform of the direct provision system including in relation to living conditions in designated centres, improvements in supports available for protection applicants and changes to the existing determination process.⁴ Two high profile cases in recent years also impacted on the direct provision system: the High Court decision in *CA v Minister for Justice*⁵ led to the introduction of an independent complaints mechanism for persons living in direct provision, while the decision of the Supreme Court in *NHV v Minister for Justice*⁶ struck down the absolute prohibition on

¹ See generally FLAC, 'Direct Discrimination? An Analysis of the System of Direct Provision in Ireland' (FLAC 2003); Liam Thornton, 'Upon the Limits of Rights Regimes: Reception Conditions of Asylum Seekers in Ireland' (2007) 24(2) *Refugee* 86; Claire Breen, 'The Policy of Direct Provision in Ireland: a Violation of Asylum Seekers' Right to an Adequate Standard of Housing' (2008) 20(4) *International Journal of Refugee Law* 611; FLAC, 'One Size Doesn't Fit All: A Legal Analysis of the Direct Provision and Dispersal System in Ireland 10 years on' (FLAC 2009); Liam Thornton, 'Social welfare law and asylum seekers in Ireland: an anatomy of exclusion' (2013) *Journal of Social Security Law* 66; Liam Thornton, 'The rights of others: asylum seekers and direct provision in Ireland' (2014) 3(2) *Irish Community Development Law Journal* 22.

² See e.g. AIDA, 'National Country Report: Ireland' (2013) which noted at p. 34 "The Irish Refugee Council has collected evidence that conditions in many DP centres are sub-standard to the point of inhumane. Broken, dilapidated furniture in common areas and infestations of mice, cockroaches and insects have been reported. Whole families including both parents and children of school-going age are often allocated just one room. Teenage children commonly share with siblings or parents of the opposite sex. Single residents and single mothers are often required to share bedroom and bathroom facilities. A culture of fear and the constant threat of transfer mean residents are frequently afraid to complain and are discouraged from interacting with inspectors. Residents report incidents of intimidation and harassment by staff in some centres. Allegations have been made of abusive and foul language directed towards residents and frequent threats of transfer."

³ For example, Coakley notes that "while Ireland's Office of the Refugee Applications Commissioner maintain that all claims for protection are processed within 12 weeks of being filed, many asylum-seekers have spent a significant number of years resident in an Irish accommodation centre": Liam Coakley, "Length of time spent in Ireland's direct provision accommodation system, the threat of deportation and the asylum seeker's ability to think about voluntary return" (2014) IV(4) *Migration Policy Practice* 22.

⁴ *Working Group to Report to Government Working Group on the Protection Process on Improvements to the Protection Process, including Direct Provision and Supports to Asylum Seekers: Final Report* (Department of Justice 2015).

⁵ [2014] IEHC 432.

⁶ [2017] IESC 35.



the right to work for asylum seekers and ultimately led to the State's decision to opt into the Recast Reception Conditions Directive.⁷

Despite some improvements to the direct provision system as a result of these developments, a report by NASC in 2017⁸ highlighted that not all of the McMahon recommendations were implemented, including the introduction of vulnerability assessments, measures to address the backlog in processing protection applications and improvements in physical conditions in some direct provision centres. The Ombudsman's Annual Report for 2019⁹ noted a number of complaints related to the use of emergency accommodation as part of the direct provision system, sometimes in remote locations with limited access to services and supports.

Direct provision and the pandemic

As of March 2020, there were approximately 7,400 people living in direct provision and emergency accommodation in Ireland.¹⁰ Concerns were quickly expressed about the impact of the pandemic on those living in direct provision, including the ability to maintain social distancing guidelines in light of the sometimes overcrowded living conditions.¹¹ Direct provision was described by one infectious disease specialist as a “powder keg” for COVID19,¹² with calls from NGOs including the Irish Refugee Council to move people in at-risk categories to alternative locations in order to enable self-isolation and cocooning.¹³ While the HSE extended access to temporary accommodation for healthcare workers living in direct provision,¹⁴ and the Department of Justice introduced a number of measures in light of

⁷ Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection (recast) [2013] OJ L180/96.

⁸ NASC, 'Working Paper on the Progress of Implementation of the McMahon Report' (2017).

⁹ The Office of the Ombudsman, *Annual Report 2019* (Office of the Ombudsman 2020).

¹⁰ Neil Michael, 'Residents in Direct Provision Centres Can't Socially Distance Themselves' *The Irish Examiner* (23 March 2020) <<https://www.irishexaminer.com/news/arid-30989473.html>> accessed 23 June 2021.

¹¹ Colman O'Sullivan, 'Asylum Seekers Fear Increased Risk of Infection due to Overcrowding' *RTE News* (5 April 2020) <<https://www.rte.ie/news/2020/0405/1128671-direct-provision-coronavirus/>> accessed on 23 June 2021.

¹² Eamonn Faller, an infectious disease specialist registrar at Cork University Hospital, said “Direct Provision centres are, in effect, huge powder kegs for Covid-19/coronavirus. The government can't insist on social distancing and isolation of the most vulnerable in society while these centres remain hopelessly overcrowded. There are many vulnerable people in Direct Provision who have no way to self-isolate. Moving these people out of these centres is absolutely crucial and must be done without delay”. Irish Refugee Council, 'Move Most Vulnerable out of Direct Provision Centres Now' (22 March 2020) <<https://www.irishrefugeecouncil.ie/news/move-most-vulnerable-out-of-direct-provision-centres-now>> accessed 23 June 2021.

¹³ Sorcha Pollak, 'Coronavirus: Outbreaks in Direct Provision Centres Could Be “Devastating”' *The Irish Times* (10 March 2020) <<https://www.irishtimes.com/news/social-affairs/coronavirus-outbreaks-in-direct-provision-centres-could-be-devastating-1.4199164>> accessed on 24 June 2021.

¹⁴ HSE, 'Temporary Accommodation for Healthcare Workers during COVID-19' (9 April 2020) <<https://healthservice.hse.ie/staff/coronavirus/policies-procedures-guidelines/temporary-accommodation-for-healthcare-workers.html>> accessed on 24 June 2021.



the pandemic including off-site self-isolation facilities,¹⁵ MASI (Movement of Asylum Seekers in Ireland) issued a statement criticising the Department's response on the basis that the measures "[did] not adequately address the situation of asylum seekers having difficulty observing social distancing."¹⁶

These concerns were brought into sharp relief when it emerged in April 2020 that a number of residents at the Skellig Star Hotel in Cahersiveen, a recently opened direct provision facility, had tested positive for COVID19.¹⁷ There were reports that residents at the Skellig Star were being unlawfully deprived of their liberty,¹⁸ although the Department of Justice insisted that the doors were not locked and that residents were merely advised to adhere to HSE guidelines regarding self-isolation for the duration of the quarantine period. Other complaints raised included inadequate cleaning and sanitation protocols, lack of social distancing in relation to communal meals and the lack of Garda vetting for some staff prior to the opening of the centre.¹⁹ There were calls for an inquiry into the decision to transfer over 100 asylum seekers to the Skellig Star in the midst of the pandemic and the lack of consultation with the local community around the opening of the centre.²⁰ At the end of July 2020, up to 30 residents at the Skellig Star began a hunger strike in protest at conditions there.²¹ In response, Minister for Justice Helen McEntee announced the closure of the centre on a phased basis within the next few months.²²

¹⁵ Laura Fletcher, 'Plans for Self-isolation Facility for Asylum Seekers' *RTE News* (23 March 2020) <<https://www.rte.ie/news/2020/0323/1124908-direct-provision-covid-19/>> accessed on 24 June 2021.

¹⁶ MASI, 'Statement on the Government's Appalling Response to Covid-19 in Direct Provision' (11 April 2020) <www.masi.ie/2020/04/11/statement-on-the-governments-appalling-response-to-covid-19-in-direct-provision/> accessed on 24 June 2021.

¹⁷ Sorcha Pollak, 'Covid-19: Testing under way at Cahersiveen Direct Provision Centre' *The Irish Times* (21 April 2020) <<https://www.irishtimes.com/news/social-affairs/covid-19-testing-under-way-at-cahersiveen-direct-provision-centre-1.4234583>> accessed 24 June 2021.

¹⁸ Shamim Malekmian, 'Covid-19: Controversy Erupts in Cahersiveen, Co Kerry over Locking In of Asylum Seekers' *Hot Press* (30 April 2020) <<https://www.hotpress.com/culture/covid-19-controversy-erupts-cahersiveen-co-kerry-locking-asylum-seekers-22814020>> accessed 24 June 2021.

¹⁹ See e.g. Neil Michael and Anne Lucey, 'Skellig Star: Basic Covid-19 Precautions Missing Weeks after First Virus Cases Identified' *The Irish Examiner* (30 July 2020) <<https://www.irishexaminer.com/news/munster/arid-40024517.html>> accessed 24 June 2021; Michael Clifford, "'Disregard for Garda Vetting" at Cahersiveen Direct Provision Centre' *The Irish Examiner* (1 July 2020) <<https://www.irishexaminer.com/news/arid-31008488.html>> accessed 24 June 2021.

²⁰ NASC, Irish Refugee Council, Doras Luimni and Graham Clifford, 'Joint Letter to An Taoiseach Regarding the Skellig Star Direct Provision Centre' (3 June 2020) <<https://nascireland.org/news/2020/joint-letter-taoiseach-regarding-skellig-star-direct-provision-centre>> accessed 24 June 2021.

²¹ Stephen McDermott, 'Direct Provision Residents in Kerry Go On Hunger Strike over Demands to be Moved to New Accommodation' *The Journal* (28 July 2020) <<https://www.thejournal.ie/direct-provision-skellig-star-hotel-hunger-strike-5161698-Jul2020/>> accessed 24 June 2021.

²² Harry McGee, 'Controversial Skellig Star Direct Provision Centre in Kerry to Close' *The Irish Times* (30 July 2020) <<https://www.irishtimes.com/news/politics/controversial-skellig-star-direct-provision-centre-in-kerry-to-close-1.4318045>> accessed 24 June 2021.



However, reports subsequently emerged of further outbreaks in other direct provision centres.²³ On 10 August 2020 the Irish Refugee Council published a report entitled *'Powerless': Experiences of Direct Provision During the Covid-19 Pandemic*, which reported that 50% of respondents were unable to socially distance themselves from other residents during the pandemic and 42% shared a bedroom with a non-family member.²⁴ As the CEO of the IRC Nick Henderson commented on the release of the report, "Until and unless single or household occupancy accommodation is provided, Direct Provision will remain vulnerable to outbreaks."²⁵

Pandemic Unemployment Payment

There was also criticism of the exclusion of asylum seekers who had been in employment from the COVID-19 Pandemic Unemployment Payment Scheme.²⁶ Although this payment had initially been granted to some asylum seekers who were unable to work because of the pandemic, the Department of Employment Affairs and Social Protection subsequently decided that asylum seekers living in direct provision were not eligible for the PUP of €350 as their bed and board was provided and they were eligible for the direct provision allowance of €38.80. The Irish Human Rights and Equality Commission expressed concern about the exclusion of asylum seekers from the PUP scheme²⁷ and Dr Liam Thornton queried the lawfulness of this exclusion on a number of grounds.²⁸ In a speech on 3 August 2020, Taoiseach Micheál Martin announced a reversal of the policy excluding people living in direct provision from the payment, stating: "Following reports that there was an issue with people in Direct Provision settings being reluctant to come forward for tests because of fear of losing income, we have decided that, lest there be any doubt, Direct Provision residents will be treated the same as any other citizen in terms of social protection supports when it comes to Covid-19."²⁹

²³ Michelle Hennessy, 'New Clusters in Meat Plants, Direct Provision Centres and Among Traveller Community' *The Journal* (5 August 2020) <<https://www.thejournal.ie/clusters-coronavirus-5168408-Aug2020/>> accessed 24 June 2021.

²⁴ Irish Refugee Council, "'Powerless': Experiences of Direct Provision during the Covid-19 Pandemic' (10 August 2020) <<https://www.irishrefugeecouncil.ie/news/powerless-experiences-of-direct-provision-during-the-covid-19-pandemic>> accessed 24 June 2021.

²⁵ *ibid.*

²⁶ See, e.g., Liam Thornton, 'Excluding asylum seekers from pandemic unemployment payment' (*Exploring Law, Exploring Rights Blog*, 29 May 2020) <<https://liamthornton.ie/2020/05/29/excluding-asylum-seekers-from-pandemic-unemployment-payment/>> accessed 24 June 2021.

²⁷ Irish Human Rights and Equality Commission, 'Letter to Minister for Employment Affairs and Social Protection' (29 May 2020) <<https://www.ihrec.ie/app/uploads/2020/05/28-May-2020-IHREC-Letter-to-Minister-for-Employment-Affairs-and-Social-Protection.pdf>> accessed 24 June 2021.

²⁸ Liam Thornton, 'Challenging the Unlawful Exclusion of Asylum Seekers from Pandemic Unemployment Payment' (*Exploring Law, Exploring Rights Blog*, 4 June 2020) <<https://liamthornton.ie/2020/06/04/challenging-the-unlawful-exclusion-of-asylum-seekers-from-pandemic-unemployment-payment/>> accessed 24 June 2021.

²⁹ 'Speech by An Taoiseach, Micheál Martin TD, Post Cabinet Briefing, 4 August 2020' (4 August 2020) <<https://merrionstreet.ie/en/news->



Reforming direct provision

On 5 June 2020, as the Government confirmed that Ireland was on course to move to phase 2 of the roadmap for easing the COVID-19 restrictions, the Expert Group on the Provision of Support, including Accommodation, to Persons in the International Protection Process chaired by Dr Catherine Day delivered a briefing note on its work to date.³⁰ According to *The Irish Times*,³¹ the group said “the coronavirus pandemic has exposed the ‘unsuitability’ of the current system” and made a number of recommendations that could be introduced immediately to improve the direct provision system. The Minister for Justice welcomed the briefing note and indicated that he had asked the Secretary General to undertake a review of the Department’s “action on direct provision in the early stages of the pandemic, with particular reference to opening centres such as the one in Cahersiveen, to inform our actions in any subsequent phases. To ensure it is done quickly as possible, this review will be conducted internally with HSE input/involvement. We will seek external expert input on it when it is near completion.”³²

The Programme for Government agreed in June 2020 between Fianna Fáil, Fine Gael and the Green Party included a commitment to ending the direct provision system and replacing it with “a new International Protection accommodation policy, centred on a not-for-profit approach.”³³ Responsibility for direct provision has transferred from the Department of Justice to the Department of Children, Disability, Equality and Integration under Minister Roderic O’Gorman, who described this pledge as “a key priority” and committed to moving people out of emergency hotel and B&B accommodation.³⁴

[room/speeches/speech_by_an_taoiseach_micheal_martin_td_post_cabinet_briefing_4_august_2020.html](#)> accessed 24 June 2021.

³⁰ Department of Justice, ‘Statement by Ministers Flanagan and Stanton Regarding the Direct Provision System’ (5 June 2020) <<https://www.gov.ie/en/press-release/cce37-statement-by-ministers-flanagan-and-stanton-regarding-the-direct-provision-system/>> accessed 24 June 2021.

³¹ Jack Power, ‘Covid-19 Has Exposed ‘Unsustainability’ of Direct Provision System - Expert Group’ *The Irish Times* (5 June 2020) <<https://www.irishtimes.com/news/social-affairs/covid-19-has-exposed-unsustainability-of-direct-provision-system-expert-group-1.4272131>> accessed 24 June 2021.

³² Department of Justice (n 30).

³³ Department of An Taoiseach, *Programme for Government: Our Shared Future* (June 2020).

³⁴ Sorcha Pollak, ‘Roderic O’Gorman Says He Wants to Take the “Meanness” out of Direct Provision’ *The Irish Times* (17 July 2020) <<https://www.irishtimes.com/news/politics/roderic-o-gorman-says-he-wants-to-take-the-meanness-out-of-direct-provision-1.4306324>> accessed 24 June 2021.



The report of the Day Group was published in September 2020.³⁵ The report made a series of recommendations to end direct provision and transform the international protection process by mid-2023. One of the key recommendations was an end to congregated and segregated accommodation of applicants for international protection by mid-2023. The report also recommended a number of reforms to the system of direct provision in the interim, including the appointment of HIQA as the independent inspectorate body responsible for inspecting direct provision centres and ensuring compliance with the National Standards for Accommodation Centres due to enter force in January 2021. Welcoming publication of the report, Minister O’Gorman said “The Government agrees with the Advisory Group’s conclusion that the current system of Direct Provision is not fit for purpose and must be replaced.”³⁶

Following on from the Day Report, the Government White Paper was published in February 2021.³⁷ The White Paper proposes a new system to replace the current system of direct provision. Under the new system, people arriving in the State who claim international protection, during an initial phase lasting no more than four months, will be accommodated in one of a number of Reception and Integration Centres, which are to be newly built to a high specification and operated by not-for-profit organisations on behalf of the State. During this orientation period, people will receive integration supports to help them adjust to living in Ireland, including English language tuition and employment activation supports. After their first four months in Ireland, people whose protection claims are still being processed will move to own-door or own-room accommodation in the community, for which they will pay a means-tested rent. Applicants will be entitled to seek paid work after six months, and they will be encouraged and supported to do so. Integration supports will continue to be available to people who need them. According to the White Paper, it is envisaged that the new system will be fully operational by December 2024.

Reactions to the White Paper were broadly positive. The Irish Refugee Council welcomed the publication of the White Paper, describing it as “a seminal moment in the long campaign to end direct

³⁵ Department of Justice, *Report of the Advisory Group on the Provision of Support, including Accommodation, to Persons in the International Protection Process* (September 2020).

³⁶ Department of Children, Equality, Disability, Integration and Youth, ‘Minister O’Gorman and Minister McEntee Publish the Report by the Advisory Group on Direct Provision and Announce a Reduction in the Waiting Period for International Protection Applicants to Access Work’ (21 October 2020) <<https://www.gov.ie/en/press-release/59532-minister-ogorman-and-minister-mcentee-publish-the-report-by-the-advisory-group-on-direct-provision-and-announce-a-reduction-in-the-waiting-period-for-international-protection-applicants-to-access-work/>> accessed 24 June 2021.

³⁷ Department of Children, Equality, Disability, Integration and Youth, *A White Paper to End Direct Provision and to Establish a New International Protection Support Service* (February 2020).



provision.”³⁸ Catherine Day commented that “the White Paper puts the asylum seeker at the centre of future asylum policy, taking a human rights approach built on mutual respect and trust”, but also noted that political will and regular monitoring will be necessary to deliver on the White Paper’s ambitions.³⁹ While the White Paper broadly reflected the Day Report recommendations, it did not adopt the recommendation on granting permission to remain to people who have spent two or more years in the process. It is notable that the Day Report itself regarded the clearing of this backlog as essential to the success of the proposed reforms.

Conclusions

In the twenty-one years since its introduction, the system of direct provision has been the subject of repeated criticism. The Covid-19 pandemic brought the deficiencies of the system into even sharper relief. Until recently, government policy was based on trenchant defence of the system of direct provision in the face of an overwhelming body of evidence that the system was not fit for purpose. The recent commitment to ending the system of direct provision is welcome, as is the publication of the White Paper which sets out a detailed roadmap for achieving that goal. For the thousands of people who continue to live within the system, it is imperative that this commitment becomes a reality without delay.

³⁸ Irish Refugee Council, ‘Irish Refugee Council Welcome White Paper, Focus Now on Implementation’ (26 February 2021) <<https://www.irishrefugeecouncil.ie/news/irish-refugee-council-welcome-white-paper>> accessed 24 June 2021.

³⁹ Catherine Day, ‘White Paper a Big Step towards Ending Direct Provision’ *The Irish Times* (6 March 2021) <<https://www.irishtimes.com/opinion/white-paper-a-big-step-towards-ending-direct-provision-1.4502192>> accessed 24 June 2021.



Chapter VI: Income maintenance for those unable to work for health-related reasons

Mel Cousins

The overall objective of this report is a high-level critical analysis of the public health response to the pandemic. In that context, this chapter provides an initial assessment of the State and employer response in terms of income support (both occupational and social welfare) to enable people to stay at home from work etc, thereby allowing the pandemic suppressing measures to be effective. In order to do this, it is necessary to put the COVID response in the context of the overall support for sickness-related work absence (section 1). This is followed by a discussion of the main response to COVID, the extended illness benefit scheme (section 2) and an overview of the very limited evidence on the impact of COVID (section 3). Finally, in section 4, we discuss proposals for reform.

