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Special Issue:
COVID-19 and Legal Responses on the Island of Ireland

Guest Editors:
Ollie Bartlett, Neil Maddox, Ronagh McQuigg and Andrea Mulligan

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COVID-19 and legal responses on the island of Ireland: introducing the key themes

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The COVID-19 pandemic is a public health emergency that is unprecedented in scope. As of April 2022, approximately 500 million confirmed cases of COVID worldwide have been reported to the World Health Organization (WHO), with in excess of 6 million deaths as a result of the virus.[1] In Northern Ireland, there have to date been around 700,000 confirmed cases and over 3000 deaths due to the virus,[2] whilst in the Republic of Ireland, there have been approximately 1.5 million confirmed cases, with around 7000 deaths.[3] This special issue will examine key legal themes that have characterised and conditioned the responses to the pandemic in both jurisdictions on the island of Ireland, as well as connect these themes to developments outside of Ireland.

The special issue arose from a virtual symposium which took place in December 2020, and which was organised jointly by the Irish Association of Law Teachers and the Northern/Ireland Health Law and Ethics Network. The symposium aimed to provide a forum in which researchers who were studying the legal issues arising from COVID-19 policy responses could share insights and discuss connections between their work. Other such fora had already been set up on the island of Ireland and were conducting very interesting work – this symposium hoped to build on this platform by offering perhaps the first opportunity for legal scholars across the island of Ireland and

1 WHO, 'WHO coronavirus (COVID-19) dashboard'.
2 Department of Health, 'COVID-19 Statistics Northern Ireland'.
3 WHO, 'Ireland situation'.

beyond to come together in order to understand how their work on COVID-19 responses might have synergies with that of like-minded colleagues.

The response to the symposium call was heartening, with scholars based across Europe coming together in a one-day, online format to present a mixture of work at various stages of progress. It was clear from the event that interest amongst the legal academic community for debating the legal problems raised by government responses to COVID, as well as the manner in which COVID has exacerbated existing societal issues, runs deeper and broader than many realised. Scholars at the symposium shared insights across a diverse range of legal fields, from human rights to data protection to competition law. This indicated – much as is already known – that COVID has caused problems that can be studied from most legal disciplinary perspectives. It also indicated that there is more dynamic scholarship being conducted by legal academics with a connection to the island of Ireland than many at the event might have thought. Consequently, we hope that through the pages of this special issue we can illustrate the breadth of work that is being conducted on the impact of COVID on this island, and in so doing encourage others to bring forward their own work on what is surely the most all-enveloping societal event of recent history.

The Guest Editors would like to express their thanks in particular to Mark Flear, the Chief Editor of the *Northern Ireland Legal Quarterly*, who gave his time generously to leading the organisation of the symposium, as well as to the initiation of this special issue. We would also like to thank the participants of the symposium for a stimulating debate, the fruits of which are reflected in the pages of this special issue, as well as to the anonymous reviewers who very kindly read and commented on the article drafts. Particular thanks go to Heather Conway, the Co-Editor of the journal, for her support during the process of developing this special issue, as well as to Marie Selwood for her editorial assistance.

It is notable that the responses of the two jurisdictions on the island of Ireland to the pandemic have diverged in many respects, as is analysed in the first two articles in this collection. As Mary Dobbs and Andrew Keenan discuss, pandemics highlight the issue of multilevel governance and where and how powers should be allocated. This issue comes clearly into focus in epidemiological units where internal jurisdictional boundaries exist, as in the case of the island of Ireland. In April 2020, the respective Departments of Health in Northern Ireland and the Republic of Ireland signed a memorandum of understanding which recognised the need for cross-border cooperation in dealing with the pandemic. However, whilst there have been some elements of cooperation and coordination, the governance approaches in the

two jurisdictions have appeared to remain largely independent of each other. The authors thus consider whether the proposed cooperative approach was appropriate in light of subsidiarity and the surrounding context; whether the largely independent approaches by the Republic of Ireland and Northern Ireland were appropriate; and whether a two-island approach might provide a viable alternative.