Overview of the Irish sickness benefit system

The Irish approach to compensating employees who are unable to work due to illness involves a mixture of occupational welfare (sick pay schemes agreed between employers and employees with no statutory basis) and statutory illness benefit (IB) paid by DSP. Ireland is one of the few EU countries which has no statutory sick pay.¹

Unfortunately, relatively little is known about current sick pay arrangements. A 2008 survey by the CSO found that 64% of employees had access to paid sick leave as part of their employment.² There was no statistically significant difference between the proportion of men and women reporting the availability of paid sick leave. However, younger employees and non-Irish nationals had significantly lower levels of access to sick pay. Paid sick leave was also related to education levels and earnings with 78% of those with third level education having access compared to only 50% of those with primary education or lower. This presumably relates to the type of work in which such workers are engaged. For example, only 24% of employees in the hotels and restaurants sector reported that they had access to paid sick leave. However, the survey did not look at eligibility conditions, duration of sick leave or levels of sick pay.

¹ Slavina Spasova *et al*, *Non-standard workers and the self-employed in the EU: social protection during the Covid-19 pandemic* (OSE, 2021). The others are Cyprus, Greece and Portugal. However, where sick pay is provided this must be on a non-discriminatory basis in line with the Employment Equality Acts, 1998 – 2015. See, for example, *User Interface Designer v Engineering Company*, ADJ-00023614.

² CSO, *Working Conditions: Quarterly National Household Survey*, (2010).



Illness benefit is, in contrast, widely available and all employees earning over €30 per week are insured for illness benefit. It is payable to persons who are 'incapable of work' based on a medical report by their GP.³

The response to the COVID crisis

In response to the COVID crisis, one of the first actions of Government in 2020 was to introduce an expanded illness benefit for person unable to work due to COVID or who were advised to avoid working. In practice, the crisis turned out to be much more significant than originally feared and the main demand for social welfare payments has been from persons who have lost their employment without directly being affected by the virus. The Government responded to this shortly afterwards by introducing the Pandemic Unemployment Payment (PUP).

Illness benefit (COVID-19) is a payment for employed and self-employed persons who are advised to self-isolate by a doctor or the HSE or have been diagnosed with COVID-19. Unlike standard illness benefit (IB) (which only applies to insured employees) it also applies to the self-employed. The personal rate for this payment is €350 per week, as compared with the normal IB rate of €203.

To receive the enhanced payment, one must be:

- self-isolating on the instruction of a doctor or the Health Services Executive (HSE) or diagnosed with COVID-19, and
- be absent from work and confined to your home or a medical facility

The legal basis for the payment is the Social Welfare (Consolidation) Act 2005 as amended by the Health (Preservation and Protection and other Emergency Measures in the Public Interest) Act 2020. Relatively little of the detail of the payment is set out in the Act and much is left to implementing regulations to be adopted by the Minister for Social Protection.⁴ In legal terms, IB (COVID-19) is simply a form of illness benefit and it would appear that the general rules in relation to illness benefit should apply to it, subject of course to the specific provisions set out in the Health Act 2020 and the Regulations.

³ See generally Mel Cousins and Gerry Whyte, *Social Security Law in Ireland* (Kluwer 2020).

⁴ See SI no 97/2020.



The Health Act 2020 (as regards social protection) initially was in effect until 20 May 2020 but this has been extended until 30 June 2021.⁵

A person is entitled to IB (COVID-19) if she is incapable of work, or is deemed to be incapable of work, by virtue of—

- (a) being certified in the prescribed manner by a registered medical practitioner as being a person—
 - (i) who is diagnosed with COVID-19, or
 - (ii) who is a probable source of infection of COVID-19,
- (b) having been notified, in the prescribed manner, by a medical officer of health or such other person as may be prescribed, that he or she is a probable source of infection of COVID-19,
- (c) being deemed to be a probable source of infection of COVID-19, or
- (d) being a person in respect of whom an order under section 38A(1) of the Health Act 1947 is in force (This provides for the detention and isolation of persons in certain circumstances in relation to limiting the spread of COVID-19).

Thus, a person need not be actually incapable of work but can, as in the case of standard IB, be deemed to be incapable of work in certain circumstances. The Regulations provide that that a person who is not incapable of work shall be deemed to be incapable of work by reason of a specified infectious disease by virtue of (a) being certified by a doctor as being a person who is a probable source of infection of Covid-19, (b) having been notified by a medical officer of health that he or she is a probable source of infection of Covid-19, or (c) being a person in respect of whom an order under section 38A(1) of the Health Act 1947 (concerning the detention or isolation of a person necessary to prevent the spread of Covid-19) is in force.

One potential issue is that while the Department of Social Protection (DSP) website states that a person 'self-isolating on the instruction of a doctor or the HSE' will be entitled to payment,⁶ the Act and Regulations state that a person must be a *probable* source of infection. While self-isolating persons are presumably a *possible* source of infection, it is difficult to see that they could be classified as a *probable* source in many cases. Amendments to include 'possible or probable' in the section were ruled out of order during the passage of the Bill, presumably as a theoretical charge on the Exchequer.

⁵ By SI no 133/2021.

⁶ <<https://www2.hse.ie/conditions/coronavirus/coronavirus.html>> accessed 2 July 2021.



This issue could perhaps have been avoided had the wording of the current Regulations been used (Social Welfare (Consolidated Claims, Payments and Control) Regulations 2007, article 20). This provides that a person is deemed to be incapable when s/he is under medical care for a disease or disablement and when it is certified by a doctor that because of the disease or disablement he or she should not work and he or she does not work. Arguably, a person self-isolating on the instructions of a doctor could be considered to be *under medical care* and thus be deemed to be incapable. However, it seems very unlikely that the award of IB to persons who are only possibly (rather than probably) infectious will be challenged.

Regulations provide that a person is not entitled to benefit in respect of any day of incapacity for work, if he or she is entitled to full wages, salary, or paid sick leave and is entitled to a reduced rate or reductions in the rate of illness benefit in respect of any day of incapacity for work, if he or she is entitled to reduced wages, salary, or paid sick leave, for those same days, which is less than the rate of illness benefit to which he or she would otherwise be entitled.

The normal requirement of waiting days before a person becomes entitled to IB does not apply in this case.

The Act provides that the Minister may introduce regulations to amend the PRSI contribution conditions which must be satisfied to qualify for IB claims arising from COVID-19. The Regulations now provide that where a person is entitled to benefit if, immediately before claiming illness benefit, she

- (a) is an employed contributor who (i) has qualifying contributions in respect of not less than 1 contribution week in the 4 weeks immediately before claiming illness benefit, and (ii) has not engaged in employment since the date of her claim for illness benefit, or
- (b) is a self-employed contributor, or has verified that she was self-employed immediately before claiming illness benefit by making a declaration that she (i) was engaged in self-employment immediately before claiming illness benefit, (ii) has not engaged in self-employment since the date of her claim, and (iii) will have reckonable income in the current contribution year and will be liable for the payment of a self-employment contribution.



The Act allows the Minister to vary, by regulation, the rate of IB payment to a claimant who meets the qualifying requirements for IB arising from COVID-19. This was originally intended to be €305 per week but was subsequently increased to €350, *ie* €147 more than the standard personal rate.

Section 6 of the Health Act 2020 gives the Minister sweeping powers to make regulations ‘for the purposes of giving full effect to the relevant provisions’. In particular, it states that such regulations may, in particular, but without prejudice to the generality of the foregoing, provide for all or any of the following:

- (a) the matters referred to as prescribed by the relevant provisions;
- (b) the procedure by which, and manner in which, a person is certified to be a relevant person;
- (c) notwithstanding the generality of paragraph (b), the procedure by which, and manner in which, a person is deemed to be a probable source of infection of COVID-19;
- (d) the requirements in relation to which, and the manner in which, a relevant person shall notify the Minister of the circumstances of his or her incapacity, or deemed incapacity, for work;
- (e) additional conditions for entitlement of a relevant person to illness benefit;
- (f) such additional, incidental, consequential or supplemental matters as the Minister considers necessary or expedient for the purposes of giving effect to the relevant provisions.

In an attempt to protect these powers from accusations of allowing the Minister to legislate, section 40A(2) (as inserted) does set out several general policies and principles to which the Minister should have regard, including ‘the nature and potential impact of COVID-19 on individuals, society and the State’. While there might be some issues concerning the delegation of legislative powers to the Minister (in the light of Article 15.2 of the Constitution), it seems unlikely that any challenge will be made to the legislation and, even if it was, one might expect that the courts would adopt a flexible approach given the context (which is specifically emphasised in the preamble to the Act).

In terms of numbers, the number of people receiving IB (COVID-19) has always been much smaller than those receiving the PUP. In early April 2021, there were just over 2,000 people in receipt of IB (COVID-19).⁷ In total, up to that date, 146,000 people had been medically certified for receipt of IB (COVID-19), of whom 54% are women and 46% are men. The sectors with the highest number of claimants are wholesale and retail trade (22% of the total), human health and social work (18%) and

⁷ This compares to 437,000 in receipt of PUP at the same time.



manufacturing (14%). Only very limited data is reported by DSP and it is not clear how many are ill as opposed to deemed incapable or whether people return to work after the payment ceases or go onto another social welfare payment.

Impact of COVID-19

There is, unfortunately, very limited evidence about the extent to which these arrangements addressed the needs of workers affected by COVID. Some studies have highlighted the fact that some groups of workers who are likely to be particularly affected by COVID-19 had relatively low rates of access to sick pay. For example, the Oireachtas Special Committee on COVID-19 Response found that:

The transmission of Covid-19 in congregated settings such as nursing homes, direct provision centres and meat plants was facilitated by the fact that workers felt compelled to attend for duty even though they were potential carriers of the virus due to the absence of income support...⁸

The Committee concluded that the majority of staff in meat plants and in private nursing homes do not have access to sick pay.⁹ A Migrant Rights Centre report found that, based on a survey of 151 workers from the meat processing sector, 90% of workers are not covered by occupational sick pay schemes in the event of injury or illness.¹⁰ Neither report appears to consider whether such workers were entitled to illness benefit or, if not, why this should have been the case.

Conclusions

As a result of COVID, pressure for some form of statutory sick pay has emerged in Ireland. A Sick Leave and Parental Leave (COVID-19) Bill 2020 was introduced in the Dáil by the Labour Party in September 2020. Subsequently, the Oireachtas Special Committee on COVID-19 Response issued a report recommending the establishment of a statutory sick pay requirement for low-paid workers, such as those working in nursing homes and meat plants.¹¹

⁸ *Final Report of the Special Committee on Covid-19 Response* (Houses of the Oireachtas 2020) 15. This finding is presumably based on evidence to the Committee although it does not appear to have carried out any actual research.

⁹ The Committee heard that only 20% of Meat Industry Ireland members paid sick pay to their workers.

¹⁰ Migrant Rights Centre, *Working to the Bone: The Experiences of Migrant Workers in the Meat Sector in Ireland* (2020).

¹¹ *Final Report of the Special Committee on Covid-19 Response* (n 8).



The Minister for Enterprise, Trade and Employment Leo Varadkar has said that the Government 'is committed to introducing a statutory sick pay scheme that works for employees and employers as quickly as possible'.¹² Following this, the Department of Enterprise, Trade and Employment (DETE) launched a public consultation process on the introduction of a statutory right to paid sick leave for all employees.¹³

However, in a recent submission to the Oireachtas Committee on Enterprise, Trade and Employment, the Department appeared to be rather unenthusiastic about the concept of imposing any 'financial burden on employers'.¹⁴ According to DETE some of the issues identified in the response to the consultation cut across other Government departments, such as taxation issues and illness benefit, and an interdepartmental group has been set up to deal with these matters.

Indeed, it has been proposed to introduce statutory sick pay of several occasions in the past, dating back to at least 1987 and most recently in 2012, but this has always been strongly opposed by employers¹⁵ and, to a certain extent, trade unions and such plans have never come into force.¹⁶ It would appear that the current plan, if it survives the deadly embrace of DETE, is for statutory sick pay of up to two weeks with a maximum sick pay amount.

In the past, proposals for sick pay have come from the DSP and have been seen as a privatisation of the illness benefit scheme, perhaps contributing to trade union concerns. However, on this occasion, and in the light of COVID-19, trade unions such as SIPTU have supported mandatory sick pay. In addition, employers' representatives recognise that many of their members are currently particularly dependent on the state and in a weakened position to oppose sick leave. However, it remains to be seen whether the outcome of this process will result in any significant policy benefit overall.

In terms of providing appropriate cover for persons who are ill while reducing sickness absence and promoting return to work for people who have had to take leave due to illness, comparative studies suggest that there is much to be said for involving employers centrally in the process. The OECD has

¹² <<https://www.gov.ie/en/press-release/eadce-tanaiste-invites-views-on-statutory-sick-pay-scheme/>> accessed 16 June 2021.

¹³ Ibid.

¹⁴ Martin Wall, 'Department aims for fair sick pay scheme' *The Irish Times* (11 March 2021) 14.

¹⁵ <<http://agenda.ibec.ie/1avtcqeiiab>> accessed 16 June 2021.

¹⁶ See the debate on the topic in 2012 when some parties now calling for statutory sick pay opposed the then Government's proposals for sick pay: *Dáil Debates* (2012) 773(19), 24 October 2012.



emphasised the need for cultural change supported by financial and other incentives for all actors (employers, individuals, medical professionals and social security authorities) to promote work-retention and return to work.¹⁷ As part of this', reforms need to take into account the overall labour market and social welfare systems to ensure that particular approaches will have a positive impact and not simply lead to a transfer of costs from one sector to another or a transfer of claimants from one scheme to another.

The Netherlands has been one of the leading countries in the EU in reforming sickness supports by engaging employers. The Dutch sickness and disability system has undergone extensive reform in the last two decades. Responsibility for payment during sick leave was transferred to employers initially for 1 year, later extended to 2 years.¹⁸ The employer is now responsible for continued payment of 70% of wages for 104 weeks (subject to a maximum wage). This percentage can be increased by collective wage agreements. In 2002, a Gatekeeper Protocol was introduced which sets out detailed structure as to the rights and obligations of employers and employees in cases of sickness absence. There have been several evaluations of the impact of these reforms. For example, Van Sonsbeek and Gradus found that the combined reforms had led to a fall in inflows to disability pension of over 60%.¹⁹

It would, perhaps, be unrealistic to propose to make Irish employers responsible for the costs of payments to the extent that this has happened in the Netherlands or to impose a mandatory Gatekeeper Protocol. However, the Dutch experience does emphasise both the importance of engaging employers centrally in the process and the need for a coherent system which provides incentives for people (state agencies, employers and employees) to behave in the manner desired by policy. Sadly, the experience of COVID-19 (and indeed more generally) would suggest that there is little if any possibility that the Irish Government will be able to adopt or implement such a coherent approach.

¹⁷ OECD, *Sickness, Disability and Work: Breaking the Barriers* (2010).

¹⁸ Many small and medium employees reinsure against these costs but studies have not found any impact on the rate of sickness absence from an employer's choice of whether to insure or not.

¹⁹ Jan-Maarten Van Sonsbeek and Raymond HJM Gradus, 'Estimating the effects of recent disability reforms in the Netherlands' (2013) 65(4) *Oxford Economic Papers* 832.



Chapter VII: Remote Working Support as Public Health Policy Measures

Niamh Egleston, Alan Eustace and Sara-Jane O'Brien

Context

Remote working became mandatory for all but essential front-line workers on 27 March 2020, and has remained either mandated or advised by Government on a continuous basis since then. This chapter will examine the extent to which the state has facilitated and supported remote working during this time.¹ It must be recalled that the ability to work from home has disproportionately been the preserve of higher earners. It should also be noted that the Department of Enterprise, Trade and Employment published a new remote working strategy in January 2021,² building on an earlier research report³ and public consultation.⁴ This strategy is intended to shape Ireland's future approach to remote working (with legislation expected in September 2021), and will be referred to later in the chapter. For the moment, we will focus on the actions the government has taken to date. We will consider: 1. Financial supports for PAYE workers; 2. Financial supports for self-employed; 3. Supports for students; 4. Infrastructure and public service supports; 5. Indirect support, in the form of guidance and complementary legal support from state agencies. We will then make recommendations for the future in light of the government's strategy.

Financial support for PAYE workers⁵

PAYE employees are entitled to a number of tax reliefs on expenses incurred while working from home, such as light, heat, telephone and broadband/internet connectivity. An employer may pay up to €3.20 to their employee without a benefit in kind arising - meaning that this amount is tax-free.⁶ If

¹ It is worth noting that many countries have struggled to adapt to remote working during the pandemic within the confines of existing labour, social security and tax law. For some discussion, see Keith Ewing and John Hendy, 'Covid-19 and the Failure of Labour Law: Part I' (2020) 49(4) *Industrial Law Journal* 497. There has been at least one case before the WRC which upheld a worker's claim to constructive unfair dismissal after her request to work remotely was rejected by the employer: see <[Compensation for office worker who resigned after employer would not let her work from home - Independent.ie](#)> and <[Eugene F. Collins | Recent WRC decision - Request to work remotely | Eugene F. Collins](#)> accessed 19 April 2021.

² <<https://enterprise.gov.ie/en/Publications/Making-Remote-Work.html>> accessed 26 March 2021.

³ <<https://enterprise.gov.ie/en/Publications/Remote-Work-in-Ireland.html>> accessed 26 March 2021.

⁴ For results of this consultation, see <<https://enterprise.gov.ie/en/What-We-Do/Workplace-and-Skills/Remote-Working/Consultation-on-Guidance-for-Remote-Working/>> accessed 26 March 2021.

⁵ It is not proposed to consider subsidies to businesses that may have had indirect benefits for PAYE workers, such as the Temporary Wage Subsidy Scheme.

⁶ Taxes Consolidation Act 1997, section 118. See <<https://www.revenue.ie/en/employing-people/employee-expenses/e-working-and-home-workers/index.aspx>> accessed 30 March 2021.



no such allowance is paid, or for expenses above that threshold, the employee must claim tax relief at the end of the year whereupon they will be reimbursed. This is called 'Remote Working Relief'. Under that scheme, an employee can claim for:

- 10% of the cost of electricity and heat incurred (apportioned based on the number of days worked at home over the year)
- 30% of the cost of broadband incurred, apportioned based on the number of days worked at home over the year. This is a Revenue concession which commenced in the 2020 tax year and will apply for the duration of the pandemic.⁷

In a similar vein, equipment provided by employers does not constitute a benefit in kind for taxation purposes. Claims may also be made for any other vouched expenses incurred 'wholly, exclusively and necessarily' in the performance of the duties of their employment.⁸ However, in circumstances where home working equipment is not provided, capital items such as laptops, computers, office equipment and office furniture are not allowable costs.

Recommendations

The first problem with the structure of tax deductions for remote working is that it must be claimed at the end of the year. This can cause serious cash-flow problems for workers, especially the low-paid. There should be a specific tax credit set up for remote workers that can be offset against PAYE on an ongoing basis (subject to adjustment for under- or over-payment at the end of the year). Not only would this relieve cash-flow difficulties, but it would also significantly ease the administrative burden on taxpayers.

The second is that the proportion of expenses that can be claimed back is too low. During the pandemic, when families may have had parents and children all working and learning remotely for long periods of time, there would be significant costs in respect of broadband internet in particular. Additional bandwidth usage may have required workers to invest in costly upgrades to their domestic package. It should be borne in mind that many employers have saved significant expenditure on heating, electricity and internet connection for their offices during the pandemic, shifting that cost

⁷ Revenue, *e-Working and Tax* (October 2020): <<https://www.revenue.ie/en/tax-professionals/tdm/income-tax-capital-gains-tax-corporation-tax/part-05/05-02-13.pdf>> accessed 15 June 2021.

⁸ See Revenue, *General Rule as to Deduction of Expenses in Employment* (January 2020): <<https://revenue.ie/en/tax-professionals/tdm/income-tax-capital-gains-tax-corporation-tax/part-05/05-02-20.pdf>> accessed 11 June 2021.



onto their employees. As such, there is ample scope to increase the payment that employers should make to employees to reimburse such expenses.

Third, relatedly, the Commission for Energy Regulation put in place a moratorium on disconnections from gas and electricity mains supply during Level 5.⁹ This should be extended to other levels of public health restrictions. There is no equivalent protection against disconnection from internet and mobile service, although most service providers have made voluntary commitments to make additional bandwidth available where possible, help customers keep costs down, and ‘engage with any customer that contacts them who is in financial difficulty as a result of COVID-19 and has difficulty paying their bills to agree the best way of keeping them connected to voice and data.’¹⁰ Both moratoriums should be placed on a statutory footing, along with robust price controls.¹¹ Disconnection from essential services is serious in any circumstances but particularly during the pandemic, when people’s income is reduced, they have additional healthcare needs, and are working remotely.

Finally, it is difficult to determine where the boundary lies between work equipment and a benefit in kind, particularly if employers require workers to use their own devices like laptops and mobile phones for work. This posed difficulties before the pandemic, and has only increased in circumstances of remote working.

Financial support for the self-employed

Whilst the government has announced a raft of new social-welfare measures for self-employed persons,¹² there appear to be no special measures for working from home arising from Covid-19. Additional business expenses arising in this manner are to be deducted in the ordinary way.

⁹ <[COVID-19 Information - Commission for Regulation of Utilities \(cru.ie\)](#)> accessed 16 April 2021.

¹⁰ <[ComReg welcomes Telecoms Industry Commitments to assist consumers during COVID-19 | Commission for Communications Regulation](#)> accessed 16 April 2021.

¹¹ There are some protections already in place: see <[Utility companies rule out Level 5 disconnections \(rte.ie\)](#)> accessed 16 April 2021.

¹² <[gov.ie - COVID-19 Social Welfare Schemes available to a self-employed person \(www.gov.ie\)](#)> accessed 11 April 2021. See, for example, Financial Provisions (Covid-19) (No 2) Act 2020, section 10. This continued a recent trend towards parity of tax credits and other treatment of self-employed and PAYE workers.



Recommendations

The same difficulties arise in respect of cash-flow problems for self-employed workers as for PAYE employees. Grants or loans should be made available to self-employed workers specifically to acquire equipment necessary for remote working. Where necessary, these can be offset against business accounting and tax arrangements at the end of the year. Otherwise, no additional support specific to this group is necessary - however, many of them will benefit from other measures proposed in this chapter.

Financial Supports for Third-Level Students

Most third-level students have been working remotely during the pandemic. The ordinary supports for students have been maintained, with some additional funding. The €168m support package for higher education in July 2020 included an additional €8m for the student assistance fund (on top of the existing €8m);¹³ Budget 2021 provided an additional €20m for SUSI and increased the income threshold for eligibility.¹⁴ This funding will, in part, enable students to work remotely.¹⁵

In addition, new funding programmes were established specifically to support remote learning. As part of the July 2020 support package, €15m was made available to fund laptop computers and other devices for students.¹⁶ Budget 2021 included €50m in direct payments to students (€250 *per* student), which again may contribute towards costs associated with remote learning. Indeed, in a press release the Minister for Further and Higher Education Simon Harris noted that the fact that students had little or no access to on-campus learning, and his hope that this payment may alleviate some of the hardships incurred as a result.¹⁷ This must, one assumes, include the Specific funding was allocated to third-level institutions to facilitate remote learning.¹⁸

¹³ <[gov.ie - Minister Harris announces €168 million package for third level institutions and students \(www.gov.ie\)](https://www.gov.ie/en/press-release/be878-minister-harris-welcomes-payment-of-250-to-71000-students/)> accessed 7 April 2021.

¹⁴ <https://usi.ie/wp-content/uploads/2020/10/Student-Reaction-A-Guide-to-Budget-2021.pdf> accessed 7 April 2021.

¹⁵ For more information on the impact of the pandemic on SUSI, see <[Do you have a question about Covid-19 and student grant funding? Check out our Covid-19 FAQ. - SUSI : SUSI](#)> accessed 7 April 2021.

¹⁶ <[gov.ie - Minister Harris announces €168 million package for third level institutions and students \(www.gov.ie\)](https://www.gov.ie/en/press-release/be878-minister-harris-welcomes-payment-of-250-to-71000-students/)> ; [Funding approved for third level online learning \(rte.ie\)](#)> accessed 7 April 2021.

¹⁷ <<https://www.gov.ie/en/press-release/be878-minister-harris-welcomes-payment-of-250-to-71000-students/>> Accessed 17 April 2021.

¹⁸ <[gov.ie - Minister Harris announces €168 million package for third level institutions and students \(www.gov.ie\)](https://www.gov.ie/en/press-release/be878-minister-harris-welcomes-payment-of-250-to-71000-students/)> ; <[Funding approved for third level online learning \(rte.ie\)](#)> (links accessed 7 April 2021).



Most non-EEA students are ineligible for government assistance or student grants in Ireland, including SUSI.¹⁹ Previously this also meant asylum seekers were ineligible, though access has been expanded to include some members of this group in recent years.²⁰ As a result such students cannot access the €250 direct payment, nor benefit from funding allocated to universities and higher education institutions to facilitate access to ICT equipment for disadvantaged students.²¹ Students whose refugee status has been recognised, or who have been granted certain permanent residence permissions are eligible for government support.²²

Recommendations

Students have had to replicate in their homes the resources they normally rely on universities to provide, including study spaces, exam halls, and research libraries to name a few. Thus similar issues around the increased costs of electricity, heat, and connectivity arise in respect of students as those discussed above in respect of PAYE workers. As a result we repeat our call for statutory moratoriums on disconnection, as well as price controls on relevant infrastructure.

Students also experience a number of unique difficulties. For those who are also PAYE workers, the line between costs incurred while working from home as versus studying from home is blurred, making it difficult to delineate their eligibility for tax-free allowances or remote working relief. This is especially the case for postgraduate research students who may also be doing paid research, or employed to teach or assess undergraduate students. Students who are *not* PAYE workers will not benefit from the measures discussed in Section 1, despite their incurring the exact same cost burdens as PAYE workers in many respects. Admittedly, some students may work from their family home, in which case family members' ability to apply for tax deductions will benefit them. However, not all parents are PAYE workers, not all parents work from home, and not all students live with parents.

¹⁹ See generally: <<https://susi.ie/eligibility-criteria/>> accessed 15 April 2021.

²⁰ The Department of Education recently launched a pilot grant scheme for certain asylum seeker students: <<https://www.education.ie/en/Learners/Services/Pilot-Support-Scheme/student-grant-scheme-for-asylum-seekers.html>> Accessed 16 April 2021. Asylum seekers who are eligible for this support scheme (i.e. those resident in Ireland for over three years) can now generally access SUSI funding.

²¹ <<https://www.gov.ie/en/publication/5b3c7-student-grants/#apply-for-a-student-grant>> accessed 9 April 2021. <<https://www.gov.ie/en/press-release/be878-minister-harris-welcomes-payment-of-250-to-71000-students/>> accessed 14 April 2021.

²² This includes those with so-called 'subsidiary protection' or who have been granted a Stamp 4 residence permission. See generally <<http://www.irishstatutebook.ie/eli/2020/si/76/made/en/print>> accessed 17 April 2021.



A number of costs specific to third-level have not been accounted for by the government, particularly the cost of research or course-related materials as access to campus and libraries has been curtailed or even eliminated.²³ Depending on the university's policies and circumstances, this could mean anything from ICT equipment to expensive textbooks.²⁴ The increased budget allocation for SUSI is welcome, however, many students simply will not qualify for this assistance, whether by nationality, or marginally falling outside the narrow income eligibility requirements. Those who do qualify for SUSI have long lamented its inadequacy and the modest adjustments announced by Minister Harris were the first such changes to SUSI since 2012, despite soaring rents and costs of living.²⁵ ICT access grants are not available to certain students for similar reasons, and their usefulness is thus limited. Similarly, whilst the €250 direct payment will be welcome, it cannot properly alleviate the expense of a full year without proper access to campus support and access to university resources.

Students should receive greater financial support for home working than they have thus far. This can be achieved through targeted payments, like grants for heating, electricity, materials/equipment and internet connectivity. Where appropriate, expansions of existing schemes including the SUSI grant system - through amending income thresholds and nationality criteria (perhaps to favour residence as the ultimate criteria) should be implemented - as this funding can be offset against a wide range of costs. Increases in the amount payable to students under SUSI should also be considered.

Non-EEA students ought to have been at the very least eligible to apply for access to ICT equipment through the government's new scheme on the same basis as Irish and EEA students. As regards the €250 direct payment, EEA and Irish students received this regardless of income, whereas non-EEA students were almost completely excluded from the payment with no consideration for their economic situation. In this respect, a system based more around need than nationality should have been considered.

Finally, there is no mechanism like the Workplace Relations Commission to intervene where students are experiencing difficulties in the relationship with their education institution. The Higher Education

²³ For example, shielding students, or those who have returned home to live in rural areas that cannot travel long distances to visit libraries or avail of click and collect services.

²⁴ For example, a copy of near-mandatory law text, Bryan McMahon and William Binchy, *The Law of Torts* (4th edn, Bloomsbury 2013), costs €275: <<https://www.bloomsburyprofessional.com/ie/law-of-torts-9781847669179/>> accessed 16 April 2021.

²⁵ <<https://www.irishmirror.ie/news/irish-news/four-five-students-fear-wont-22549302>>; <<http://www.universitytimes.ie/2020/05/usi-to-lobby-government-for-reform-of-shoddy-and-broken-susi-grant/>> accessed 16 April 2021.



Authority does not perform this function, and students' unions have limited powers and resources. The extent to which university obligations for the safety, health and welfare of students on university property applies where students are working remotely is unclear. Consideration might therefore be given to a Higher Education Ombudsman who could take legal action in support of students, including over remote working issues. At the very least, there should be standardised guidance issued to third-level students and institutions on remote working and learning best practice (including in respect of examinations), rather than being left up to each institution as seems to be the current position, with dramatic variations in practices between institutions.²⁶

Infrastructure and public services

The government's advice to work from home during the Covid-19 pandemic (and subsequent closure of academic institutions, public libraries and other similar amenities) ignores the fact that many homes in Ireland do not have an internet connection. Indeed, the CSO notes that as many as 9% of homes have no internet connection at all,²⁷ and that of the homes in Ireland that are connected, 47% of those use mobile, rather than fixed, broadband.²⁸ Reasons for not having an internet connection include digital illiteracy, poverty, or reliance on a connection outside the home, with areas outside Dublin having a higher proportion of non-connectivity.²⁹ This is to say nothing of speed or stability of connection, as the National Broadband plan (which aims to install high-speed internet across Ireland, particularly in rural areas) still only aims to be completed within the next seven years, and indeed suffered significant disruption as a result of the numerous bans on construction work over the course of the pandemic.³⁰

²⁶Students had calls for so-called 'no detriment' policies rejected: <<http://www.universitytimes.ie/2020/04/trinity-to-reject-unworkable-no-detriment-but-offer-backup-options/#:~:text=it%20says%20that%20the%20idea,the%20Covid%2D19%20pandemic%E2%80%9D.&text=Students%20will%20sit%20the%20modules,of%20the%20alterations%20to%20assessments>>. Other universities which had implemented such policies now appear to have changed their minds: <<https://universityobserver.ie/no-more-no-detriment-says-ucd-management/>>. Overall, students report feeling more stressed and disconnected than ever as the pandemic continues: <<https://www.irishtimes.com/news/education/students-call-on-universities-to-ensure-grades-do-not-suffer-in-online-exams-1.4220226>>; <<https://www.irishexaminer.com/news/arid-40238165.html>> all accessed 16 April 2021.

²⁷<<https://www.cso.ie/en/releasesandpublications/ep/p-iss/h/informationssocietystatistics-households2019/>> accessed 13 April 2021.

²⁸<<https://www.cso.ie/en/releasesandpublications/ep/p-iss/h/informationssocietystatistics-households2019/householdinternetconnectivity/>> accessed 13 April 2021.

²⁹<<https://www.cso.ie/en/releasesandpublications/ep/p-iss/h/informationssocietystatistics-households2019/householdinternetconnectivity/>> accessed 13 April 2021.

³⁰<<https://nbi.ie/rollout-plan/>> accessed 13 April 2021.



Childcare has been a persistent difficulty throughout the pandemic. Parents working remotely, particularly women, have been called upon to juggle full-time work in extenuating circumstances whilst providing full-time childcare and even homeschooling.³¹ This has been particularly acute for parents of disabled children, whose children likely have additional educational needs, and also in some cases increased medical vulnerability to Covid-19. Although special measures were introduced to maintain limited childcare support for essential workers who could not work remotely, no provision was made for people working remotely outside the normal childcare and education system, which itself was severely impacted by the pandemic at various times. This includes limited support provided to parents seeking to arrange home learning: whilst government guidelines were issued, these were mostly aimed at schools and teachers, leaving them to interact with parents. This means rather than a co-ordinated support for parents, they have been left to manage with whatever individual schools or teachers have put in place.³² All of this is to say nothing of the extraordinary cost of childcare in Ireland generally.³³

Finally, as most private leisure, recreation and wellbeing facilities have been closed for the majority of the time since March 2020, Irish people have been almost totally reliant on outdoor, public resources to protect the mental and physical wellbeing necessary for productivity at work. There are vast gaps in access to these facilities, depending often on local income levels and geography. These gaps are exacerbated further by the introduction and re-introduction of travel limits during various stages of the pandemic. Simply, at various times if one did not live within 2-5km of green space then there was no legal access to it. Naturally, this profoundly impacts those living in disadvantaged inner-city and urban areas. However, rural areas are also - perhaps counterintuitively - negatively impacted here as much land in rural areas is privately owned, and there is a dearth of public recreational space or facilities. Even those free, completely public open spaces that do exist such as beaches are not without their issues, as chronic mismanagement has meant that even these resources are not necessarily usable.

³¹<<https://www.irishtimes.com/news/ireland/irish-news/covid-19-has-sharpened-inequalities-faced-by-women-in-work-research-1.4540861>> accessed 17 April 2021.

³² See, for example: <<https://www.education.ie/en/Schools-Colleges/Information/continuity-of-schooling/continuity-of-schooling.html#parents>>; <<https://www.scoilnet.ie/>>; <<https://www.pdst.ie/DistanceLearning>>. The authors note that the national broadcaster did introduce education programming to aid in home learning: <<https://www.rte.ie/learn/home-school-hub/>> all accessed 13 April 2021.

³³<<https://www.irishtimes.com/news/politics/oireachtas/irish-childcare-costs-are-the-highest-in-the-world-like-a-second-mortgage-1.3714666#:~:text=Ireland%20now%20has%20the%20highest,not%20make%20a%20living%20wage>> accessed 13 April 2021.



Recommendations

Future public health policy measures must account for the extraordinary burdens placed upon people working from home, particularly women, in terms of childcare. The government has committed to keeping schools open as a matter of priority, and childcare has also been prioritised during reopening phases.³⁴ However, this will not be much comfort in the event that another surge causes schools and childcare facilities to be closed. Of course, the best way to ensure schools and childcare facilities remain open is to keep community transmission of the virus at low enough levels that these facilities can open safely. In default, then proper contingency planning must be put in place to ease the burdens of childcare and home learning on working parents and carers. Suggested measures include increased support for parents home-schooling, like dedicated government resources and guidelines and increased remote Special Needs Assistant support for parents of disabled children.³⁵ Indeed, the government actually froze mainstream class SNA allocations until next academic year, a regrettable development.³⁶ We observe below that employers have been reminded of the burdens faced by families with children, and asked to make certain accommodations for employees facing these increased caring burdens. This is a start, but there are limits to any approach that does not ultimately address the affordability and accessibility of professional childcare. Quite apart from the contribution it can make to public health policy by enabling remote working where that proves necessary, the state should be providing free or heavily-subsidised childcare. Consideration could be given to making childcare expenses tax-deductible for PAYE or self-employed workers along the lines of the carer's tax credit, since (as we have seen) childcare is necessary for those people to work.

Internet connectivity, and particularly stable, high speed broadband connectivity must be made widely available in order to facilitate working from home. In this respect, the authors note the many positive elements of the Government's Rural Development Strategy, which include commitments to optimising digital connectivity, as well as to enhance public services and revitalising rural communities.³⁷ The plan also commits to improving public spaces and amenities for leisure, culture and recreation. This coupled with the recently announced Remote Working Strategy could prove fruitful ground for improvements to the problems outlined above. We recommend these strategies be fully and properly

³⁴ <<https://www.rte.ie/news/politics/2020/0913/1164922-micheal-martin-twip/>> accessed 13 April 2021.

³⁵ The authors note the summer 'catch-up' programmes which have been implemented. These are welcome for children, but increased support for their carers during lockdowns must also be implemented. For more information, see: <<https://www.education.ie/en/Parents/Services/summerprovision/home-based-information-faqs-for-parents.pdf>> accessed 15 April 2021.

³⁶ <<https://www.gov.ie/en/service/37848-sna-allocations/>> accessed 15 April 2021.

³⁷ <<https://www.gov.ie/en/publication/4c236-our-rural-future-vision-and-policy-context/#optimising-digital-connectivity>> accessed 15 April 2021.



implemented. Dublin city council is currently drafting its development plan for 2022-2028.³⁸ The authors commend the draft submissions for considering propositions to improve public amenities and access to public space, and will watch the implementation of the strategy with interest.

In the interim, in imposing public health restrictions, government should be mindful of the possibility that certain restrictions may cut Irish people off from important health and wellbeing resources that support their ability to work from home entirely. Measures such as strict immediate travel restrictions should be carefully considered, and weighed against the ability of people to access outdoor public space for example.

Local authorities should be encouraged to promote home worker-friendly measures such as the proper maintenance of existing facilities (*eg* waste-water management for outdoor swimming areas).³⁹ Where possible, increased investment in the upkeep and creation of such facilities should be actively encouraged and carried out.

Indirect supports

In addition to the above, the government has made available ‘soft support’ in the form of guidance issued to workers and employers on remote working.⁴⁰

It is worth recalling that the ordinary obligations on employers to protect workers’ safety, health and welfare still apply during conditions of remote working.⁴¹ The Department of Enterprise, Trade and Employment has issued guidance that covers subjects like safety, training, equality and data protection.⁴² The Health and Safety Authority has produced detailed guidance including videos on ergonomics for desk work.⁴³ This is important because we know there is evidence of employees suffering injuries from working at kitchen tables *etc* during the pandemic.⁴⁴ The Revenue

³⁸ For more information, see <[Development Plan 2022 - 2028 | Dublin City Council](#)> accessed 19 April 2021.

³⁹ Of course, this is a pressing public health measure in itself.

⁴⁰ See <[Guidance for Working Remotely - DETE \(enterprise.gov.ie\)](#)> accessed 16 April 2021.

⁴¹ For discussion of these, see Des Ryan, ‘Safeguarding Employees’ Welfare during COVID-19: Is Employment Law ‘Working From Home’?’ (Trinity Covid-19 Observatory blog, 22 July 2020) <<https://tcdlaw.blogspot.com/2020/07/safeguarding-employees-welfare-during.html>>; and Deirdre Ahern and Suryapratim Roy (eds), ‘Law and Policy Responses to Covid-19 in Ireland: Supporting Individuals, Communities, Businesses, and the Economy’ (Trinity Covid-19 Observatory, November 2020) <[Covid-19 Public Policy Report.pdf \(tcd.ie\)](#)> (accessed 19 April 2021) ch 3.

⁴² See <[Guidance for Working Remotely - DETE \(enterprise.gov.ie\)](#)> accessed 26 March 2021.

⁴³ See <https://www.hsa.ie/eng/topics/remote_working/> accessed 26 March 2021.

⁴⁴ See, for example, Laura Slattery, ‘Working from home: new costs, new stresses and little relief’, *The Irish Times*, 26 May 2020; Mark O’Connell, ‘If you injure yourself working from home, is your employer responsible?’ *The Irish Times*, 29 May



Commissioners provided clear guidance, granted remote working concessions and collaborated with the Minister for Finance in the drafting and implementation of supports.⁴⁵

There is now a statutory code, developed by the Workplace Relations Commission and promulgated by Minister Varadkar on 31 March 2021,⁴⁶ on the right to disconnect.⁴⁷ Although not formally binding, it will be used to interpret the relevant legislation on working time.

Meanwhile, the statutory body Citizens' Information notes that the state has also asked employers to accommodate employees with caring and healthcare needs during the pandemic, including offering paid compassionate leave, flexibility in allocating shifts, allowing flexible working hours among other recommendations.⁴⁸ As mentioned above, the Health and Safety Authority has also issued guidance on working from home for employers and employees which suggest a number of ways in which both employers and employees can safely manage home working.⁴⁹

Recommendations

Legislation for remote working should be brought in as a matter of urgency. The government is currently consulting on the form this legislation will take (on which more below). The government should also legislate for a right to disconnect. There are significant flaws with the current legal position and the WRC code of practice, which will be the subject of a later report from the Observatory. Overall, there should be less reliance on 'soft supports' in place of legislation.

Conclusions

In summary, our recommendations in respect of the different categories of measures deployed during the pandemic are:

2020. See also *McCarthy v ISS Ireland Ltd* [2018] IECA 287. Deirdre Ahern and Suryapratim Roy (eds), 'Law and Policy Responses to Covid-19 in Ireland: Supporting Individuals, Communities, Businesses, and the Economy' (Trinity Covid-19 Observatory, November 2020) <[Covid-19 Public Policy Report.pdf \(tcd.ie\)](#)> (accessed 19 April 2021) 40-42.