The article by Katharina Ó Cathaoir and Christie MacColl also discusses the divergences in approach between the two jurisdictions, and considers the two separate legislative strategies which were adopted to tackle COVID-19, despite the island comprising a single epidemiological unit. The authors argue that adopting conflicting approaches, while maintaining an open border, was potentially counterproductive to viral suppression and threatened public compliance. The article evaluates and contrasts the framings of 'reasonable excuses' adopted by the Republic of Ireland in the Health Act 1947 (Section 31A – Temporary Restrictions) (COVID-19) Regulations 2020 and Northern Ireland in the Health Protection (Coronavirus Restrictions) Regulations No 2 (Northern Ireland) 2020. The authors analyse the differing approaches to restrictions on movement and identify discrepancies between the framing of reasonableness in terms of *inter alia* exercise, visiting cemeteries and essential items; and argue that a lack of clear reasoning, alongside the publication of complex legislation and conflicting government guidance, ultimately contributed to a climate of public confusion and created difficulties for enforcement. The article also explores the transparency, clarity and proportionality of coronavirus restrictions more generally and considers the broader implications on human rights.

The next article in this special issue focuses on reshaping relationships between the state and the market during a pandemic. As Emma McEvoy discusses, one of the legislative responses to the COVID-19 pandemic has been the loosening of public procurement rules and policies. Under normal circumstances, the process for procuring medical supplies is time-consuming and administratively burdensome, but in March 2020, the European Union Public Procurement Directives were relaxed to allow procurers to follow quick and simplified procedures. Allowing for the rapid procurement of COVID-19-related contracts was necessary to secure access to emergency supplies from a globally disrupted supply chain. However, the rules still remain in a relaxed state. The article questions if it is now appropriate to restore the full application of the rules and analyses both the positive and negative implications of the use of accelerated procurement procedures.

The special issue then proceeds to focus on data in the responses to the pandemic. Edoardo Celeste, Sorcha Montgomery and Arthit

Suriyawongkul examine digital technology and privacy attitudes in the context of COVID-19. The authors explain how the current pandemic is a 'technological' one, where digital tools are employed for multiple purposes, from contact tracing to quarantine enforcement. The adoption of these technologies gives rise to issues relating to the rights to privacy and data protection. However, privacy and data protection can only be restricted on justified and proportionate grounds, with a complete surrender deemed as compromising the essence of these rights. The authors argue that the widespread mistrust of public and private actors responding to the crisis evidences a divergence between the formal legality of the technological solutions adopted and the legal reality that brings about the Irish public's perception of government measures as potentially infringing their fundamental rights.

Maria Grazia Porcedda then explores the data protection implications of data-driven measures other than apps adopted in Ireland to contain the spread of COVID-19. The author argues that data protection must be approached as a qualified fundamental right enshrined in the Charter of Fundamental Rights of the European Union and given practical application by the implementation of the General Data Protection Regulation and the Data Protection Act 2018 at national level. The article analyses data-driven measures aimed at collecting personal data and special categories of personal data and highlights issues at the level of delivery which affect the legality of such measures in terms of fundamental rights. The author then provides suggestions for redressing the shortcomings of the measures in question.

The final section of the collection focuses on suffering during the pandemic. As Ronagh McQuigg argues, it must be remembered the COVID-19 pandemic has caused serious health concerns beyond actual cases of the virus itself. Since the onset of the pandemic, incidents of domestic abuse have increased dramatically around the world, including on the island of Ireland. Essentially, the lockdown measures which were adopted by many states, although necessary to limit the spread of the virus, have nevertheless had the impact of exacerbating the suffering of many victims of domestic abuse. Those already living in abusive relationships found themselves to be even more isolated and trapped in such situations, given the lockdown and social-distancing measures which have been imposed. In addition, the widespread anxiety caused by the COVID-19 pandemic in terms of health concerns and financial worries increased tensions within many relationships, all too often resulting in violence. The article discusses the increased levels of domestic abuse in Northern Ireland and the Republic of Ireland as a result of the pandemic, and analyses the steps taken in response by each jurisdiction. The author argues that, although meritorious steps were taken to respond to the increased rates of domestic abuse, essentially

the pandemic has exposed and exacerbated pre-existing problems with the responses of both jurisdictions to this issue.

The special issue also includes a commentary in which Ollie Bartlett revisits legislation put before the Dáil on the eve of the COVID-19 pandemic that sought to introduce a right to health into the Irish Constitution. The legislation stalled on account of the election of the 33rd Dáil in February 2020, followed closely by the first COVID lockdown, and the subsequent formation of a new coalition Government in June 2020. However, the author argues that the controversy surrounding policy choices that had to be made during the response to COVID-19, specifically the many which involved a choice between conflicting healthcare and public health priorities, reinforce the necessity of raising once again the debate about a constitutional right to health. As the author illustrates, many of the traditional arguments against constitutionalising a right to health are no longer sustainable in light of the collective experience of COVID. Consequently, a national debate on the future of the right to health in Ireland should no longer be avoided and, indeed, should be prioritised given the need to make reforms to resolve the inadequacies in the existing legal structure laid bare by COVID.