⁴⁵ Pat Mahon and Sean Walsh, 'Legislating in a Crisis: The Temporary Wage Subsidy Scheme' (2020) 2 Irish Tax Review.

⁴⁶ SI no 159/2021.

⁴⁷ WRC statement on the code of practice: <[code-of-practice-for-employers-and-employees-on-the-right-to-disconnect.pdf \(workplacelrelations.ie\)](#)> accessed 19 April 2021.

⁴⁸ <https://www.citizensinformation.ie/en/employment/employment_rights_during_covid19_restrictions.html> Accessed 17 April 2021.

⁴⁹ <https://www.hsa.ie/eng/topics/remote_working/homeworking_guidance_9mar21_v8.pdf> accessed 16 April 2021.



- Set up specific tax credit for remote workers that can be offset against PAYE on an ongoing basis;
- Increase rate of direct payment to workers and proportion of expenses that are tax-deductible;
- Moratorium on disconnection from utilities, including internet and mobile connection;
- Clarity on benefits-in-kind in respect of equipment for working remotely;
- Financial support for self-employed to invest in remote working equipment;
- Clarity on entitlement to working from home relief when some time is spent working and other time studying;
- Broaden SUSI eligibility and increase funding;
 - and / or provide grants for academic textbooks and other resources when libraries are inaccessible;
 - and / or make available targeted remote working relief for students who do not work;
- Standardised guidance on best practice for remote learning at third-level, potentially enforced by a statutory body where disputes arise;
- Provide affordable childcare and more places;
- Standardised resources for home-schooling parents;
- Remote SNA support for children with special educational needs;
- Employer accommodation of parents for helping with home-schooling;
- Improve broadband connectivity, especially in rural areas;
- Implement Our Rural Future Strategy;
- Public infrastructure developments must account for a need for local amenities and public green space in suburbs and the 'commuter belt';
- Legislate for right to request remote work and the right to disconnect.

In addition to the measures consolidated in this section, the Government has recently published its strategy on remote working,⁵⁰ and opened public consultation on legislating for a right to request remote working.⁵¹ The strategy does not appear to directly address many of the concerns in this chapter, although a number of positive points do stand out:

⁵⁰ See <[Making Remote Work: National Remote Work Strategy - DETE \(enterprise.gov.ie\)](#)> accessed 16 April 2021.

⁵¹ See <[Public Consultation on the introduction of a Right to Request Remote Work - DETE \(enterprise.gov.ie\)](#)> accessed 16 April 2021. There are a number of problems with the legislative model that seems to be in contemplation in this consultation. It appears DETE is planning to legislate around a norm by which established workers would request to work entirely remotely for a definite or indefinite period of time, rather than a more flexible arrangement as proposed by the Observatory. For further information on this, see Alan Eustace and Niamh Egleston, "‘Baby, You’re the Boss at Home’: Giving Employees the Right to Work from Home" (Trinity Covid-19 Observatory blog, 18 January 2021), available at



- 'In the context of Budget 2022, the Department of Finance will review tax arrangements for remote working for employers and employees and assess the merits of further enhancements',⁵²
- The National Broadband Plan will focus on connecting households and rural 'hubs' to enable remote working.⁵³

The consultation closed on 7 May 2021. The authors have made submissions to that process. It is universally recognised that remote working will be a permanent function of the post-pandemic labour market (and third-level education experience), albeit at reduced levels. It is vital that the state make appropriate supports available to all workers, regardless of employment status. Supports need to be tailored to the realities of Irish public infrastructure, alongside robust commitments to improving that infrastructure as a matter of priority.

<<https://tcdlaw.blogspot.com/2021/01/baby-youre-boss-at-home-giving.html>> (links to earlier posts contained therein) accessed 16 April 2021.

⁵² <[Making Remote Work: National Remote Work Strategy - DETE \(enterprise.gov.ie\)](#)> (accessed 16 April 2021) 17.

⁵³ <[Making Remote Work: National Remote Work Strategy - DETE \(enterprise.gov.ie\)](#)> (accessed 16 April 2021) 21.



Chapter VIII: Vaccines

Mark Bell and Andrea Mulligan

Vaccine Prioritisation

Principles of Vaccine Prioritisation

Even before the development of effective COVID-19 vaccinations it was clear that one of the great ethical and policy challenges of the pandemic would be deciding how to go about the distribution of vaccines across the population.¹ Various international ethics bodies have produced guidance on how to approach vaccine distribution. Internationally, the most significant of these is the WHO/SAGE values framework for the allocation and prioritization of COVID-19 vaccination² (the ‘**WHO Framework**’) and the subsequent WHO Guidance on developing a national deployment and vaccination plan for COVID-19 vaccines.³ The European Centre for Disease Prevention and Control produced a document on prioritisation of vaccines in the EU/EEA and UK.⁴ In the US context, the Hastings Center has produced ethical guidance for prioritisation of vaccination in the middle tier⁵ – those who fall into neither the highest nor the lowest priority groups – and the National Academies of Sciences, Engineering and Medicine disseminated a framework for equitable vaccine allocation across all groups in society.⁶ While the latter documents are US-focused, they undoubtedly provide useful insights and analyses that are relevant to the Irish context. Unsurprisingly, there is considerable overlap between the approach taken by those bodies and that of the WHO.

The WHO Framework identifies six core principles that should guide distribution:

- Human well-being;
- Equal respect;
- Global equity;

¹ Nuffield Council on Bioethics, *Rapid Policy Briefing: Fair and equitable access to COVID-19 treatments and vaccines* (29 May 2020).

² WHO SAGE values framework for the allocation and prioritization of COVID-19 vaccination (WHO, 14 September 2020).

³ *Guidance on developing a national deployment and vaccination plan for COVID-19 vaccines* (WHO, Interim Guidance, 16 November 2020).

⁴ ‘Key aspects regarding the introduction and prioritisation of COVID-19 vaccination in the EU/EEA and the UK’ (ECDPC, 26 October 2020).

⁵ Berlinger et al, ‘Ethical Challenges in the Middle Tier of Covid-19 Vaccine Allocation: Guidance for Organizational Decision-Making’ (The Hastings Center, 15 January 2021).

⁶ Gayle et al, *Framework for Equitable Allocation of Covid-19 Vaccine: A Consensus Study Report of the National Academies of Sciences, Engineering and Medicine* (National Academies Press (US) 2 October 2020).



- National equity;
- Reciprocity; and,
- Legitimacy.

Though important, reciprocity is characterised by the WHO as being of narrower scope and more limited importance than the other five principles. The WHO expressly cautions against making vaccine allocation decisions based solely on public health considerations. It acknowledges that the pandemic is more than just a public health issue, and so vaccination – the solution to the pandemic – cannot proceed on narrow public health grounds alone:

...the COVID-19 pandemic is having a devastating impact on many important aspects of social and individual life, and not just public health and the economy. Determining how best to deploy vaccines requires taking into account the various ways in which vaccines can make a difference, and the many different groups whose lives could be improved as a consequence.⁷

Vaccine distribution is, therefore, a complex task, which aims to tackle the effects of the pandemic on social and individual life. Being such a complex task, it is natural that it should provoke much public debate and disagreement. The WHO acknowledges that this process of debate and disagreement is in fact part of the process of equitable vaccine distribution. Using an express values framework to shape vaccine allocation ensures transparency which in turn facilitates debate and allows those that disagree with the approach to prioritization to question the current structure and to ‘press their case for inclusion’.⁸

NIAC

A central actor in vaccine allocation and prioritisation in Ireland is the National Immunisation Advisory Committee (NIAC). NIAC is an independent body separate from the Department of Health and the HSE, which was established within the Royal College of Physicians of Ireland in 1998.⁹ Its role is to provide expert guidance on immunisation to the Chief Medical Officer in the Department of Health. The CMO is not bound to follow that advice. NIAC does not have a statutory basis. Its membership is

⁷ WHO Framework (n 2) 5.

⁸ WHO Framework (n 2) 5.

⁹ <<https://www.hse.ie/eng/health/immunisation/hcpinfo/guidelines/>> accessed 11 June 2021.



drawn from ‘a broad range of medical and healthcare organisations’,¹⁰ the vast majority of whom are medical doctors.¹¹ There are two lay members.

In Chapter 1 this report addressed the decision-making role of NPHEt vis-à-vis government and identified a number of serious problems, especially with regard to accountability. Many parallel problems arise with regard to NIAC. NIAC has an even narrower composition than NPHEt, drawing more heavily on the medical profession. This can, of course, be explained by reference to NIAC’s narrower remit: it looks only at vaccination. However, it is widely acknowledged, including by the WHO, that vaccination rollout is not merely a medical or healthcare decision. It requires consideration of a much broader range of societal factors. There is no indication that NIAC was qualified to consider these, nor that anyone expected it to.

In tracing the relationship between NPHEt and governmental decision-making¹² we observed that there were a number of instances where the government pushed back on or diverged from NPHEt’s advice but that this had not occurred since December 2020, apparently due to the sense that the government had made poor decisions in respect of the Christmas opening up. Since then, the government has appeared to follow NPHEt advice more or less to the letter. NIAC has only become very active in terms of providing advice on COVID-19 vaccination since December 2020, and delivered the bulk of its most influential advice since March 2021. This included its advice as to the use of the AstraZeneca vaccine, which initially recommended the halting of its use and then confined it to those aged 60-69, with significant effects on vaccine rollout.¹³ It appears that the government has followed all advice provided by NIAC. This is somewhat surprising given NIAC’s apparent incompetence to consider factors outside of the narrow medical/health realm. It falls to government to assess all other aspects of vaccine decision-making so it is surprising that those separate factors have not in any instance caused government to reject or diverge from NIAC’s recommended position.

The First Vaccination Prioritisation Phase

In Ireland, vaccine prioritisation can be broken down into two distinct phases, which demonstrate a stark divergence in approach. The initial Provisional Vaccine Allocation Groups were released on 8

¹⁰ <<https://www.hse.ie/eng/health/immunisation/hcpinfo/guidelines/>> accessed 11 June 2021.

¹¹ <<https://www.rcpi.ie/policy-and-advocacy/national-immunisation-advisory-committee/who-we-are/>> accessed 11 June 2021.

¹² Conor Casey, David Kenny, and Andrea Mulligan, ‘Public Health Governance: The Role of NPHEt’, this report, chapter 1.

¹³ NIAC, *Recommendations for the use of COVID-19 Vaccine AstraZeneca* (NIAC, 19 March 2021)



December 2020.¹⁴ NIAC released updated advice on 22 February 2021,¹⁵ but the most significant revision to the Allocation Groups took place on foot of NIAC's advice of 29 March 2021.¹⁶ It is useful therefore to look at vaccination prioritisation in two halves: prior to March 2021 and post-March 2021. The Allocation Groups released on 8 December 2020 consisted of 15 groups, as follows:

1. Adults aged ≥ 65 years who are residents of long-term care facilities
2. Frontline healthcare workers
3. People aged 70 and older
4. Aged 16-69 and at very high risk of severe COVID-19 disease
5. Aged 65-69 whose underlying condition puts them at a high risk of severe disease and death
6. People aged 65-69, other healthcare workers, and key vaccination programme workers
7. Aged 16-64 and at high risk of severe COVID-19 disease
8. Residents of long-term care facilities aged 18-64
9. Aged 18-64 years living working in crowded accommodation where self-isolation and social distancing is difficult to maintain
10. Key workers in essential jobs who cannot avoid a high risk of exposure to COVID-19
11. People essential to education and who face disease exposure
12. Aged 55-64 years
13. People in occupations important to the functioning of society
12. People aged 55-64
13. Other workers in occupations important to the functioning of society
14. Other people aged 18-54
15. People aged under 18 and pregnant women

This original prioritisation was based on a range of factors including age, status as a healthcare worker, life circumstances including socioeconomic position and comparative disadvantage, and occupation. In respect of each group, a Rationale and relevant Ethical Principles were identified. For example, evidencing a concern for life circumstances and social disadvantage, the rationale provide for Group 9, was 'Disadvantaged sociodemographic groups more likely to experience a higher burden of

¹⁴ <<https://www.gov.ie/en/publication/39038-provisional-vaccine-allocation-groups/>>. This website is regularly updated. The page as created on 8 December 2020 can be found here: <<https://web.archive.org/web/20201208201922/https://www.gov.ie/en/publication/39038-provisional-vaccine-allocation-groups/>> (links accessed 11 June 2021).

¹⁵ NIAC, 'Updated Recommendations: Priority Groups for Covid-19 Vaccination' (NIAC, 22 February 2021).

¹⁶ *ibid.*



infection'. The supporting ethical principles were moral equality, minimising harm and fairness, alongside the explanatory comment that 'Prioritising this group recognises that structural inequalities make some people more vulnerable than others to COVID-19'. Group 10 addressed both the essential nature of the occupation and the vulnerability of the people concerned and was justified by the rationale 'High risk of exposure as unable to work without physical distancing'. Group 11 – those essential to education - was also occupation focused and justified by reference to the rationale 'To maintain the opening of full-time education of all children who have been disproportionately impacted from the pandemic' and underpinned by the ethical principle of minimising harm, and also the ethical principle of reciprocity in view of the additional risk borne by those involved in education.

The Allocation Groups were accompanied on their original publication by a Department of Health document entitled *Allocation Framework for Equitable Access to COVID-19 Vaccine(s)* (the "**Vaccines Framework**").¹⁷ This impressive document set out the core ethical principles that underpinned the original approach to vaccine prioritisation. These were:

- Moral equality of all persons;
- Minimisation of harm;
- Fairness, and
- Reciprocity.

The Framework also pointed to the importance of the procedural values of: transparency, inclusiveness, responsiveness, reasonableness and accountability. In doing so, it built on the *Ethical Framework for Decision Making in a Pandemic*, published by the Department of Health in the early phase of the pandemic.¹⁸ The Vaccines Framework was firmly situated in the international ethics literature and ethics guidance of expert bodies disseminated prior to and during the course of the COVID-19 pandemic. It also expressly sought to promote and adhere to human rights law and standards.¹⁹ The Vaccines Framework self-described as a 'multi-value ethical framework where principles are combined and balanced'.²⁰ Like many such ethical frameworks, it presented a set of

¹⁷ Department of Health, *Allocation Framework for Equitable Access to COVID-19 Vaccines* (undated), available at <<https://assets.gov.ie/110691/6fbfb97e-a18e-44b6-8087-27486e922752.pdf>> accessed 11 June 2021.

¹⁸ This document was produced by the Pandemic Ethics Advisory Group, a subgroup of NPHET, which existed during the first phase of the pandemic. Dept of Health Ethical Framework for Decision Making in a Pandemic, available at <<https://www.gov.ie/en/publication/dbf3fb-ethical-framework-for-decision-making-in-a-pandemic/>> accessed 11 June 2021. This group was disbanded, see also, Casey, Kenny and Mulligan (n 10) 12.

¹⁹ Vaccines Framework (n 17) 4.

²⁰ Vaccines Framework (n 17) 4.



principles that must be applied to a given circumstance by a decision-maker, with a full appreciation of the context of the application.²¹ A clear description of each principle is provided, with some notes about how it may play out in the vaccine priority context. Minimising harm is described as encompassing COVID-related mortality and morbidity, but also encompassing concern for the other kinds of harm suffered as a result of the pandemic, including psychological, economic and social harm. It is expressly noted that the principle may justify prioritising vaccinations for groups with an elevated risk of disease such as those in direct provision centres and prisons, as well as those necessary to provide essential services such as Gardaí and teachers.²² Following the lead of the WHO/SAGE, the Vaccines Framework described reciprocity as more marginal than the other three principles, but emphasised its importance in requiring that special consideration be given to those groups that play an essential role in responding to the pandemic, and acknowledging its link to fairness and solidarity in that it recognises the assumption of greater risks by certain persons in order to protect the general population.

About a month prior to release of the original Allocation Groups, NIAC released a document entitled 'Interim Recommendations Priority groups for SARS-CoV-2 vaccine'²³. It described the aims of the COVID-19 vaccination programme as being to maximise benefits and to minimise disruption to society, and stated that its approach was based on equity, justice, fairness and transparency.²⁴ While differing somewhat in emphasis, this document does not seem wildly out of step with the Vaccine Framework, especially as the approach to phases and groups for prioritisation was broadly similar, and broadly in line also with the priority groups announced on 8 December 2020. The precise relationship between NIAC and the Vaccine Framework – if any existed at all – is not clear.

When the 15 original Allocation Groups were ultimately released on 8 December 2020, it was clear that they had been carefully crafted by reference to the best available ethical literature and guidance, as well as by reference to public health logistics and purely medical concerns. The approach taken to vaccination was a rich one that attempted to take into account a range of factors. Age was at all times known to be a central risk factor and has been central to all iterations of the Allocation Groups, but the original approach supplemented this with concern for a broad range of other factors including social disadvantage and inequality, status as an essential worker, and occupational risk. The

²¹ This approach is most notably found in the 'principlism' approach to ethical decision-making used in medical ethics and bioethics. Beauchamp and Childress, *Principles of Biomedical Ethics* (7th ed, OUP 2013)

²² Vaccines Framework (n 17) 7.

²³ NIAC, 'Interim Recommendations Priority groups for SARS-CoV-2 vaccine' (2 November 2020).

²⁴ *ibid* 2.



complexity and richness of this approach required that the rationale and ethical principles justifying each group were set out clearly, as done very effectively in the early versions of the Allocation Groups.

The Second Vaccination Prioritisation Phase

From December 2020 it was widely understood that this was the approach to vaccination prioritisation that was to be adopted. January 2021 saw a frightening surge in the number of cases, and Ireland entered what was to be more than a four-month Level 5 lockdown. During that time, schools were necessarily closed and much attention was devoted to the question of how they could be safely opened again. Meanwhile, the vaccination programme commenced, starting with healthcare workers and those in the highest age brackets. At the end of March a dramatic revision to the Allocation Groups was announced by Health Minister Stephen Donnelly.²⁵ The 15 original groups were replaced with 9 Allocation Groups, as follows:

1. Adults aged ≥ 65 years who are residents of long-term care facilities
2. Frontline healthcare workers
3. People aged 70 and older
4. People aged 16-69 with a medical condition that puts them at very high risk of severe disease and death
5. People aged 65-69 whose underlying condition puts them at a high risk of severe disease and death
6. Other people aged 65-69 and key workers essential to the vaccine programme
7. People aged 16-64 who have an underlying condition that puts them at high risk of severe disease and death
8. Residents of long-term care facilities aged 16-64
9. People aged 64 years and younger, and people aged 16-64 living or working in crowded settings (in parallel)

The shift in policy was based on NIAC advice that the vaccine programme should shift to an age-based model. While NIAC acknowledged there may be an increased risk for certain ethnic groups or certain occupations, it stated that the single highest risk factor was age, and that other risks should lead to

²⁵ Press Release, 'Minister Donnelly announces update to Ireland's Vaccination Prioritisation List' (30 March 2021). Available at <https://www.gov.ie/en/press-release/93f8f-minister-donnelly-announces-update-to-irelands-vaccination-prioritisation-list/> accessed 11 June 2021.



prioritisation only within age brackets. It concluded that going forward ‘An operationally simple, age-based programme for those aged 16-64 in descending order is the most equitable and efficient way of continuing the vaccination rollout.’²⁶ While the NIAC document retains a reference to ‘moral equality of the person, minimising harm, fairness, and reciprocity’ as being part of the Vaccination Programme Aims, these are conspicuously less prominent than similar values in its November document.

Reflecting NIAC’s change in approach, a shift away from an express ethics foundation can also be found in other aspects of the current vaccinations policy. While each of the original 9 groups originally had an accompanying rationale and ethical principle, there is now only one reference to ethical principles, and the rationales are based purely on risks of hospitalisation and death. Notably, the Vaccine Framework has been removed from the Vaccine Allocation Website,²⁷ and not replaced with any comparable document. Nor is there any way to access the original Allocation Groups – and their accompanying information – other than through using the Internet Archive.²⁸ While the NIAC’s March guidance is readily available, this sparse document contains no reference to the Vaccine Framework, nor does it make any attempt to fully explain the radical shift in policy it advocates. It is comprised largely of statistics concerning the age-related risk posed by COVID-19. It contains no data on risks to essential workers such as Gardai or teachers. It makes no reference to risks posed by carceral settings such as prison or direct provision. While paying lip service to a richer ethical approach that promotes “moral equality of the person, minimising harm, fairness, and reciprocity” there is very little evidence in the document of any application of these principles and no explanation of how their application could look so very different in March 2021, as compared to November/December 2020.

From the very outset of the pandemic it was clear that age was perhaps the most significant risk factor. In its March advice NIAC only advocated one departure from the age-based rule and that was with regard to the prioritization of members of the traveler, Roma and homeless communities, whom it acknowledged were at higher risk of infection, hospitalization and/or death.²⁹ Finally, a strange feature of the NIAC March guidance is that it favours an age-based approach in part because it is operationally simple, and yet the document contains no operational analysis whatsoever. Indeed, the narrow composition of NIAC may mean that it would never have been capable of carrying out an

²⁶ NIAC, ‘Updated Recommendations: Priority Groups for Covid-19 Vaccination’ (NIAC 29 March 2021) 1.

²⁷ It can still be found elsewhere on the government webpages, apparently in an archive: <<https://assets.gov.ie/110691/6fbfb97e-a18e-44b6-8087-27486e922752.pdf>> accessed 11 June 2021.

²⁸ <<https://archive.org/>> accessed 11 June 2021.

²⁹ NIAC (n 26) 8.



operational analysis. Even if this radical shift in policy can be justified, there is no doubt that there was a failure by Government and by NIAC to justify it. While it was transparently acknowledged by all concerned that the policy had changed significantly, no explanation was ever provided as to how the ethical considerations that had weighed so heavily in the original allocation were deemed virtually irrelevant in the March revision.

Occupational Risk

The change in the vaccination policy provoked much public comment, most notably in respect of the decision to no longer prioritise vaccination based on occupational risk. Criticism was loudest from teachers and from Gardaí, arguably because both groups are highly organized and exert significant political and social influence.³⁰ Other, less well-organised groups such as those in essential retail and public transport, were presumably also dismayed at the news. It is important to recognise that the change in policy away from giving some priority based on occupation was a break with both the ethical framework previously espoused by the Government, and with an approach that is well established in the international literature and guidance. Guidance from the WHO/SAGE, the Hastings Center and the ECDPC all contemplate the prioritization of groups based on occupational risk. Importantly, the definition of such workers is not confined to those with comparatively high social status such as teachers and Gardaí but also extends to people that work in essential food supply.³¹ The authors of the Hastings Center guidance specifically caution against the risk of prioritization of groups with greater political power. The reason for prioritising essential workers is partially based on harm minimisation or human wellbeing rationales, because the health of such persons are essential to continued efforts in fighting the pandemic. However, vaccination based on occupational risk is also justified by reference to the principle of reciprocity. Many essential workers outside the healthcare professions had to go to work during the phases of the pandemic when the risk was greatest, when anyone who could work from home was very grateful to do so. The prioritisation of essential workers in vaccine allocation is in part a gesture of recognition of that risk. As the WHO observes in its guidance, reciprocity is in this way similar to but broader than the moral emotion of gratitude.³² The

³⁰ See eg Ciara O'Loughlin, 'Garda body says new vaccine priority system shows "shocking disregard for frontline workers"' *The Irish Independent* (31 March 2021) available at <<https://www.independent.ie/irish-news/health/garda-body-says-new-vaccine-priority-system-shows-shocking-disregard-for-frontline-workers-40260104.html>>; O'Brien et al, 'Taoiseach signals Government will not change vaccine priority for teachers' (*The Irish Times*, 7 April 2021) available at <<https://www.irishtimes.com/news/education/taoiseach-signals-government-will-not-change-vaccine-priority-for-teachers-1.4530922>> (links accessed 11 June 2021).

³¹ See examples of essential work in Berlinger et al (n 5), *Ethical Challenges in the Middle Tier of Covid-19 Vaccine Allocation: Guidance for Organizational Decision-Making* (The Hastings Center, 15 January 2021) 9.

³² WHO Framework (n 2) 8.



Government's decision not to vaccinate essential workers is a decision to break with the principle of reciprocity and to choose not to express that gratitude. In the Irish context, particular questions have to be asked about the fact that the Government initially stated that essential workers would be prioritised – via the original Allocation Groups – and subsequently changed the policy. It did so after a period of months when essential workers remained at work – or in the case of teachers, worked hard to get schools back to work – under conditions that were extremely dangerous. The fact that there was such a promise, that was subsequently reneged upon, has to make this an especially problematic disregard of the principle of reciprocity.

Vulnerable Populations

The other major point of criticism of the revised vaccination policy concerns the approach to vulnerable or disadvantaged groups in society. NIAC recommended that members of the travelling, Roma and homeless communities be prioritized, and this was apparently supported by Government. This is to be welcomed. However, questions remain as to where these communities fit in the Allocation Groups. No mention is made of any of these communities in the 9 Allocation Groups. It is possible that vaccination of these groups is being prioritized nonetheless, but there is a serious dearth of transparency in relation to this. NIAC did not recommend prioritization of vaccination for people in prisons or in direct provision, in an express departure from the Vaccines Framework. It appears that these groups will now be vaccinated by age, though again, it is very difficult to access any information about how exactly these groups will be vaccinated. It is possible that such settings will be covered by Group 9 – 'People aged 64 years and younger, and people aged 16-64 living or working in crowded settings' but this is not clear, nor is it obvious that Group 9 would allow for people in such settings to be vaccinated any faster than the general population. Some of the international guidance is silent on the prioritisation of persons in carceral settings. However, guidance from the US – which has a very substantial prison and immigration detention population – is strong on this point. Guidance from the Hastings Center emphasizes the special duties of the state to persons who live in carceral or immigration detention settings because those persons have little or no ability to protect themselves from infection, and flags the risk that such populations will be overlooked in vaccine prioritization due to stigma.³³ Equally, the National Academies' guidance recommends prioritizing these populations on the basis that they would have little or no opportunity to follow public health measures such as social

³³ Berlinger et al (n 5) 8.



distancing.³⁴ The failure of the vaccination policy to give adequate consideration to the position of these groups is to be regretted.

Legitimacy

As with all aspects of pandemic decision-making, legitimacy is essential to vaccine allocation. In identifying legitimacy as a core principle, the WHO/Sage comment that:

What is required for decision-making bodies to be legitimate in the context of COVID-19 vaccine decision-making includes, but is not limited to: transparency in decision processes, outcomes, and reasoning; reliance on best available evidence; articulation and incorporation of shared social values in the decision process and outcome; and appropriate representation, influence and input by affected parties, with no tolerance for personal, financial or political conflict of interest or corruption.

In some regards this has been done well in the Irish context. NIAC provides a reasonably high degree of transparency in publishing all advice provided to the CMO. However, as discussed above, that advice has on occasion been inadequately reasoned. Because the advice is often followed without question by Government, it plays no role in plugging the explanation gap. For example, when it decided to accept NIAC's radical recommendation for change to vaccination prioritisation the Government should have stepped in and explained why such a change was ethically justified, when NIAC failed to do so. Similarly, it was up to the Government to explain precisely what its operational analysis was, which was also absent from the NIAC document.

Just as in pandemic governance more broadly, vaccination allocation has seen failures in public engagement and dialogue.³⁵ As the WHO/SAGE comment, disagreement about vaccine allocation is almost inevitable and people who are unhappy with allocation decisions need to be able to question them. The National Academies characterise this process of engagement as central to the principle of fairness, which they say requires input from affected groups into the decision-making process.³⁶ Ideally, they say, people should have the right to appeal a decision that affects them. The Irish process has been seriously lacking in this regard, providing no mechanism whatsoever – aside from the media

³⁴ Gayle et al (n 6).

³⁵ Casey, Kenny and Mulligan (n 10) 27-28.

³⁶ Gayle et al (n 6) 97-98.



– through which to engage in meaningful consultation with the general public. The absence of any process is evident in NIAC’s description of its prioritisation review methodology. No reference is made to a structured consultation procedure of any kind, and it comments: ‘a number of unsolicited submissions from clinical and advocacy groups, Oireachtas members and individuals were considered.’³⁷ While the consideration of such comments is presumably to be welcomed, it is quite clear that none were ‘solicited’.

Finally, a great challenge faced by the vaccination programme was that of corruption. Unsurprisingly, the WHO/SAGE caution that to ensure legitimacy vaccination programmes must show ‘no tolerance for personal, financial or political conflict of interest or corruption’. Two scandals in particular seriously undermined confidence in the Irish vaccination programme. One of these concerned the distribution by the Master of the Coombe maternity hospital of surplus vaccinations to family members of hospital staff. This led to an independent review being carried out by senior counsel Brian Kennedy.³⁸ The second episode entailed the Beacon Hospital providing surplus vaccines to a group of teachers from a fee-paying secondary school in a different county. This too led to an independent review, which is ongoing.³⁹ In both instances there were persons to whom the vaccinations could more legitimately have been given: medical and midwifery students in the case of the Coombe, and its own vulnerable patients, in the case of the Beacon Hospital. Both episodes caused significant public outcry. They demonstrated a vulnerability in the system in two senses. First, in that delivery of vaccinations depends to a great extent on the honour and reliability of those involved, and there was perhaps a lack of safeguards to prevent against these kind of misappropriations. Second, the Government seemed at a loss as to whether and how to respond and appropriately sanction those involved. The response in the case of the Beacon was to suspend the delivery of vaccinations.⁴⁰ This seems less than optimal, in the context of a vaccination programme that surely requires as many hands on deck as possible. It is not clear that any sanction was imposed on the Coombe, which would in any event probably not have been delivering vaccinations once vaccination of its own staff was complete.

³⁷ NIAC (n 27) 4.

³⁸ <<https://www.coombe.ie/our-news/independent-review>>. Full text of the report of the independent review available at: <<https://static1.squarespace.com/static/5df2275ab592b63d2d87fd51/t/6065d947f26878485b9b9f59/1617287521841/Independent+Review>> (links accessed 11 June 2021).

³⁹ Dwyer, ‘Beacon Hospital “unreservedly apologises” after vaccine controversy, orders independent review’ (thejournal.ie, 29 March 2021) available at <<https://www.thejournal.ie/beacon-hospital-order-independent-review-following-vaccine-controversy-5395308-Mar2021/>> accessed 11 June 2021.

⁴⁰ Hurley, ‘Donnelly asks HSE to suspend Beacon Covid vaccine programme’ (RTE News, 27 March 2021) available at <<https://www.rte.ie/news/2021/0327/1206526-beacon-hospital-vaccine/>> accessed 11 June 2021.



Mandatory Vaccination

The COVID-19 pandemic has raised the question of whether mandatory vaccination would be permissible in Ireland. While vaccine refusal or vaccine hesitancy has not been widely studied in Ireland, it is believed that rates are low. This seems to remain the case in relation to attitudes to COVID-19 vaccines, albeit hesitancy rates may be higher in relation to the AstraZeneca vaccine and among women under 30.⁴¹ Depending on how the vaccination programme progresses and how hesitancy rates evolve, there may be a point at which mandatory vaccination may need to be considered and for that reason, we consider it in this chapter. We stress, however, that this is not currently a pressing matter of public policy.

The Right to Refuse Treatment

The issue of mandatory vaccination is primarily a question of constitutional law. Were mandatory vaccination to be rolled out, it would almost certainly be done via legislation and the question that would arise is whether such legislation would be constitutional. There is no doubt that the Constitution protects the right of a competent adult to refuse a vaccination, as an element of the right to refuse treatment. This right is robustly protected by the Constitution, and extends to the right to refuse life-saving treatment.⁴² However, even in the foundational case on that right, the Supreme Court acknowledged that it may be qualified in the context of infectious diseases. In *Re a Ward of Court*⁴³ the Supreme Court considered the question of withdrawal of treatment from a person who lacked capacity to consent. Denham J provided one of the leading formulations of the right to refuse treatment in Irish law:

Medical treatment may not be given to an adult person of full capacity without his or her consent. There are a few rare exceptions to this e.g., **in regard to contagious diseases** or in a medical emergency where the patient is unable to communicate. This right arises out of civil, criminal and constitutional law. If medical treatment is given without consent it may be trespass against the person

⁴¹ Clarke, 'Vaccine refusal rates are 'tiny' in Ireland but AstraZeneca pause caused anxiety' (*Irish Examiner*, 19 March 2021) available at <<https://www.irishexaminer.com/news/arid-40247276.html>>; Hutton, 'One in five women under 30 uncertain about getting Covid-19 vaccine' (*The Irish Times*, 3 May 2021) available at <<https://www.irishtimes.com/news/health/one-in-five-women-under-30-uncertain-about-getting-covid-19-vaccine-1.4553762>> (links accessed 11 June 2021).

⁴² *Re a Ward of Court (Withholding of Medical Treatment)* [1996] 2 IR 79; *Fitzpatrick v FK (No 2)* [2008] IEHC 104, [2009] 2 IR 7; *Governor of X Prison v McD* [2015] IEHC 259.

⁴³ *Re a Ward of Court (Withholding of Medical Treatment)* [1996] 2 IR 79.



in civil law, a battery in criminal law, and a breach of the individual's constitutional rights.⁴⁴ (Emphasis added)

The courts have expressly acknowledged, therefore, that the right to refuse treatment may legitimately be limited for the purposes of halting the spread of an infectious disease. Admittedly, the passage above appears to be directed to treatment rather than to vaccination but there is no reason why they should be treated differently. Indeed, mandatory vaccination would in many cases be less invasive than mandatory treatment, which would likely involve physical restraint for a longer period.

Mandatory vaccination may also engage the right to bodily integrity.⁴⁵ However, this right has been characterised as one which protects persons from risks or threats to health, rather than as a right which affords a person a general right of non-interference with one's body.⁴⁶ As such, for this right to be engaged in the context of mandatory vaccination, the rights-holder would have to demonstrate a risk to health arising from the vaccine, rather than merely a general objection to it.

The Health Act 1947 and Infectious Diseases Regulations 1981

An important part of the constitutional picture is the legislative scheme that is in place to govern restrictions of liberty in the context of infectious diseases. Part IV of the Health Act 1947 governs Infectious Diseases and Infestations and established wide-ranging powers to address these public health threats. Section 38 provides for the detention and isolation of persons who are a probable source of infection. Non-compliance with orders made under this section is a criminal offence.⁴⁷ The constitutionality of Section 38 was challenged in the context of a *habeas corpus* application in *S(VT) v HSE*.⁴⁸ Because Section 38 addresses mandatory detention, rather than mandatory treatment or vaccination, the focus of the Court was on whether the provision constituted an unjustified interference with the right to liberty, rather than on the right to refuse treatment. The court concluded that the applicant had failed to prove that the section was unconstitutional. Edwards J concluded:

⁴⁴ *Re a Ward of Court (Withholding of Medical Treatment)* [1996] 2 IR 79 at 156.

⁴⁵ *Ryan v AG* [1965] IR 294.

⁴⁶ *State (C) v Frawley* [1976] 1 IR 365, *State (Richardson) v Governor of Mountjoy Prison* [1980] ILRM 82.

⁴⁷ Section 38, Health Act 1947, sections 38(4), (5).

⁴⁸ *S (VT) v HSE* [2009] IEHC 106. Note that as a matter of procedure, the High Court's view was that if it found that the law under which the applicant was detained was unconstitutional, it would have been obliged to refer the matter to the Supreme Court by way of case stated (§233).



The power created by section 38 supports an important public interest objective, namely, it assists in safeguarding against the spread of particular infectious diseases amongst the general population by facilitating, where necessary, the compulsory effective isolation of a person who is suffering from such a disease. I am satisfied that the provision is therefore benign, and that it is of an essentially paternal character.⁴⁹

While the judgment is not especially detailed and is unusual in not framing the matter as one concerning proportionality, its comments may be of interest in illuminating potential judicial attitudes to other measures aimed at protecting public health in the context of infectious diseases. Given the dearth of case law in the area, the case would almost certainly be relied upon by the State in defending any challenge to a mandatory vaccination regime. In this regard it is interesting to note the Court's apparent characterisation of the 'paternal' nature of the legislation as a positive aspect.

The Health Act 1947 has been substantially amended since the onset of the COVID-19 pandemic, including through the addition of a further section on detention and isolation,⁵⁰ and measures regarding mandatory quarantine for travellers. The most important regulations made pursuant to the Health Act 1947 are the Infectious Disease Regulations 1981, as amended. These regulations confer wide-ranging powers on health officers or medical officers of health, including to 'make such enquiries and take such steps as are necessary or desirable for investigating the nature and source of such infection, for preventing the spread of such infection and for removing conditions favourable to such infection.'⁵¹ The constitutionality of these regulations has never been considered by the Courts.

Proportionality Analysis and Mandatory Vaccination

If the legislature was to enact a law imposing mandatory vaccination, its impact on the right to refuse treatment, or the right to bodily integrity if engaged, would likely be subject to proportionality analysis. Proportionality is acknowledged as the dominant constitutional test where a legislative measure restricts a constitutional right.⁵² It requires that the measure that restricts the constitutional right:

⁴⁹ *S (VT) v HSE* [2009] IEHC 106, §350.

⁵⁰ Section 38A.

⁵¹ Infectious Diseases Regulations 1981 (SI no 390/1981), Regulation 11.

⁵² This contrasts with the scenario where a legislative measure balances two constitutional rights, where the rationality test applies: *Tuohy v Courtney* [1994] 3 IR 1. See generally: Gerard Hogan et al, *Kelly: The Irish Constitution* (5th edn, Bloomsbury Professional 2018) §7.1.42 ff.



- (a) be rationally connected to the objective and not be arbitrary, unfair or based on irrational considerations;
- (b) impair the right as little as possible, and
- (c) be such that their effects on rights are proportional to the objective.⁵³

In the context of COVID-19, the proportionality framework would likely mean that a mandatory vaccination would only be constitutional if certain circumstances and conditions were fulfilled before the legislation was introduced, and if the legislation could be demonstrated to exhibit certain safeguards. The proportionality test affords a significant degree of discretion to the courts, and the Irish courts have often applied it inconsistently,⁵⁴ so it is not positive to be definitive about how it would operate in this context. However, a couple of matters seem clear:

- The State would be required to pursue a comprehensive regime of voluntary vaccination before progressing to mandatory vaccination. If it did not do so, the regime could be criticised for being based on irrational considerations, for impairing rights too much, and for failing to properly identify the objective. If there is no evidence that a mandatory system is necessary – and this could only really be ascertained by reviewing vaccine refusal rates in a voluntary system – then the measure would be unlikely to satisfy the proportionality test.
- The State would need to demonstrate a risk to the population arising from vaccine refusal. This would likely need to be based on analysis that showed that herd immunity could not be achieved without a mandatory scheme. If herd immunity could be achieved without mandatory vaccination, then the scheme would not impair the right as little as possible, nor would the effect be proportional to the objective.
- The State might also be required to demonstrate that the risk posed by those refusing a vaccine could not be mitigated by any other strategy, such as by requiring them to adhere to social distancing and mask-wearing measures indefinitely.
- If those refusing a vaccine are willing to take a different vaccine, the State may be required to offer a choice of vaccines.

⁵³ *Heaney v Ireland* [1994] 3 IR 593 at 607.

⁵⁴ See discussion above in *Kelly: The Irish Constitution* (n 52).



Central to all aspects of the proportionality analysis would be the fact that the context for the intervention is a global pandemic on a scale the Irish State has never encountered previously. This means that the objective being pursued is one of unparalleled importance, which in turn affects the operation of the proportionality test.

In summary, it seems that if a serious problem emerges in respect of vaccine refusal in Ireland in the course of the rollout of the vaccination programme, the State would likely be entitled to roll out a programme of mandatory vaccination, subject to the conditions flagged above.

Quasi-Mandatory Vaccination: Denial of Access to Services Based on Vaccination Status

In the next section we consider the permissibility of vaccine requirements in the context of employment. A slightly different situation concerns the imposition of vaccination requirements in respect of access to State services such as education. An example of this has already arisen in the healthcare context whereby the HSE has prohibited nursing and healthcare students from taking up unpaid educational placements in hospital if they refuse vaccination.⁵⁵ While noting that such rules are likely to be imposed by administrative decision-makers rather than by legislation, it would appear that they would fall to be assessed via a broadly similar proportionality analysis.⁵⁶ A crucial difference between vaccination requirements and mandatory vaccination is - very simply – that the person is not subjected to a compulsory medical intervention. Rather, he or she retains the right not to be vaccinated, but faces the reality that this limits his or her autonomy in other aspects of life. As the interference with a right is less, it is commensurately easier to justify that interference. For example, it may not be necessary to wait for a full or close-to-full rollout of the vaccination programme to see whether a significant number of people will refuse vaccinations before imposing vaccination requirements of this kind, nor would it be necessary to be fully informed of the likely effect on herd immunity. It would likely be sufficient to assess that unvaccinated persons in certain contexts – such as schools or hospitals - would pose a public health threat to others. The principle of proportionality

⁵⁵ Murray, 'Nursing students who refuse Covid-19 vaccine banned from taking up clinical placements with HSE' (*The Irish Independent*, 31 March 2021) available at <<https://www.independent.ie/news/nursing-students-who-refuse-covid-19-vaccine-banned-from-taking-up-clinical-placements-with-hse-40262779.html>> accessed 11 June 2021.