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Territorial approaches to a pandemic: a pathway to effective governance?

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ABSTRACT

Pandemics, including COVID-19, highlight the issue of multilevel governance, where and how powers should be allocated, and the challenge of ensuring coherency. This issue comes clearly into focus in epidemiological units where internal jurisdictional boundaries exist, as in the case of the island of Ireland with the border between Northern Ireland/the United Kingdom and Ireland. This article evaluates the approaches to policy-making on the island of Ireland, and considers whether the two jurisdictions adequately addressed cross-border issues in light of the concept of subsidiarity. The core focus is on a COVID-19 Memorandum of Understanding (MOU) agreed between Ireland and Northern Ireland in April 2020, with consideration also of proposals for a two-island approach. The article argues that subsidiarity would call for a centralised approach or at least substantial cooperation to facilitate effective policy implementation and coherency. The MOU reflects these ideas, through supporting substantial cooperation, but with some significant weaknesses that manifest in its implementation. Alternative issues arise when considering a potential two-island approach. Together, the MOU and the alternative of a two-island approach highlight that context is a crucial consideration for subsidiarity and evaluating the approaches to cross-border issues. It can make centralisation and substantial cooperation (and therefore coherency more generally) significantly more challenging and thereby also highlights the limits of subsidiarity.

Keywords: cooperation; COVID-19; cross-border; governance; Ireland; pandemic; subsidiarity.

INTRODUCTION

Pandemics, such as COVID-19, raise numerous questions and tensions, encompassing issues of human rights, constitutional law, patenting, fairness and much more. One fundamental issue considered here is: where should decision-making powers rest – whether this be regarding restrictions, vaccinations, distribution of resources or otherwise? This article starts from the premise that this is a matter of *public* health and therefore the main roles rest with *public* bodies or decision-makers, rather than focusing on the role of private organisations or individuals (significant though they may be). Instead, the question instead turns to which public bodies, or rather, bodies at which levels?

The answer to this may appear simple at first glance. Pandemics are also a *global* public health issue, since a pandemic by its very nature crosses territorial borders and its impacts are felt worldwide. It would appear logical that an international organisation (eg the United Nations (UN) or WHO (World Health Organization)) should determine public policy, resource-building and distribution etc. However, despite some elements of cooperation or even centralisation, the pandemic was largely addressed on a territorial basis linked to existing power allocations, facilitating varying and even conflicting approaches to a global issue, including within individual epidemiological units.[1] Whilst the significance of cross-border issues,[2] multilevel governance and subsidiarity[3] have been flagged within the literature, it has understandably been limited to date and further investigation is merited. Furthermore, the approach to centralisation within individual nation states has varied, with contrasting examples available.[4]

This article focuses on the island of Ireland, where a single epidemiological unit is divided in two by jurisdictional boundaries – with Ireland to the South and Northern Ireland (part of the United

1 Eg in the US, as noted by A Delaney, 'The politics of scale in the coordinated management and emergency response to the COVID-19 pandemic' (2020) 10(2) Dialogues in Human Geography 141–145.

2 A M Pacces and M Weimer, 'From diversity to coordination: a European approach to Covid-19' (2020) 11(2) European Journal of Risk Regulation 283; A Alemanno, 'The European response to Covid-19: from regulatory emulation to regulatory coordination?' (2020) 11(2) European Journal of Risk Regulation 307; and A Renda and R Castro, 'Towards stronger EU governance of health threats after the Covid-19 pandemic' (2020) 11(2) European Journal of Risk Regulation 273.

3 M Maggetti, 'Beyond Covid-19: towards a European Health Union' (2020) 11(4) European Journal of Risk Regulation 790; and M Dobbs, 'National governance of public health responses in a pandemic?' (2020) 11(2) European Journal of Risk Regulation 240.