⁵⁶ *Meadows v Minister for Justice, Equality and Law Reform* [2010] 2 I.R. 701. See generally on constitutional rights in administrative decision-making: Gerard Hogan, David Gwynn Morgan and Paul Daly, *Administrative Law in Ireland* (5th ed, Round Hall 2019) §17-153 ff.



might, however, require the rules to be reviewed in due course as more people are vaccinated, herd immunity is gradually achieved, and the risk posed by the unvaccinated is reduced.⁵⁷

Vaccines Requirements and Employment

As the roll-out of vaccines becomes more widespread, there is a growing debate on whether, and to what extent, employers may impose requirements on their employees to be vaccinated against Covid-19. In the media, this has been given the shorthand of ‘no jab, no job’ policies,⁵⁸ but it could also relate to other measures that an employer might consider, such as only permitting those who are fully vaccinated to cease working from home and to return to the office. In response, commentary has identified a range of legal issues that may constrain employers from introducing such measures.⁵⁹ These include:

- compliance with constitutional rights,⁶⁰ such as the right to bodily integrity, and fundamental human rights, such as privacy or freedom of conscience;⁶¹
- in respect of existing employees, the ability of an employer to impose unilaterally a new contractual requirement to be vaccinated;
- the obligations of data protection law in respect of gathering and storing information on whether employees have received the vaccine;
- the extent to which occupational health and safety legislation provides a basis for an employer imposing such a duty;

⁵⁷ In the context of exclusion from schools it should be noted that other rights may be engaged such as the right to free primary education under Article 42.4. Where children are concerned, the question of State intervention in familial decision-making may also be relevant (Article 42A).

⁵⁸ eg BBC, ‘Coronavirus: “No jab, no job” policies may be legal for new staff’ (2021): <<https://www.bbc.com/news/business-56113366>> accessed 11 June 2021.

⁵⁹ Andrew Noble, ‘No jab, no job: why your employer can’t sack you for not taking the COVID vaccine in UK’ (2021): <<https://theconversation.com/no-jab-no-job-why-your-employer-cant-sack-you-for-not-taking-the-covid-vaccine-in-uk-154403>>; Marcello Floris, ‘Vaccinating Europe: balancing employer and worker rights’ (2021): <<https://www.internationalemploymentlawyer.com/news/vaccinating-europe-balancing-employer-and-worker-rights>> accessed 11 June 2021.

⁶⁰ Conor O’Mahony, ‘Could the State introduce compulsory vaccination laws?’ (2020): <<https://www.rte.ie/brainstorm/2019/0423/1045277-could-the-state-introduce-compulsory-vaccination-laws/>> accessed 11 June 2021.

⁶¹ In the recent case of *Vavříčka and others v Czech Republic* (Applications nos. 47621/13, 3867/14, 73094/14, 19298/15, 19306/15 and 43883/15), the Grand Chamber of the European Court of Human Rights held that the applicant’s critical opinion of vaccination lacked ‘sufficient cogency, seriousness, cohesion and importance’ to engage the freedom of thought or conscience protected by Art 9 of the European Convention of Human Rights (para 335). This was, however, in a context where the applicant had initially objected to the vaccination of his children on health grounds and it was only later in legal proceedings that he raised concerns based on philosophical convictions (para 29).



- the lawfulness of any penalties imposed upon on employees who refuse to get vaccinated, or who decline to disclose this information to their employer, including the ultimate sanction of dismissal;
- the risk that a vaccine requirement for current or future employees breaches anti-discrimination legislation.

This section will focus on the last issue: compliance with anti-discrimination law. Looking at this more closely indicates that the legality of imposing a vaccine requirement upon employees is likely to depend on the specific context of the role being performed. This will also be a relevant consideration for some of the other legal questions listed above.

Protected Grounds in Anti-Discrimination Law

In media discussion of vaccine requirements, it is not unusual to hear the assertion that such measures are discriminatory against those who do not wish to be vaccinated. In the legal context, 'discrimination' has a specific meaning and it is necessary to determine whether treating someone differently because of their refusal to get vaccinated falls within the forms of discrimination prohibited by law. A starting point is to identify which of the protected characteristics found within anti-discrimination law may be engaged by a vaccine obligation. In Ireland, the Employment Equality Acts (EEA) 1998-2015 prohibit discrimination on nine grounds: gender, civil status, family status, sexual orientation, religion, age, disability, race, Traveller community. Being treated differently because of a personal objection to any or certain vaccines is not a protected ground. Notably, section 6(2)(e) EEA defines the religion ground as 'religious belief', or not having such a belief. A deep-seated objection to vaccines, which is not rooted in any religious belief, will not fall within the category of beliefs protected by the EEA.

Prohibited Discrimination

The EEA prohibits several forms of discrimination. Direct discrimination entails treating a person less favourably than another person is, has been or would be treated in a comparable situation on any of the protected grounds.⁶² If a workplace vaccination policy applies to all employees, or all employees performing a particular type of work, then it is unlikely to constitute direct discrimination. It should

⁶² s6(1) EEA.



be noted that section 6(2A) EEA prohibits less favourable treatment 'related to' pregnancy. Currently, there are restrictions on when Covid vaccines may be taken during pregnancy; the HSE recommends that vaccination occurs after 14 weeks of pregnancy and before the end of 33 weeks.⁶³ If an employee is temporarily unable to comply with a vaccine requirement for a reason related to pregnancy, then it would very likely constitute unlawful discrimination if she was treated less favourably as a result.

Although direct discrimination is unlikely to arise, there are circumstances where a vaccine obligation is potentially in breach of the prohibition of indirect discrimination. This exists where an apparently neutral provision puts persons with a particular characteristic (*eg* religious belief) at a particular disadvantage, unless the provision is objectively justified by a legitimate aim and the means of achieving that aim are appropriate and necessary (s22 and s31 EEA).

Obviously, at the present time, vaccines are not generally available to the working age population and they are being primarily distributed by age categories. There will be a transitional period when, for example, persons over 55 have access to the vaccine, but those in younger age cohorts generally do not. Clearly, at that point in time, to advertise a job as only open to those who have already been vaccinated would place persons under the age of 55 at a particular disadvantage. That situation is, however, temporary, so it is more important to focus on what happens when we have reached the point where any employee could have had the vaccine if they chose to do so.

The first scenario to consider is those employees who have not received the vaccine due to medical advice. Currently, persons who have had a severe allergic reaction to any of the ingredients in the vaccine are advised not to get a Covid vaccine.⁶⁴ It is possible that a person falling into this category will satisfy the definition of disability within s2(1) EEA, so a vaccine obligation could be indirectly discriminatory on grounds of disability unless the employer can justify this requirement. In addition, there is a duty on employers to provide reasonable accommodation for persons with disabilities (s16 EEA). An employer would have to explore whether appropriate measures could be taken in this situation to allow the person to continue in employment, such as working from home.⁶⁵ In relation to disability discrimination, it is important also to note that the definition of disability extends to persons with psychosocial impairments, such as anxiety disorders or phobias. There may be situations where

⁶³ HSE, 'Covid-19 Vaccines and Pregnancy' (2021): <<https://www2.hse.ie/screening-and-vaccinations/covid-19-vaccine/getting-your-vaccine/pregnancy.html>> accessed 11 June 2021.

⁶⁴ HSE, 'Getting Your Covid-19 Vaccine' (2021): <<https://www2.hse.ie/screening-and-vaccinations/covid-19-vaccine/getting-your-vaccine/getting-your-vaccine.html>> accessed 11 June 2021.

⁶⁵ See further, Niamh Egleston and Alan Eustace, "'Baby, You're the Boss at Home": Giving Employees the Right to Work from Home - Part III' (18 January 2021) <<https://tcdlaw.blogspot.com/2021/01/baby-youre-boss-at-home-giving.html>> accessed 11 June 2021.



a person's reason for not getting vaccinated is related to a psychosocial impairment, which may trigger the application of the disability provisions of the EEA.

Another scenario that may arise relates to employees who decline to get vaccinated due to their religious beliefs.⁶⁶ Many faith communities are supportive of the vaccination programme, so it appears that it will be less common for individuals to refuse vaccination on religious grounds (at least in Ireland). Nevertheless, it is reasonable to anticipate that there may be individuals who explain their objection to vaccination on the basis of religious belief. For example, in the USA, some have expressed religious objections to the Johnson and Johnson vaccine.⁶⁷ With respect to establishing indirect discrimination, individuals whose religious practices are less common may find it difficult to demonstrate that that a group of persons, sharing their characteristic, is placed at a particular disadvantage. If particular disadvantage to persons sharing a particular religious belief can be established, then it remains open to the employer to seek to justify the requirement.

Justifying a duty to vaccinate

This brief discussion indicates that anti-discrimination law is not necessarily or automatically incompatible with an employer imposing a duty on existing or future employees to take a Covid vaccine. Yet it is conceivable that circumstances arise where an objection on the part of an individual engages anti-discrimination law. Even then, there is flexibility within the law on indirect discrimination for an employer to demonstrate that their policy is objectively justified. This will require the employer to identify the aim that the policy is pursuing and to demonstrate that a mandatory vaccination requirement is both appropriate and necessary as a means of pursuing that aim. Necessity is typically read by courts as implying proportionality. Consequently, an employer could be required to show that the requirement was necessary for the specific role that the employee is performing and that no less restrictive measure would be sufficient.

⁶⁶ Debbie Kaminer, 'Can an employee object to mandatory COVID-19 vaccines on religious grounds?' (2021): <<https://theconversation.com/can-an-employee-object-to-mandatory-covid-19-vaccines-on-religious-grounds-153058>> accessed 11 June 2021.

⁶⁷ Owen Dyer, 'Covid-19: US Catholics split after bishops' conference recommends against Johnson and Johnson vaccine' (2021) *British Medical Journal* 372.



Issues for Employers to Consider

Any employer contemplating the introduction of a policy that requires employees to be vaccinated would be well-advised to consider carefully the rationale and whether this measure needs to be extended to all employees or only to certain roles. A practical step in the process of formulating such a policy is to consult recognised trade unions or other worker representatives, together with broader measures to provide information for those affected. The likelihood of such a measure surviving any legal challenge will be enhanced if the employer has a coherent, evidence-based explanation for its introduction. In this regard, it must be acknowledged that our understanding of the effects of vaccines continues to evolve. While it appears that vaccines offer substantial protection against serious illness for the vaccinated person, data is still emerging on the extent to which they inhibit or prevent transmission of coronavirus. For the time being, employers are likely to be obliged to continue with workplace safety measures to mitigate against the risk of contagion (*eg* social distancing), so an employer will need to explain why a vaccine requirement is needed *in addition to* other health and safety measures.

A key consideration for courts is likely to be whether it was reasonable for the employer to conclude that a lack of vaccination would pose a significant risk to the safety of other workers or service-users, especially if the latter are at high risk of serious illness if they contract Covid-19. For example, there are reports that some care home providers have imposed a vaccine requirement upon employees.⁶⁸ Given that a considerable proportion of deaths from Covid-19 have occurred in these settings, such an employer would have strong grounds for taking stringent measures to protect residents.

Although very many people wish to receive the vaccine, employers are likely to encounter situations where individuals decline. This needs to be anticipated in any workplace policy with a clear procedure in place. As indicated above, the legal position of the employee will be affected by the reason why they are refusing to be vaccinated. Consequently, it is important that there is a procedure that allows for dialogue between the employer and the employee in order to understand the reasons for the employee's refusal and to explore what measures might be taken in response. For a frontline care home worker, it may not be possible for an employer to accommodate a person who cannot or will

⁶⁸ Lee Peart, 'Care UK introduces no jab, no job policy' (2021): <<https://www.carehomeprofessional.com/care-uk-introduces-no-jab-no-job-policy/>> accessed 11 June 2021.



Trinity College Dublin

Coláiste na Tríonóide, Baile Átha Cliath

The University of Dublin

not be vaccinated, but for other roles it may be possible to consider alternative measures, such as permitting remote working.

In conclusion, whether the law permits an employer to impose a vaccine requirement upon employees is highly contingent on the specific circumstances of the job. The introduction of such measures must be set against the unprecedented context of a highly contagious pandemic that has created massive social and economic disruption over an extended period of time. Exceptional measures may be justified because of this context, however, they will require rigorous justification and careful planning to take account of specific factors that may affect individual employees.



Chapter IX: Public/Private Healthcare in a Pandemic

Sarah Hamill and Andrea Mulligan

Just before the World Health Organisation (WHO) declared COVID-19 a pandemic in March 2020, pictures of overwhelmed hospitals in Italy shocked the world.¹ The pictures echoed earlier scenes from Wuhan and would sadly be replicated the world over as the pandemic spread. The question facing governments, including in Ireland, was how best to manage the pandemic to prevent hospitals from collapsing under the pressure. Many of the specific public health advices designed to reduce transmission and thus pressure on hospitals and medical staff have been examined elsewhere in this report. In this chapter, the focus is on the legal framework which allowed the government to utilise private hospital capacity to manage pressure on the public system. While private hospital capacity was acquired during the pandemic, its acquisition differed, both in terms of extent and legal framework, between the initial wave of COVID-19 and subsequent waves.

The first part of this chapter offers a brief overview of Irish healthcare and Irish hospital capacity. The second part examines the agreement reached between the Health Service Executive (HSE) and the Private Hospitals Association (PHA) during the first wave of COVID-19, while the third part examines the relationship between the HSE and the PHA in subsequent waves. The fourth part provides analysis and recommendations moving forward.

Healthcare in Ireland

Healthcare has long been a thorny issue in Irish political discourse, with successive governments promising to completely overhaul the healthcare system. The system consists of a publicly funded system, run by the HSE, with a private system operating alongside it. Most consultants in Ireland are employed by the HSE under one of three main types of contracts. These contracts are referred to as Type A, B or C contracts. Those on Type A contracts cannot engage in private practice and must treat

¹ RTE News, 'Italy's Coronavirus Death Toll Rises by 133 in a Day' *RTE News* (8 March 2020) <<https://www.rte.ie/news/coronavirus/2020/0308/1120899-virus-italy-quarantine-lombardy/>> accessed 22 June 2021; RTE News, 'Covid-19: Highest Daily Death Toll as 919 Die in Italy' *RTE News* (27 March 2020), <<https://www.rte.ie/news/coronavirus/2020/0327/1126819-covid-19-italys-death-toll-reaches-8-215/>> accessed 22 June 2021.



only public patients in public settings. Those on Type B and Type C contracts can engage in private practice in addition to their public sector duties – the private practice of these consultants may be conducted on the public site, or in the case of Type C consultants and some Type B consultants, this private practice may be conducted off-site in private hospitals or rooms.² According to figures from 2019, about 57% of all consultants are on a Type B contract.³

In addition, approximately 600 “whole time private practice” (WTPP) consultants also work in the Irish health sector.⁴ They treat only private patients in private settings. These consultants are either self-employed or work in partnership structures. Private hospitals are served by both WTPP consultants, and HSE-employed consultants who have rights to engage in private practice on private sites.

Relatively high numbers of Irish people (43%) choose to purchase private health insurance to access the private system.⁵ It is well known that under normal conditions the public system (and on occasion, the private system) has extremely long waiting lists, and serious capacity problems. Even prior to the pandemic, public hospitals were bedevilled by overcrowding and long waits for beds.⁶

Ireland’s number of hospital beds per 1000 of population is significantly below the OECD average,⁷ and occupancy rates run at about 95%, the highest rate in Europe.⁸ Similarly, the number of ICU beds is low at 6 per 100,000 population compared with the European average of 11.5 per 100,000, and this figure includes beds in private hospitals.⁹ There too, occupancy rates are very high, at between 88% and 96%.¹⁰ It was clear, therefore, that if the Irish healthcare system was to face a surge in cases of

² Deirdre Collins, *Health Workforce Consultant Pay and Skills Mix 2012-2017* (Irish Government Economic and Evaluation Service 2019) 3 <<https://assets.gov.ie/25637/4757eb04a70b4836900ff250a5636783.pdf>> accessed 22 June 2021.

³ *ibid* 3, 12.

⁴ Martin Wall, ‘Private Hospitals Accused of Putting Pressure on Consultants to Sign Covid-19 State Contract’ *The Irish Times* (22 April 2020) <<https://www.irishtimes.com/news/health/private-hospitals-accused-of-putting-pressure-on-consultants-to-sign-covid-19-state-contract-1.4234546>> accessed 22 June 2021.

⁵ Sheelah Connolly and Maev-Ann Wren, ‘Universal Health Care in Ireland – What Are the Prospects for Reform?’ (2019) 5(2) *Health Systems and Reform* 94, 94 <<https://www.tandfonline.com/doi/pdf/10.1080/23288604.2018.1551700?needAccess=true>> accessed 22 June 2021.

⁶ Tommy Meskill, ‘2019 Worst Year Ever for Hospital Overcrowding – INMO’ *RTE News* (2 January 2020) <<https://www.rte.ie/news/health/2020/0102/1103925-hospital-overcrowding/>> accessed 22 June 2021.

⁷ OECD, ‘Hospital beds (indicator)’ *OECD.org* (2021) <<https://data.oecd.org/healthqt/hospital-beds.htm>> doi:10.1787/0191328e-en accessed 5 June 2021.

⁸ Brian Turner, Julien Mercille and Sean Lucey, ‘What should our Healthcare System look like after the Pandemic?’ *RTE Brainstorm* (27 May 2020) <<https://www.rte.ie/brainstorm/2020/0427/1135038-ireland-healthcare-system-future-coronavirus/>> accessed 22 June 2021.

⁹ National Office of Clinical Audit, *Irish National ICU Audit Annual Report 2018* (National Office of Clinical Audit 2020) 13 <http://s3-eu-west-1.amazonaws.com/noca-uploads/general/Irish_National_ICU_Audit_Annual_Report_2018_FINAL.pdf> accessed 22 June 2021.

¹⁰ *ibid*.



COVID-19, and especially a surge in numbers of people requiring admission to ICU, it would struggle to cope.

The First Wave of COVID-19

Concerns about the capacity of Irish hospitals to cope with COVID-19 emerged almost simultaneously with the arrival of the disease in Western Europe. With the first Irish cases confirmed in late February, the government took steps in March 2020 to take over the private hospitals in their entirety with a view to expanding capacity in the public system.

On 30 March 2020 the HSE reached an agreement with the Private Hospitals Association on the Heads of Terms of an Agreement in relation to the provision of public health services in private hospitals as a response to the Covid-19 pandemic. 18 private hospitals in Ireland signed up to the agreement, which was to last for three months. Under the arrangement the private hospitals agreed to provide full hospital capacity to the HSE, consisting of an estimated 1,900 inpatient beds, 600 day beds as well as 47 ICU and 54 high dependency unit (HDU) beds. This amounted to approximately 17% of the capacity of the public hospitals. Under the agreement, no private work was to be admitted in any of the private hospitals for the duration of the agreement, aside from continuing care to existing patients. The private hospitals would use their existing staff to deliver the public services in question, and the HSE would reimburse the private hospitals for the costs of operation during this period.

Importantly, the agreement was concluded between the HSE and private hospitals. The consultants operating out of those hospitals were not party to the agreement. Under the arrangement, the WTPP consultants were offered locum Type A contracts by the HSE, meaning that they were not entitled to continue their private practice, aside from providing for continuity of care to existing patients. Consultants on Type B and C contracts were entitled to continue to treat private patients for the duration of existing episodes of care. After that point, such patients were to be treated as public patients. On the advice of NPHET of 27th March 2020 all non-essential surgery, health procedures and other non-essential services were to be postponed. Clearly, the intention of the arrangement was to convert the private healthcare system temporarily into a public system providing only essential healthcare services, aside from minimal ongoing care to patients already in situ for non-essential procedures.



The arrangement remained in place until the end of June 2020. The cost of the arrangements was estimated at €115 million per month.¹¹ The actual occupancy rate of private hospitals remained low, at about a third of capacity,¹² throughout the duration of the arrangement, due to the fact that the increase in cases of COVID-19 was not as significant as had been feared. Nonetheless, ‘7,600 inpatient treatments, 26,000 day case procedures, 24,000 outpatient appointments, and 35,000 diagnostic tests’ were delivered as part of the arrangement.¹³ It is unclear, however, whether these treatments and tests were for those on public waiting list or whether they were provided to normally private patients seeing a Type B or Type C contract consultant. It is clear, however, that while the agreement was in place, public money was used to pay for some treatments for private patients.¹⁴

Many private consultants remained unhappy with the arrangement. About half of 600 WTPP consultants opted into the Type A contract,¹⁵ with many complaining that they should have been offered Type B or C contracts that would have allowed them continue to treat private patients. They also felt that it was not clear whether the HSE reimbursement scheme would cover the costs of private consulting rooms, which they argued interfered with their ability to ensure continuity of care for their patients. Some described the deal as a “lockout” which prevented them caring for patients at their place of work.¹⁶ Issues also arose concerning a lack of clarity as to whether private consultants were indemnified if they chose to continue to treat patients without signing the contract, and whether the public Clinical Indemnity Scheme extended to the locum Type A contracts.