4 Eg Delaney (n 1 above) regarding the US and Ireland; and the articles cited in n 2 above regarding the EU.

Kingdom (UK)) to the North. Wide-ranging cross-border issues arise here, highlighted by transboundary river basins, illegal waste dumping and the movement of livestock.[5] The Good Friday/Belfast Agreement (GFA), in conjunction with European Union (EU) membership, acted as a bridge, providing some common foundations and facilitating cooperation on cross-border matters.[6] However, Brexit now exacerbates the challenges in addressing these and other issues, leading to increased regulatory divergence in both substantive and procedural matters, as well as affecting the political will to cooperate.[7] It is in this context that the COVID-19 pandemic arose and was addressed by Ireland and Northern Ireland.[8] There is some early literature on COVID-19 in Ireland and Northern Ireland (or the UK) to date,[9] including elements regarding cross-border cooperation.[10] This literature has flagged the desirability of cross-border cooperation, but also the challenges this poses and the perception of lack of cooperation to date.[11]

This article undertakes a preliminary investigation into the policy-making approaches on the island of Ireland (until November 2021) and whether the two jurisdictions adequately addressed cross-border

5 Eg M Dobbs and V Gravey, 'Environment and trade' in C McCrudden, *The Law and Practice of the Ireland–Northern Ireland Protocol* (Cambridge University Press 2022); C Brennan, M Dobbs and V Gravey, 'Out of the frying pan, into the fire? Environmental governance vulnerabilities in post-Brexit Northern Ireland' (2019) 21(2) Environmental Law Review 84–110; M Murphy, 'Agriculture and environment – what paths will policy take?' (2020) 15 Journal of Cross Border Studies in Ireland 137–148; and C M Fraser, J Brickell and R M Kalin, 'Post-Brexit implications for transboundary groundwater management along the Northern Ireland and the Republic of Ireland border' (2020) 15 Environmental Research Letters 1–13.

6 A Hough, 'Brexit, the Good Friday/Belfast Agreement and the environment: issues arising and possible solutions' report commissioned by the Environmental Pillar in conjunction with Northern Ireland Environment Link (April 2019).

7 Eg Hough, ibid; and Dobbs and Gravey (n 5 above).

8 C O'Connor et al, 'Bordering on crisis: a qualitative analysis of focus group, social media, and news media perspectives on the Republic of Ireland–Northern Ireland border during the "first wave" of the COVID-19 pandemic' (2021) 282 Social Science and Medicine 114111, 2.

9 Eg N Murphy et al, 'A large national outbreak of Covid-19 linked to air travel, Ireland, summer 2020' (2020) 25(42) Eurosurveillance 1–6; B Kennelly et al, 'The Covid-19 pandemic in Ireland: an overview of the health service and economic policy response' (2020) 9(4) Health Policy and Technology 419–429; P Hyland et al, 'Resistance to Covid-19 vaccination has increased in Ireland and the United Kingdom during the pandemic' (2021) 195 Public Health 54–56; P Cullen and M P Murphy, 'Responses to the Covid-19 crisis in Ireland: from feminized to feminist' (2020) 28(S2) Gender, Work and Organization 348–365; and J Morphet, *The Impact of Covid-19 on Devolution: Recentralising the British State Beyond Brexit?* (Policy Press 2021).

10 Eg O'Connor et al (n 8 above).

11 Eg ibid.

issues in light of subsidiarity.[12] To achieve this, it considers three questions: firstly, whether largely independent/unilateral approaches or more centralised approaches by Ireland and Northern Ireland are appropriate. Secondly, whether the proposed cooperative approach outlined in the Memorandum of Understanding (MOU), 'Covid-19 Response – Public Health Cooperation on an All-Ireland Basis'[13] was sufficient. And finally, whether a two-island approach might be a suitable and viable alternative. In considering these questions, the article bears in mind the links between Ireland and Northern Ireland, and with Great Britain (GB) and the EU, whether economic, legal, political, cultural or otherwise. These questions have practical relevance due to the continuing presence of the pandemic, with the development of new variants, the rollout of vaccines and the likely need for new vaccines or booster shots, not to mind the inevitable occurrence of pandemics in the future.

Section one outlines the article's conceptual framework of multilevel governance and subsidiarity, considering the core arguments for allocating decision-making powers according to territories, epidemiological units or otherwise and the desirability of varying degrees of cooperation, communication, coordination and/or centralisation. We would note in advance that there exists a fluctuating spectrum from minimalistic cooperation through to full-blown centralisation of powers. Communication, coordination and coherency can be, in principle, guaranteed where centralisation exists, but may be very limited or non-existent if there is only tokenistic or superficial cooperation. The second section then evaluates the responses on the island of Ireland, including the MOU. It considers the measures taken in both jurisdictions, the timing and interaction of these measures, and the MOU's role since its creation. Finally, section three moves beyond what occurred, to consider the proposal of a two-island approach in light of Northern Ireland's position within the UK, the Common Travel Area and the broad links between GB and the island of Ireland. The implications of EU membership and Brexit will be considered throughout where relevant.

12 Broadly meaning that central authorities should only play a subsidiary or complementary role to decentralised or lower levels, rather than being primary or sole power-wielders. See section one below ('Subsidiarity in responding to a pandemic: territorial versus ecosystem/epidemiological units?').

13 See the Memorandum of Understanding.

SUBSIDIARITY IN RESPONDING TO A PANDEMIC: TERRITORIAL VERSUS ECOSYSTEM/EPIDEMIOLOGICAL UNITS?

Governance is not simply centred on nation states, as per Westphalian sovereignty, but is dispersed vertically (from the local to the global) and horizontally (including private and quasi-private bodies).[14] The result is a mish-mash of power *loci* that presents a highly complex picture.[15] It raises numerous interrelated questions, including how to determine where powers ought to be located, and how to ensure coherency where powers are distributed widely. These questions arise equally in the context of the pandemic, which entails issues of public health but also the economy, international relations, food supplies, intellectual property and more. To consider these questions, we turn to the literature on multilevel governance and regulation and, in particular, the concept of subsidiarity.

Subsidiarity is rooted in theology, economics and democracy[16] and focuses on 'the proper geographic distribution of power'.[17] It acknowledges the existence of numerous levels that could hold the powers, but calls for lower levels to hold these powers (as close to the people as possible)[18] unless there is good reason for the powers to be distributed higher up instead.[19] As discussed elsewhere,[20] this entails consideration of: (i) the significance of the issues in question, 'what degree of homogeneity/consensus or heterogeneity/conflict exists in relation to the issues and to what extent the higher levels could

14 L Hooghe and G Marks, 'Unraveling the central state, but how? Types of multi-level governance' (2003) 97 American Political Science Review 233, 233.

15 A Estella, *The EU Principle of Subsidiarity and its Critique* (Oxford University Press 2002) 114; N Chowdhury and R Wessel, 'Conceptualising multilevel regulation in the EU: a legal translation of multilevel governance?' (2012) 18 European Law Journal 335, 339; and Hooghe and Marks (n 14 above) 239.

16 Eg R Vischer, 'Subsidiarity as a principle of governance: beyond devolution' (2001–2002) 35 Indiana Law Review 103; Y Blank, 'Federalism, subsidiarity, and the role of local governments in an age of global multilevel governance' (2009) 37 Fordham Urban Law Journal 509; M Dobbs, 'Attaining subsidiarity-based multilevel governance of genetically modified cultivation?' (2016) 28(2) Journal of Environmental Law 245.

17 M Landy and S Teles, 'Beyond devolution: from subsidiarity to mutuality' in K Nicolaidis and R Howse (eds), *The Federal Vision: Legitimacy and Levels of Governance in the United States and the European Union* (Oxford University Press 2001) 414.

18 Estella (n 15 above) 81.

19 K Van Kersbergen and B Verbeek, 'Subsidiarity as a principle of governance in the European Union' (2004) 2 Comparative European Politics 142, 144.

20 Dobbs (n 16 above); and Dobbs (n 3 above).

accommodate the elements of heterogeneity';[21] (ii) the effectiveness or efficiency proffered by the different levels, including the potential for externalities and the varying capacity to internalise these externalities via centralising; and (iii) the balance between the previous two points, including potentially a call for dividing the powers over numerous levels. Applying these points to COVID-19 (or any pandemic) is not a simple matter,[22] depends significantly on the context and may potentially change over time.

Furthermore, where powers remain dispersed, ensuring coherency stays a crucial concern.[23] Indeed, where good reasons exist for both centralising and decentralising the powers, the compromise position might be to retain a decentralised approach in conjunction with an array of measures to ensure coherency. This might be achieved via various cooperation mechanisms, including communication, collaboration and coordination, without amounting to outright centralisation and including through binding and non-binding measures.

Homogeneity or accommodating heterogeneity?