Subsequent waves of COVID-19

By the time the initial arrangements with private hospitals ended, case numbers of COVID-19 had significantly declined from their peak in April 2020. As it happened, the public system coped with the first wave and was not overwhelmed. The pandemic was far from over and there was concern that there might be, as indeed there was, another surge of COVID-19. In August 2020 the HSE issued a tender for the assembly of a panel of private healthcare providers for the provision of additional healthcare capacity.¹⁷ This heralded a new approach to private healthcare resources. Instead of

¹¹ Oireachtas Special Committee on Covid-19 Response Deb 2 June 2020, 7.

¹² *ibid.*

¹³ Niamh Cahill, ‘Private Consultants and the Covid-19 crisis’ *The Medical Independent* (15 June 2020) <<https://www.medicalindependent.ie/private-consultants-and-the-covid-19-crisis/>> accessed 23 June 2021.

¹⁴ Oireachtas Special Committee on COVID-19 Response Deb 2 June 2020, 29-30.

¹⁵ Cahill (n 13).

¹⁶ *ibid.*

¹⁷ HSE, ‘HSE 14936 – Panel Agreements of Private Healthcare Providers for the Provision of Additional Healthcare Capacity’ (Central Public Procurement Information System) <<https://irl.eu->



entering into an agreement with the Private Hospitals Association and/or acquiring full capacity of some or all private hospitals, the HSE planned to enter bilateral agreements with individual private hospitals. It was clear that the complete takeover of private hospitals had not been needed. It was thought that the tender would lead to the appointment of a panel of private healthcare providers who would be eligible to enter mini-competitions for the appointment of service providers, which would be held from time to time as the need arose in the public system due to the impact of Covid-19. The goal being a more tailored and less dramatic utilization of additional capacity.

In September 2020, the HSE released a document which detailed its plans for coping with the pandemic from October 2020 to April 2021.¹⁸ The plan hoped to be able to balance a resumption of normal care, albeit in the context of an ongoing pandemic, while also coping with anticipated surges. The plan noted that it would 'seek to leverage private acute facilities in a number of ways including engaging these facilities to maintain continuity of elective procedures allowing for maximum unscheduled emergency care to take precedence in our public acute hospitals'.¹⁹ Presciently, the plan observed that if 'a significant surge occurs, the engagement of capacity from the acute private sector will be required'.²⁰

Reading the plan makes clear both the existing issues with the Irish healthcare system and the challenges that the pandemic posed. The plan rested on being able to create more acute beds but, at the same time, noted that the occupancy rates would need to be reduced from '95% average to 85% in line with clinical guidance on safe practice for patients and staff alike'.²¹ There was concern over whether or not the HSE would be able to recruit enough staff to meet the plan.²² So too was the backlog of non-COVID care noted.²³

Negotiations with the private hospitals were ongoing at the time the winter plan was released. Nonetheless the plan set out three roles for the private hospitals: surge capacity for COVID-19 cases;

[supply.com/ctm/Supplier/PublicPurchase/171452/0/0?returnUrl=ctm/Supplier/PublicTenders&b=ETENDERS_SIMPLE](https://www.supply.com/ctm/Supplier/PublicPurchase/171452/0/0?returnUrl=ctm/Supplier/PublicTenders&b=ETENDERS_SIMPLE)> accessed 23 June 2021.

¹⁸ HSE, *Winter Planning within the COVID-19 Pandemic: October 2020 – April 2021* (HSE 2020) <<https://www.hse.ie/eng/services/publications/winter-planning-within-the-covid19-pandemic-october-2020-april-2021.pdf>> accessed 23 June 2021.

¹⁹ *ibid* 3.

²⁰ *Ibid*.

²¹ *ibid* 16.

²² *ibid* 7.

²³ *ibid* 18.



addressing ‘the HSE priority needs in providing essential ongoing care’; and, addressing ‘elective care for public patients experiencing delays and the growth in waiting lists’.²⁴

In January 2021, Paul Reid, the Chief Executive Officer of the HSE, expressed optimism that private and public hospitals would continue to work together in the future.²⁵ His comments were contained in the introduction to the HSE’s National Service Plan for 2021. While he praised the adaptability of the healthcare system, he also referred to the then resurgent COVID-19 case numbers.²⁶ In fact, COVID-19 cases had significantly exceeded their previous peak when the 2021 National Service Plan was released.

Such were the case numbers that the HSE had to utilize private hospitals for surge capacity. Just three days before the Annual Service Plan was released, the Minister for Health had publicly welcomed the agreement between the HSE and several private hospitals for surge capacity,²⁷ known as the Safety Net II Agreement. The agreement saw private hospitals offer up to 30 percent of their capacity, with additional capacity to be negotiated for on an as-needed basis.

The notes accompanying the Minister of Health’s press release promised that lessons had been learned from the first agreement in the second quarter of 2020. The notes describe the agreement as a ‘safety net arrangement’ which the HSE could activate ‘on the basis of metrics which objectively indicate’ a surge in COVID-19.²⁸ However, the agreement allowed ongoing treatment of private patients and promised enabling ‘a local relationship between private hospitals and public hospitals in each area, which should result in a more streamlined service for both hospitals and patients’.²⁹

That being said, it was February 2021 before the government could confirm that 18 private hospitals had signed onto the agreement.³⁰ In addition, the surge necessitated the HSE to cease all non-urgent,

²⁴ *ibid* 17.

²⁵ HSE, *National Service Plan 2021* (HSE 2021) 2 <<https://www.hse.ie/eng/services/publications/serviceplans/national-service-plan-2021.pdf>> accessed 23 June 2021.

²⁶ *ibid* 3.

²⁷ Department of Health, ‘Minister Donnelly Welcomes Agreement with Private Hospitals’ (12 January 2021) <<https://www.gov.ie/en/press-release/66a74-minister-donnely-welcomes-agreement-with-private-hospitals>> accessed 23 June 2021.

²⁸ *ibid*.

²⁹ *ibid*.

³⁰ Dáil Deb 11 February 2021, vol 1004, no 2 <<https://www.oireachtas.ie/en/debates/question/2021-02-11/section/275/>> accessed 23 June 2021.



hospital care.³¹ According to the minutes of a special HSE board meeting on 15 January 2021, private hospitals were already taking public patients which suggests that as soon as Safety Net II was invoked the extra capacity was needed.³²

In late March 2021, *The Irish Times* reported that the HSE would be beginning to release several private hospitals from the Safety Net II agreement.³³ The same report indicated that the government hoped to use the ongoing arrangement to deal with backlogged non-COVID healthcare.³⁴

Analysis and Conclusions

With the third wave of COVID-19 beginning to recede and vaccinations against the virus on the increase, it is to be hoped that the worst is behind us. Ireland was lucky to not need the additional capacity offered by the private hospitals during the first wave but it clearly needed additional capacity during subsequent waves. In this section we draw out the lessons to be learned for the future, based on the agreement during the first wave and the Safety Net II Agreement.

The agreement reached during the first wave was made under significant time pressure and this led to negative consequences. In particular, there was a lack of clarity over key elements of the scheme such as the extent to which continuity of care could be maintained for private patients who were already in treatment, or in situ in private hospitals. The lack of clarity as to the clinical indemnity for WTPP during the first arrangement was also unfortunate.

The first agreement may have successfully acquired significant additional capacity, but it was at a significant cost. That cost looks especially high in view of the fact that much of the private hospital capacity was not ultimately used. It has to be recognized that when the arrangement was negotiated in late March 2020, the country was facing a very real prospect of the health system being overwhelmed, and the overriding objective was the securing of all possible additional capacity. That objective was achieved.

³¹ RTE, 'Hospital System Operating at "Surge Capacity" – Reid' *RTE News* (16 January 2021) <<https://www.rte.ie/news/coronavirus/2021/0116/1190176-covid-19-ireland/>> accessed 23 June 2021.

³² HSE, 'Minutes of Special HSE Board Meeting' (15 January 2021) 2 <<https://www.hse.ie/eng/about/who/board-members/minutes-of-hse-board-meeting/minutes-of-hse-nrp-board-meeting-15-january-2021.pdf>> accessed 23 June 2021.

³³ Martin Wall, 'HSE Ceases Using Facilities in Some Private Hospitals under Covid Agreement' *The Irish Times* (26 March 2021) <<https://www.irishtimes.com/news/ireland/irish-news/hse-ceases-using-facilities-in-some-private-hospitals-under-covid-agreement-1.4521322>> accessed 23 June 2021.

³⁴ Ibid.



The Safety Net II agreement, while clearly in the works for many months prior to it actually being needed, also arrived during an acute surge of COVID-19. As there was no complete takeover of private hospital beds, it improved upon the confusion caused by the first agreement where it was unclear as to precisely what services may be provided, to whom and by whom, during surge conditions. The Safety Net II Agreement was more tailored and less drastic in scope. Once again, the capacity was acquired quickly, and effectively, but this time it was acquired in proportion to need.

The Safety Net II Agreement also seems to have avoided the displeasure of the WTPP consultants. The urgency of the first agreement appears to have resulted in a lack of consultation with the WTPP consultants who complained that they were excluded from the arrangement and griped consistently while it was in place. There do not appear to have been any sustained complaints from the WTPP consultants over the second agreement.

That being said, there are still questions to be asked about balancing cost-effectiveness with the need to respond dynamically to evolving pandemic conditions. Given the increasing backlog as a result of the pandemic, it seems likely that the panel system introduced in September 2020 will be utilized by the HSE for some time to come. Hopefully the panel system will allow the HSE to identify the need for specific services and purchase them at competitive rates as the need arises. It should be noted, however, that the PHA has long campaigned for its capacity to be utilized in reducing public waiting lists.³⁵

However, it is worth considering what should happen if the HSE needs all the capacity in private hospitals again. It seems that there is a stateable case that the WTPP consultants are exercising their constitutional right to earn a livelihood when they engage in private practice, and thus they have a plausible argument that this right should not be unjustifiably interfered with by the State or by the operators of private hospitals. Given that Type B and C contracts that were already in operation continued during the first arrangement, it is difficult to see why only Type A contracts were offered to the WTPP consultants. It seems more sensible to offer Type B and C contracts, which would at the very least allow for continuity of care for private patients. A somewhat more complex question is whether such contracts should allow the WTPP consultants see new private patients or provide non-

³⁵ Simon Nugent, 'Why Can People on Irish Public Waiting Lists Choose To Be Treated in Private Hospitals in any EU Country – Except Here?' *Sunday Business Post* (17 July 2017), available via the Private Hospitals Association <<http://privatehospitals.ie/great-irish-waiting-list-paradox/>> accessed 23 June 2021.



essential private healthcare services during periods when private resources are needed to manage a public health emergency. This would appear to depend on whether those services negatively affect the public management of any such emergency.

The other aspect to note about the first agreement is that it was done on a voluntary basis. The March arrangement between the HSE and the private hospitals was entirely voluntary and - as the private hospitals were eager to emphasize - entered into because the private hospitals wanted to do their part in the fight against COVID-19. Yet trouble with the private hospitals was evident even before the first agreement concluded. Notably, the Beacon Hospital was reported to have left the PHA in June 2020, amid discontent with the arrangement.³⁶ The Beacon Hospital would be singled out for criticism by HSE CEO, Paul Reid in January 2021 for its failure to sign Safety Net II.³⁷ The Beacon promptly fired back saying that it was treating public patients under other agreements and was reluctant to let the HSE take clinical control again.³⁸ The Beacon said it had been 70% empty during the first agreement, and that up to 20% of surgeries completed in the previous months had been 'on behalf of public hospitals'.³⁹ While the Beacon did ultimately sign onto the Safety Net II Agreement, its pointed response to HSE criticism is revealing of the scale of the issues facing public hospitals as the country once again begins to re-open.

Given Ireland's experiences with three waves of COVID-19, and some signs of private hospitals being unhappy with the arrangements there is a question of whether such hospitals could be compelled to assist. Any such measure would certainly engage constitutional property rights and would likely be subject to a proportionality test. Clearly, management of a pandemic is an objective of great importance, but the effect on property rights would have to be minimised insofar as possible. While it is difficult to provide a definitive view in the abstract, any such measure would certainly have to be limited in duration, and finely targeted at addressing a specific need created by the pandemic. If sufficiently tailored and proportional, measures to compel private hospitals to cooperate could well be constitutional. Practically speaking, however, it is preferable to continue to use private resources on a voluntary basis where possible, and to secure buy-in from healthcare institutions and the medical profession.

³⁶ Cahill (n 13).

³⁷ RTE, 'Hospital System Operating at "Surge Capacity" – Reid' *RTE News* (16 January 2021) <<https://www.rte.ie/news/coronavirus/2021/0116/1190176-covid-19-ireland/>> accessed 23 June 2021.

³⁸ *ibid.*

³⁹ *ibid.*



The bigger question, however, is what the relationship between public and private healthcare will be moving forward. The already-long waiting lists for public hospitals have only grown during the pandemic. While there is some evidence of outsourcing routine public treatment to private hospitals to relieve pressure on the public system,⁴⁰ it is clear that the source of the issue is the lack of capacity in public hospitals. It is this lack of public hospital capacity which must be addressed moving forward both so that Ireland is better prepared for future pandemics or, indeed, COVID-19 surges, *and* so that routine healthcare is more efficient and effective. The challenge of navigating the use of private healthcare resources to fight COVID-19 demonstrates the fundamentally problematic nature of the bifurcated structure of Irish healthcare. Responding to a public health emergency like Covid-19 would undoubtedly be more effective under a system of universal healthcare that was adequately resourced and staffed.

⁴⁰ See, *eg*, the situation with colonoscopies. Dáil Deb 3 March 2021, vol 1004, no 7 <<https://www.oireachtas.ie/en/debates/question/2021-03-03/752/>> accessed 23 June 2021.



Chapter X: Ireland's Approach to Counting Deaths from COVID-19

Sarah Hamill

The number of deaths from a pandemic disease is one of the more important pieces of data in terms of managing a pandemic. The death toll gives insight into the seriousness of the disease and is vital in crafting appropriate public-health responses. The number of deaths is also important for 'quantifying the overall effect of the pandemic....and for future pandemic planning'.¹

When it comes to counting deaths from COVID-19, however, different countries have adopted different approaches which has made international comparisons at best difficult and at worst politically charged. The focus of this chapter is on how Ireland has counted and is counting deaths from COVID-19 with a particular focus on the legal framework for death notifications and registrations. However, it is useful to begin by setting out why the death toll matters and some of the controversies which have emerged internationally over the number of deaths. Then I set out the current procedure for counting deaths, the procedure during the pandemic, and briefly examine proposed reforms to deaths registration.

The Importance of Death Tolls in a Pandemic

When COVID-19 emerged the key questions for scientists to answer were: how it spread, how infectious was it, how serious was it, and what was its case fatality rate (CFR)? The answer to the latter two questions relies in part on the information about the number of deaths from COVID-19. Almost immediately, attempts to count deaths from COVID-19 became mired in controversy. In part this controversy was due to the sheer amount of data emerging and the speed at which the data was subjected to commentary and analysis. Almost as soon as any new information related to COVID-19 was available, a flurry of commentary emerged across mainstream media, social media, and the pre-

¹ Tom Luce, 'Covid 19: death certification in England and Wales' 2020 BMJ; 369:m1571 doi: 10.1136/bmj.m1571, <<https://www.bmj.com/content/bmj/369/bmj.m1571.full.pdf>> accessed 7 July 2021.



print servers where scientists and researchers post their research papers before they undergo, and as they are undergoing, peer review.²

Lin et al note that early in the pandemic, the death tolls were inaccurate and have since been revised upwards.³ Early figures thus led to a false sense of security with one leading American epidemiologist arguing that potentially only 10,000 Americans would die.⁴ Such figures have unfortunately been revealed as hopelessly optimistic. More worryingly, doubts over the seriousness of COVID-19, fuelled by its changing CFR, have spawned conspiracy theories about COVID-19 and protests over the public health measures necessary to control the pandemic.⁵ They have also led to high-profile spats between leading epidemiologists, including *ad hominem* attacks in scientific journals.⁶ While there is nothing new in disputes between academics, in the context of the current pandemic they have made introducing and enforcing public health measures more challenging.

The point is not to criticise academics; debate, ideally civil and reasoned debate, is central to what we do. The consensus is that there are issues with counting deaths from COVID-19 but that since the pandemic began in late 2019, the death tolls have become more accurate. Despite increasing accuracy we are unlikely to ever know the precise number of deaths from COVID-19.⁷ The issues with the death tolls early in the pandemic were caused by a number of factors: difficulty in testing every likely case of COVID-19; an early lack of awareness that COVID-19 symptoms differed between categories of patient – for example it manifested differently among the elderly than among younger patients;⁸ and, the different criteria that jurisdictions applied for counting deaths from COVID-19.

² Ricardo Jorge Dinis-Oliviera, 'COVID-19 research: pandemic versus "paperdemic", integrity, values and risks of the "speed science"' (2020) 5(2) Forensic Sciences Research 174; Nour Mheidly and Jawad Fares, 'Leveraging media and health communication strategies to overcome the COVID-19 infodemic' (2020) 41 J Public Health Policy 410

³ Timothy PH Lin et al, 'Death tolls of COVID-19: Where come the fallacies and ways to make them more accurate' (2020) 15(10) Global Public Health 1582, 1584

⁴ John PA Ioannidis, 'A fiasco in the making? As the coronavirus pandemic takes hold, we are making decisions without reliable data' *STAT* (17 March 2020) <<https://www.statnews.com/2020/03/17/a-fiasco-in-the-making-as-the-coronavirus-pandemic-takes-hold-we-are-making-decisions-without-reliable-data/>> accessed 9 June 2021.

⁵ See, eg Crystal Lee et al, 'Viral Visualizations: How Coronavirus Skeptics Use Orthodox Data Practices to Promote Unorthodox Science Online' (CHI Conference on Human Factors in Computing Systems, Yokohama/online, May 2021), <https://doi.org/10.1145/3411764.344521>, <<https://arxiv.org/pdf/2101.07993.pdf>> 4-5, 11; David Gorski, 'What the heck happened to John Ioannidis?' *Science Based Medicine* (29 March 2021) <<https://sciencebasedmedicine.org/what-the-heck-happened-to-john-ioannidis/>>; Órla Ryan, 'FactFind: Here is how Covid-19 deaths are counted in Ireland', *The Journal* (21 May 2020), <<https://www.thejournal.ie/how-are-covid-19-probable-deaths-counted-5102540-Jul2020/>> links accessed 9 June 2021.

⁶ See eg John PA Ioannidis, 'Reconciling estimates of global spread and infection fatality rates of COVID-19: An overview of systemic evaluations' (2021) *European Journal of Clinical Investigations* <<https://doi.org/10.1111/eci.13554>>; Gorski (n 5).

⁷ See Lin et al (n 3) 1583 (noting the issues with the Spanish Flu death tolls).

⁸ Health Service Executive, 'What characterizes atypical clinical presentation of COVID-19 in older patients (age 65 plus)', National Health Library and Knowledge Service, <<https://hselibrary.ie/what-characterizes-atypical-clinical-presentation-of-covid-19-in-older-patients-age-65-plus/>> accessed 3 June 2021.



Karanikolos and McKee illustrate the challenges by comparing how different countries count deaths from COVID-19. They note that some countries counted both COVID-19 cases confirmed by laboratory tests and those which were diagnosed clinically but others only count laboratory-confirmed cases.⁹ Strikingly they note that there are differences among the constituent nations of the United Kingdom with respect to counting and reporting deaths.¹⁰ Ireland, meanwhile, only reported lab-confirmed deaths until 21 April 2021 and then included likely deaths from COVID-19 since the start of the pandemic.¹¹

Indeed, one of the more notable features of the daily death toll announced in Ireland is that it often includes deaths from several months previously as well as more recent deaths. Sometimes deaths can even be de-notified as being COVID-19 deaths. These issues and particularly the lag in reporting deaths can and has led to the impression that the pandemic situation in Ireland is worse than it really is. There are, however, reasons why Ireland's death toll has involved a lag in reporting and it is to these reasons I now turn.

Death Notification and Registration in Ireland

There is currently an ongoing public consultation around the registration of deaths in Ireland. At least part of the rationale behind this consultation are the issues which the COVID-19 pandemic has revealed.¹² The public consultation paper also notes that the duties around registering deaths can add to the burden on families at a difficult time and so, even absent the pandemic, there was scope to review the process.¹³ Suggested reforms aside, this section sets out the current procedure, and the next sets out the special rules which apply to deaths from COVID-19.