An initial appraisal of COVID-19 demonstrates that it encompasses numerous issues relevant to these three points. On the first point, there is the widespread recognition of the importance of public health, human life and combating diseases, and the interrelated issues such as the economy and food security. There is some homogeneity on a very general or superficial level, but when one digs deeper one finds considerable variations (eg regarding the role of the state, prioritisation of conflicting human rights, investment in health systems etc).

Even in the context of a pandemic, there are considerable differences in aims (eg targeting 'zero-COVID', focusing on herd immunity through facilitating the spread of the disease, or simply seeking to moderate the spread and 'flatten the curve' whilst hoping for a vaccine eventually) and approaches (eg physical distancing, financial supports, provision of accommodation and mandatory masks). It is important to note that each decision will entail countervailing risks or conflict with other legitimate aims, for example through using resources intended for other public objectives, or impacting on supply chains for food or medicine. The choice in aims and approaches may be ideological, or simply linked

21 Dobbs (n 16 above) 252.

22 Dobbs (n 3 above).

23 OECD, *Water Governance in OECD Countries: A Multi-level Approach* (OECD Studies on Water, OECD Publishing 2011) 19; European Commission, 'European Governance – A White Paper', COM(2001)428, [2001] OJ C287/1 7–8; and R Brownsword, 'Regulatory coherence – a European challenge' in K Purnhagen and P Rott (eds), *Varieties of European Economic Law and Regulation* (Springer 2014).

to the resources available or current understanding.[24] Thus, sharing of resources or developing understanding might lead to shifts in aims and approaches and thereby facilitate greater homogeneity (as well as efficiency, as discussed below), whereas ideological positions can be more challenging to influence. The identification of a single, uniform correct approach is nigh on impossible, even if specific pathways are more repugnant or acceptable than others. Consequently, some degree of heterogeneity remains highly likely.

As for whether higher levels can facilitate heterogeneity in the case of COVID-19, this depends on the nature of the heterogeneity. Policy goals regarding COVID-19 can be in outright conflict with each other – for example zero-COVID versus enabling the spread to develop herd immunity. These two aims can be maintained only if the two populations remain distinct and isolated from each other (as separate epidemiological units), otherwise there is the risk of achieving neither zero-COVID nor herd immunity, with new variations also arising and spreading throughout both populations.[25] However, if there are shared aims but heterogeneity in the measures or the timing thereof, this may be more easily facilitated. Indeed, as the context will vary at times in different locations, different approaches may be necessary to achieve the same aim, for example local restrictions to prevent overloading the health system.

Therefore, it is necessary to examine localities to identify the varying aims and approaches, to determine the extent and nature of the homogeneity/heterogeneity. If there are no substantial conflicts or if any potential conflicts are limited to those of approaches, understanding or resources, then centralisation may be feasible in principle. If the conflicts are ideological, then more localised approaches may be appropriate if efficient and if negative externalities can be addressed adequately.

Effective and minimising externalities?

Designing effective policy-making for pandemics raises questions of expertise and scientific understanding; resources, including medical, financial, food, water and housing; and potential externalities, including the introduction of new sources of the disease (including

24 Pandemics entail considerable uncertainties, especially at the beginning, eg regarding transmissibility, short and long-term impacts, treatments, vaccine efficacy etc.

25 New Zealand's shift in approach in autumn 2021 exemplifies this. The continued spread of COVID-19 globally and new, more virulent, variants led to fresh outbreaks within the country and the Government considered it too challenging to maintain their zero-COVID approach. B Westcott, 'New Zealand to abandon zero-covid strategy as Delta variant proves hard to shake' (*CNN* 5 October 2021).

new variants) and supply chain disruption (including intentionally). Considerations of efficiency may support substantial centralisation or simply light-touch cooperation and the existing context may impact significantly in practice.

Pandemics rely on scientific expertise and knowledge (including medical), which would typically indicate support, in principle,[26] for centralisation of these aspects, sharing and developing specialist knowledge and expertise, before basing decisions on this. This is exemplified by the existence of the WHO, but is also seen for instance in EU and United States (US) federal agencies. This is especially important for countries that might lack access to necessary resources to develop suitable expertise. However, caveats are required: first, local knowledge and expertise is also essential, for example regarding populations, behaviour and living conditions. Second, when a new disease emerges scientific uncertainty abounds – thus, having one uniform approach or relying on the majority scientific opinion may not be appropriate or adequately 'precautionary'. This is reflected in the evolving understanding of the transmissibility of COVID-19, the development of vaccines and treatments, and the identification and evaluation of new variants. Therefore, sharing expertise, capacity-building and ensuring policymaking is well-founded is essential, but this does not negate the value of local knowledge or necessitate centralisation of the actual policymaking.[27]

The picture becomes more complex when one looks to the issue of limited resources – each individual, population and territory has varying capacity when it comes to essential resources. This has been exemplified during the pandemic, with competition for personal protective equipment, supplies for treatment (eg ventilators),[28] and more recently vaccines. Wealthier countries have taken advantage of their purchasing power for instance to pre-order vaccines,[29] whilst developing countries are left with minimal supplies and with difficulties in distributing what they do possess.[30] The result is a serious, unequal,

26 The practical success and acceptability of such centralisation is questionable, eg J Lidén, 'The World Health Organization and global health governance: post-1990' (2014) 128(2) Public Health 141.

27 Dobbs (n 3 above).

28 Eg D Smith, 'New York's Andrew Cuomo decries "EBay"-style bidding war for ventilators' *The Guardian* (London, 31 March 2020).

29 Eg 'Rich countries grab half of projected Covid-19 vaccine supply' (*The Economist* 12 November 2020).

30 Eg G Steinhauser and N Bariyo, 'Covid-19 vaccines are now reaching poor countries, but not people's arms' *Wall Street Journal* (New York, 12 November 2021).

inequitable and immoral distribution of resources.[31] In the time-sensitive situation of a pandemic, sharing resources equitably may initially impact negatively on those who have disproportionately high supplies. However, not sharing leads to higher burdens on certain populations/territories (frequently already disadvantaged, as lacking capacity to quarantine or treat patients), may lead to broader disruption of supply chains in a globalised world (where components and essential ingredients come from a diverse array of sources) and also may lead to continued spread of the disease through allowing new variants to emerge in some countries.[32] Further, some simply have more than they need and effective distribution is key, for example doctors from Cuba,[33] vaccines from Romania (due to low uptake of vaccinations, sent to Ireland instead)[34] and ventilators and oxygen generation units in Ireland[35] and Northern Ireland[36] (due to lowering the curve sufficiently at the time, sent to India). Sharing resources equitably is not merely just, but also essential pragmatically where possible, indicating that some degree of centralisation is appropriate. Again, this is reflected in the World Bank, International Monetary Fund and G20's temporary debt relief for poor countries,[37] the WHO COVAX programme[38] and the EU's approach to the internal distribution of vaccines.[39] However, where sharing of resources does not or cannot

31 UN Economic and Social Council, 'Unequal vaccine distribution self-defeating, World Health Organization chief tells Economic and Social Council's Special Ministerial Meeting' (ECOSOC/7039, 16 April 2021).

32 Ibid.

33 N G Torres and J Charles, 'Despite US warnings, Cuba's medical diplomacy triumphs in the Caribbean during pandemic' *Miami Herald* (15 April 2020).

34 D McLaughlin, 'Romania plans to deliver vaccines to Ireland in coming weeks' *Irish Times* (Dublin, 30 July 2021).

35 P Hosford, 'Ireland to send 700 ventilators to India to help fight deadly new wave of Covid-19' *Irish Examiner* (Cork, 26 April 2021).

36 'Life-saving supplies flown out to India from Northern Ireland' (*UTV News* 7 May 2021.

37 'Covid-19: G20 endorses temporary debt relief for the poorest countries' (*France24* 15 April 2020).

38 WHO, 'No one is safe, until everyone is safe'.

39 The EU intended to ensure 'equitable access' across the EU: EU Commission, 'Strategy for COVID-19 vaccines', COM/2020/245 final, pt 1. While the main focus is on the EU member states, the Commission also referred to non-EU states, eg 'while leading the global solidarity effort' (pt 1) and noted its commitment to 'the principle of universal, equitable and affordable access to COVID-19 vaccines' globally, including extra support for more vulnerable countries (pt 4). See also discussion of the EU's 2014 Joint Procurement Agreement (to procure medical countermeasures), similarly aimed at equitable and cost-effective access, by E McEvoy and D Ferri, 'The role of the Joint Procurement Agreement during the COVID-19 pandemic: assessing its usefulness and discussing its potential to support a European Health Union', (2020) 11(4) European Journal of Risk Regulation 851.

occur (eg provision of suitable housing in the short term for massive populations), this will also impact policymaking negatively.