⁹ Marina Karanikolos and Martin McKee, 'How comparable is COVID-19 mortality across countries' (2020) 26(2) Eurohealth 45, 46.

¹⁰ Ibid 48.

¹¹ Ibid 46.

¹² General Register Office, *Consultation on the revision of the method by which deaths are notified and registered in Ireland* (18 February 2021) <<https://www.gov.ie/en/consultation/aa3b2-public-consultation-on-revision-of-death-registration-process/>> accessed 9 June 2021.

¹³ Ibid 1.



Under Part 5 of the Civil Registration Act 2004, as amended, all deaths in the state should be registered within three months of the date of death.¹⁴ I say should be rather than must as, while the legislation indicates that registering is a duty, a failure to abide by that duty attracts no legal penalty.¹⁵ The only recourse if the death is not registered in time is that a notice can be served on a person to attend a registrar and register the death.¹⁶ Though how, absent registration, the registrar is to know of the death is not explained.

Deaths registered more than twelve months after their occurrence attract additional formalities,¹⁷ but these formalities are at the registrar's end rather than the registering person's end. Such deaths cannot be registered 'without the consent in writing of the Superintendent Registrar of the authority by which the register is employed' and this consent must be noted in the register.¹⁸

The end result is that up to twenty percent of deaths are not registered within three months of their occurrence.¹⁹ As the official figures for deaths only count registered deaths, recent official figures are often inaccurate.²⁰ That Ireland allows deaths to be registered at any time after the death, is one reason why Ireland's daily death tolls from COVID-19 include deaths from previous months. Before examining other sources of the lag in reporting, it is helpful to set out the basic process of registering a death.

In Ireland, the 2004 Act stipulates that a 'qualified person' must register the death. Typically, this person will be a relative but, if there are no relatives who have 'knowledge of the required particulars in relation to the death,'²¹ the duty falls to another person with knowledge of the death.²² The relatives should have been provided with a Death Notification Form (DNF) by a medical practitioner which will detail the cause of death in a portion of the form called the Medical Certificate of the Cause of Death (MCCD). The relatives can then complete the rest of the DNF with additional information about the deceased. Once the DNF is completed it should be given to a registrar to register the death.

¹⁴ Civil Registration Act 2004, s 37 (1). Certain deaths outside the state may be registered under section 38, while section 39 requires 'specified records' to be kept of certain categories of deaths which shall also be registered in Ireland. Unless otherwise specified, all citations hereafter are to the Act as amended.

¹⁵ Civil Registration Act 2004, s 37 (2); General Register Office (n 12) 1.

¹⁶ Civil Registration Act 2004, s 37 (2).

¹⁷ Civil Registration Act 2004, s 40 (1)

¹⁸ Civil Registration Act 2004, s 40 (1)-(2)

¹⁹ General Register Office (n 12) 1

²⁰ Ibid 1.

²¹ Civil Registration Act 2004, s 37(1) (a).

²² Ibid, s 37(1), (5)(a)-(i).



Once registration is complete a death certificate is issued.²³ As a result of the pandemic, the General Register Office (GRO) made changes to death notification which allowed the DNF to be posted or emailed to the registrar.²⁴

The basic process, detailed above, can be complicated by a range of factors. Under section 42, if the person died following an illness and ‘was attended during that illness by a registered medical practitioner’ that practitioner must sign the DNF.²⁵ Here, the Coroners Act 1962, as amended, requires that the deceased have been ‘seen and treated...within one month before ...death’.²⁶ Both the Public Consultation document and the information provided by Citizens Information state that the medical practitioner must have seen the deceased within 28 days which is a more precise term than month.²⁷ The rise of telemedicine during the pandemic could also give rise to questions over whether a doctor has ‘seen and treated’ a patient but that is an issue for another day.

Of more interest is what happens should the deceased not have died from an illness they had been treated for within 28 days of their death. In such cases where the deceased has not been attended by a medical practitioner or where the medical practitioner is not satisfied as to the cause of death, the medical practitioner must inform the coroner.²⁸ The coroner, while appointed by the State, acts independently in the public interest to investigate certain categories of deaths.²⁹ These deaths fall under Part 2A of the Coroners Act 1962 and are classed as reportable deaths. It is then for the coroner to decide if a post-mortem is needed, though in some cases a post-mortem *must* be ordered.³⁰ The coroner can also decide if an inquest is needed and in some cases an inquest must occur,³¹ or can direct the medical practitioner to complete the MCCD and so issue the DNF to relatives.³² If the coroner should undertake further investigations, they will only issue a Coroners Certificate once these investigations are complete. This certificate is issued to the registrar and once it is issued the death can be registered.³³

²³ General Register Office (n 12) 4

²⁴ Central Statistics Office, ‘Information Note on the Implications of COVID-19 on the processing of Death Certificates’ <<https://www.cso.ie/en/releasesandpublications/in/vs/informationnoteontheimplicationsofcovid-19ontheprocessingofdeathcertificates/>> accessed 3 June 2021.

²⁵ Civil Registration Act 2004, s 42(1)

²⁶ Coroners Act 1962, s 16A (1)(b). Unless otherwise specified, all citations hereafter to are to the Act as amended.

²⁷ General Register Office (n 12) 4; see also <https://www.citizensinformation.ie/en/death/after_a_death/death_cert.html> accessed 9 June 2021.

²⁸ Coroners Act 1962, ss 16A, 16B

²⁹ See, eg, Dublin District Coroner’s Court, <<https://www.dublincoronerscourt.ie/about/>> accessed 9 June 2021.

³⁰ Coroners Act 1962, s 33 A (1)

³¹ *Ibid*, ss17-18.

³² General Register Office (n 12) 4.

³³ General Register Office (n 12) 4. Civil Registration Act 2004, s 41.



If a post-mortem is not required, the 2004 Act indicates that the coroner will provide a certificate to the registrar. In practice, however, it would seem that where there is no post-mortem the coroner will 'direct that the medical practitioner complete the MCCD and issue the DNF to relatives.'³⁴ If a post-mortem is required, then there may be significant delays. The HSE advises that post-mortem reports can take 'at least six weeks' to complete and this will be longer if the case is complicated.³⁵ It is possible for the coroner to issue a temporary certification which can allow the death to be registered.³⁶ It should be noted that post-mortems do not necessarily delay burials by the same amount of time as they delay registration of the death.

Once a death is registered with the General Registrar's Office (GRO), that office will include the death in its weekly submissions to the Central Statistics Office (CSO). The CSO then assigns an Underlying Cause of Death (UCOD) to each death record.³⁷ The CSO publishes this data quarterly but that data is only provisional, with the final data unavailable for up to 22 months from the end of the reference period.³⁸ Ireland's CSO uses the tenth revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10),³⁹ to provide codes for the UCOD. ICD-10 codes are also used for public health statistics more generally and are not limited to UCODs.

Reporting and Counting COVID-19 Deaths

To facilitate counting of deaths from COVID-19, the World Health Organisation (WHO) created emergency codes to be used in reporting COVID-19.⁴⁰ These were first released in February 2020 and have since been updated with additional codes for 'conditions that occur in the context of COVID-

³⁴ General Register Office (n 12) 4.

³⁵ Hospice Friendly Hospitals Programme, *Information About Post-Mortems*, online:

<<https://www.hse.ie/eng/services/list/3/acutehospitals/hospitals/cavanmonaghan/information-on-post-mortems.pdf>> accessed 3 June 2021.

³⁶ Central Statistics Office (n 24).

³⁷ Dáil Debates 21 April 2021, vol 1005, written question 138, <<https://www.oireachtas.ie/en/debates/question/2021-04-21/138/>> accessed 9 June 2021.

³⁸ Ibid.

³⁹ World Health Organisation, International Statistical Classification of Diseases and Related Health Problems, 10th Revision, <<https://icd.who.int/browse10/2010/en>> accessed 9 June 2021.

⁴⁰ WHO, Emergency use ICD codes for COVID-19 disease outbreak, (2020) <<https://www.who.int/standards/classifications/classification-of-diseases/emergency-use-icd-codes-for-covid-19-disease-outbreak>>



19',⁴¹ COVID-19 vaccination, and adverse reactions to such vaccines.⁴² For these codes to be of any use in counting Irish deaths from COVID-19, the deaths must have actually been registered first.

It should hardly be a surprise that the arrival of a pandemic necessitated changes to the process of registering deaths. As set out above, there are certain categories of deaths which must be reported to the coroner. In the context of COVID-19, there are two, relevant types of reportable deaths for ascertaining the effect of the pandemic. The first is 'any death caused wholly or partly by...a notifiable disease or condition' where the notification is required by some other enactment,⁴³ and the second is any death occurring in nursing homes or care homes or similar.⁴⁴ COVID-19 was made a notifiable disease in February 2020 by the Infectious Diseases (Amendment) Regulations 2020 (SI No 53 of 2020). Shortly after, the Coroners Society of Ireland issued guidance which noted that 'Confirmed and suspected or possible Covid-19 related deaths are reportable to the relevant District Coroner in every case'.⁴⁵

Consequently, early in the pandemic all deaths or suspected deaths from or related to COVID-19 were reportable to the coroner. Such a situation meant and continues to mean that the "normal" procedure for registering these deaths is interrupted. An interruption does not necessarily mean that the death will fail to be registered within three months, however. The Coroners Act 1962, as amended, does not mandate post-mortems for notifiable diseases, a post-mortem may be requested but this would fall under the coroner's discretion. For COVID-19, the Coroners Society of Ireland's guidance on post-mortems for confirmed or suspected cases envisioned 4 scenarios:⁴⁶

- 1) Deaths following a confirmed diagnosis of COVID-19;
- 2) Deaths in hospital following testing for COVID-19 where the test results were outstanding at the time of death;
- 3) Deaths in hospital 'from respiratory failure/adult respiratory distress syndrome before investigation';

⁴¹ Ibid.

⁴² Ibid.

⁴³ Coroners Act 1962, sch 2, para 13(a).

⁴⁴ Ibid, sch 2, para 23.

⁴⁵ Statement of Coroners Service from the Coroners Society of Ireland, *Guidance in Relation to the Coroners Service and Deaths due to Covid-19 infection* (11 March 2020) <http://coroners.ie/en/COR/Coroners_Service_COVID-19_110320.pdf/Files/Coroners_Service_COVID-19_110320.pdf> accessed 9 June 2021.

⁴⁶ Ibid.



- 4) Deaths outside of hospital where COVID-19 infection is suspected but no test had been taken prior to death.⁴⁷

The Guidance indicated all such deaths should be reported to the District Coroner but that there was no need for a post-mortem following either a confirmed diagnosis (scenario 1) or positive *ante mortem* test result (scenario 2), unless the death had other circumstances mandating a post-mortem. If the test result for COVID-19 is negative in scenario 2, a post-mortem may be ordered. For scenarios 3 and 4, there should be a post-mortem test for COVID-19 which, if positive, would follow the procedure for scenario 1 and if negative, a post-mortem may be directed. In the case of scenario 4, the body should be taken to a mortuary after death. Once the screening and/or post-mortem is complete, the body may be released to 'the person entitled under law'.⁴⁸ If a post-mortem is ordered or required there will be a delay but that delay may not necessarily hinder the registration of the death if a temporary certificate is issued.

The second type of reportable death, those which occur in nursing homes or care homes, has revealed serious shortcomings. Cusack notes that other jurisdictions do not mandate the reporting of all such deaths and the fact that Ireland does may make Ireland's care home death figures look worse than other jurisdictions.⁴⁹ Admittedly, no jurisdiction has covered itself in glory in terms of protecting care home residents from COVID-19.⁵⁰ Ireland's robust notification system for deaths in care homes is to be commended but it is to be hoped the dire figures on care home deaths prompt reforms so that residents are better protected in future.

The issue with deaths from COVID-19 being reportable to the coroner is that this might delay registration of the deaths. However, the counting of Irish deaths from COVID-19 does not simply rely on the information gleaned from the registration of deaths. The official, State figures might rely on the registered information but the figures reported in NPHE's daily briefings come from the Health Protection Surveillance Centre (HPSC).

⁴⁷ Ibid.

⁴⁸ Ibid.

⁴⁹ Denis A Cusack, 'COVID-19 pandemic: Coroner's database of death inquiries with clinical epidemiology and total and excess mortality analyses in the District of Kildare March to June 2020' (2020) 76 *Journal of Forensic and Legal Medicine* 102072, 4-6.

⁵⁰ See, eg, Adelina Comas-Herrera et al, 'Mortality associated with COVID-19 outbreaks in care homes: early international evidence' (2020), LTCovid.org, <<https://ltccovid.org/wp-content/uploads/2020/06/Mortality-associated-with-COVID-21-May-3.pdf>> accessed 9 June 2021.



The HPSC is 'Ireland's specialist agency for the surveillance of communicable diseases' and 'is part of the Health Service Executive' (HSE).⁵¹ The HPSC came into being in 2005 when the National Disease Surveillance Centre (NDSC), which had existed since 1999, moved to the HSE and was re-named.⁵² The NDSC was never put on a statutory footing despite its first annual report from 1999 noting that there was an intention to put it on a statutory footing,⁵³ an intention that was repeated in 2001,⁵⁴ and then vanished without ever being realised. There was no statutory reference to the HPSC until 2020 when the Health (Preservation and Protection and other Emergency Measures in the Public Interest) Act 2020, amended the Health Act 1947 to require the Minister of Health to have regard to the HPSC's advice when making regulations to control COVID-19.⁵⁵

That being said, the HPSC is empowered by the Infectious Diseases Regulations 1981-2021, to collect data about diagnoses of notifiable diseases.⁵⁶ Data about COVID-19, including deaths, is collected by being entered into the national infection disease surveillance system, Computerised Infectious Disease Reporting (CIDR), which receives data from the eight regional Departments of Public Health (DPH). Laboratory notifications are made directly to CIDR, while clinicians' notifications are added to CIDR via the DPHs.⁵⁷

The CIDR data on deaths is drawn from the information DPHs provide when they investigate cases or from the coroners' files received by the DPHs. The 'HPSC may also receive coroners' files to cross reference with regional DPH data'.⁵⁸ The HPSC also gets daily information from the General Registrar's Office (GRO) about COVID-19 deaths.⁵⁹ There is a slight circularity here as it is unclear how the

⁵¹ HPSC, About HPSC, <<https://www.hpsc.ie/abouthpsc/>> accessed 20 May 2021.

⁵² HPSC, *Annual Report 2004* (HPSC 2004) 3, available at <<https://www.hpsc.ie/abouthpsc/annualreports/annualepidemiologicalreports1999-2016/File,1438,en.pdf>> accessed 3 June 2021.

⁵³ NDSC, *First Annual Report of the National Disease Surveillance Centre* (NDSC 2001), 4, available at <<https://www.hpsc.ie/abouthpsc/annualreports/annualepidemiologicalreports1999-2016/File,521,en.pdf>> accessed 3 June 2021.

⁵⁴ NDSC, *Annual Report 2001* (NDSC 2002), 3, available at <<https://www.hpsc.ie/abouthpsc/annualreports/annualepidemiologicalreports1999-2016/File,519,en.pdf>> accessed 3 June 2021.

⁵⁵ Health Act 1947, s 31A(2)(a)(vi) as amended by Health (Preservation and Protection and other Emergency Measures in the Public Interest) Act 2020, s 10.

⁵⁶ Originally the 1981 regulations required medical officers of health of the public health boards to be notified (Infectious Diseases Regulations 1981, SI 390 of 1981), in 2000 the regulations were amended to indicate the NDSC should be notified (Infectious Diseases (Amendment) Regulations, 2000, SI 151 of 2000, art 4(1)-(2)), and in 2004, the regulations were again amended to remove references to the NDSC and to include references to the HPSC which was described as a centre of the HSE (Infectious Diseases (Amendment) Regulations 2004, SI 865 of 2004, art 4).

⁵⁷ HPSC, *Epidemiology of COVID-19 in Ireland: Frequently Asked Questions*, <<https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/surveillance/epidemiologyfrequentlyaskedquestions/>> accessed 9 June 2021.

⁵⁸ Ibid.

⁵⁹ Ibid.



information required by the CIDR is being supplied if the supplier does not already have a certification from the coroner. As such, the source of HPSC's figures for deaths remains somewhat opaque. It seems as though the HPSC gets figures for likely or assumed cases of COVID-19 which sometimes are de-notified upon further investigation but it also gets delayed figures from the GRO.

Outside of the HPSC's figures, the CSO has experimented with other sources in order to be able to provide more timely and reliable data about excess deaths. Excess deaths form another piece of information used to ascertain the effect a pandemic is having. The CSO worked with information from RIP.ie, an online obituaries service, to calculate 'an estimated figure for excess mortality in Ireland'.⁶⁰ The CSO's partnership with RIP.ie was confirmed by the Taoiseach's department in response to a question in the Dáil from Mattie McGrath, TD.⁶¹ It is striking that data from an online obituaries service is more timely and seemingly more reliable than the official deaths register. Not surprisingly the end result has been to highlight the need for reform of the death registration process in Ireland.

Proposed Reforms to the Deaths Registration Process

In 2021, the government tasked the GRO with undertaking a public consultation around the death registration process. The GRO's consultation includes a table setting out how deaths are registered in other European countries. The table is a little misleading as its information for Northern Ireland says that any death must be registered in five days.⁶² This is inaccurate. NI Direct makes it clear that the five-day period starts when the MCCD is received from a doctor or hospital *not* from the date of death.⁶³ That being said, the current process in Ireland is somewhat unusual with its long time period for registering a death.

The GRO proposes dividing the death registration process into three stages: notification, MCCD certification, and registration. The first stage requires the doctor who pronounces death to notify the HSE within 24 hours. The MCCD stage would stay the same as currently but, under the proposals, the MCCD would also be sent to the HSE and would have to be sent within five calendar days. The registration stage would then see the relative or other qualified person register the death within five

⁶⁰ Dáil Debates 21 April 2021, vol 1005, written question 138, <<https://www.oireachtas.ie/en/debates/question/2021-04-21/138/>> accessed 9 June 2021.

⁶¹ Ibid.

⁶² General Register Office (n 12) 13.

⁶³ NI Direct, Registering a death with the district registrar, <<https://www.nidirect.gov.uk/articles/registering-death-district-registrar>> accessed 20 May 2021.



working days from the receipt of the MCCD. The end result would be that most deaths would be registered no later than two weeks from death instead of three months or more.⁶⁴ The GRO does not anticipate these proposals interfering with the process when deaths are referred to the coroner.⁶⁵

Three points are worth noting about the GRO's proposals. First, they envisage an electronic notification from the doctor pronouncing death and for the MCCD to be sent electronically to the HSE.⁶⁶ Given the May 2021 cyber-attack on the HSE, the proposed benefits of an electronic process over a paper-based process may need some rethinking. At the very least, the May 2021 attack illustrates some key vulnerabilities of an electronic system. Presumably increased cyber security for the HSE will resolve these issues.

Secondly, it is clear that the GRO's proposals have drawn on the practice in other jurisdictions but they have also omitted some practices. For example, the practice in Northern Ireland is that the MCCD should be completed immediately, with the registration of death occurring within five working days of receipt of the MCCD.⁶⁷ The proposed reforms in Ireland echo current practice in Northern Ireland. However, in Northern Ireland, no funeral or cremation can take place until the death is registered.⁶⁸ The GRO's proposed reforms include no such reference to a similar measure in Ireland. Finally, while the proposed reforms do now include independent death notifications, it is likely that the official figures will still rely on actual registration of the deaths.

Conclusions

The COVID-19 pandemic has highlighted the need for reform of many areas in Irish life, including what happens after death. COVID-19 has revealed Ireland's system for registering deaths to be too lenient with respect to time periods allotted for registration. This has meant that the daily reported deaths are sometimes from some time period before, which has skewed how the pandemic is appearing to the public both nationally and internationally. So too has it sometimes meant that deaths are over-counted, though such numbers remain miniscule. The current lack of clarity around how deaths from COVID-19, and COVID-19 cases, are counted in Ireland also cuts against the need for transparency that

⁶⁴ General Register Office (n 12) 6-7.

⁶⁵ Ibid 7-8.

⁶⁶ Ibid 5.

⁶⁷ Births and Deaths Registration (Northern Ireland) Order 1976, s 25.

⁶⁸ Births and Deaths Registration (Northern Ireland) Order 1976, ss 29-30



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is central to 'good pandemic governance'.⁶⁹ It is heartening that legal reforms to the death registration process are being considered and it is to be hoped that the other issues highlighted by deaths from COVID-19 are also similarly addressed.

⁶⁹ Conor Casey, David Kenny, and Andrea Mulligan, 'Public Health Governance: The Role of NPHE', chapter 1 of this report, 11.



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