However, it is the issue of externalities, and in particular the spread of COVID-19,[40] that poses fundamental challenges and demands at the very least close cooperation and potentially large-scale centralisation of policymaking. Disease spreads through epidemiological units, which might entail the population of a dwelling-house, a town, a country, a continent or all of the above. Isolation or spatial-distancing approaches can temporarily sub-divide an epidemiological unit (potentially according to jurisdictional or territorial boundaries), but once these cease then the disease can continue to spread through the main unit once more. It is essential that epidemiological units at least cooperate carefully and preferably centralise some policymaking if their approach to pandemics, including COVID-19, is to be effective. If not, then the aims can be delayed temporarily, if not hindered indefinitely. For instance, country A might seek to isolate itself or impose internal restrictions, creating temporary units, but if COVID-19 persists elsewhere then, once the restrictions are removed, the disease (including new variants) may spread through country A. This is facilitated by the nature of the disease (highly transmissible) and the mobility of the global population – as exemplified by New Zealand and its reluctant shift away from a zero-COVID approach.[41] However, whether country A seeks to develop herd immunity, flatten the curve or seek zero-COVID, a shift in the population can impact negatively on any of these aims.[42]

Balancing the (re)allocation of powers?

Overall, there are push and pull factors regarding (de)centralisation of powers. Typically, substantial cooperation and especially centralising powers would improve efficiency and help internalise (and negate) negative externalities. Subsidiarity therefore would call for some degree of centralising across epidemiological units if COVID-19 is to be effectively addressed, although building in flexibility to address variations in localities. If this does not occur, substantial cooperation (including communication, collaboration, coordination or otherwise) is essential to ensure coherency and avoid policies being undermined. However, the question of homogeneity or heterogeneity of aims and approaches will vary depending on the context, with knock-on effects for the appropriate allocation of powers. Furthermore, other contextual factors may tip the balance towards or away from the centralising of powers.

40 As mentioned, other aspects such as global supply chains can be negatively affected.

41 See n 25 above.

42 Dobbs (n 3 above).

Generally, bearing in mind the nature of a pandemic, where *loci* share the same aims for the pandemic, the balance would fall in favour of centralisation, in particular, where they are located proximately and/or are in the same epidemiological unit. This would also help resolve conflicts in approach that might undermine the shared aims. In contrast, where *loci* have irresolvable conflicting aims, then subsidiarity would indicate that centralisation is unlikely to be appropriate. Further, while there should be some attempt at cooperation, this may also not be possible on more than a superficial level, instead long-term isolation from the relevant location/population might be necessary, until either the context or the aims have adapted sufficiently. For instance, if one country were ideologically in favour of facilitating the spread of the disease and aiming for herd immunity while another was seeking eradication of the disease, the latter would need to isolate the two populations from each other.[43] Of course, the potential for long-term isolation may also affect pandemic policy.

However, society is not starting from a blank slate. Pandemics occur in an existing context, where ideologies and beliefs are established, where resources are already distributed, and where political, economic and cultural relationships already exist. This includes territorial boundaries, as well as international and domestic laws. These relationships and other factors could (i) affect the decisions about where powers ought to be (re)allocated and/or (ii) need to be amended to facilitate the effective and appropriate allocation and use of powers. Further, if various elements need to be amended, but cannot or will not be in the time available,[44] this may affect the appropriate *loci* of powers, as highlighting conflicting fundamental aims or undermining the potential efficiency of such actions. For example, if a global approach were appropriate in a vacuum, but the constitutions of several nation states prohibited the centralising of power, this would make centralisation unavailable as an option, at least whilst the constitutions remained unaltered. However, this does not necessarily prevent less formal cooperative measures to facilitate coherency. Thus, contextual factors such as the existing territorial boundaries, legal parameters and political, economic and cultural relationships may affect the appropriate *loci* for power, or simply be a complicating factor and need to be taken into account.

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43 This raises further complicated questions regarding the responsibilities of states (and individuals) not to harm others – and whether they can or should be obliged to take measures to avoid such occurrences. This is comparable with ideas of non-transboundary harm in environmental matters and nuisance for landowners.

44 This is particularly relevant in the case of pandemics, due to the time sensitivity of decision-making: amendments to legal relationships may simply take too long.

A final point regarding the passage of time must be noted. A pandemic is an evolving situation; knowledge progresses, treatments and vaccines are potentially developed and tested, and resources are created and dissipated, but also the pandemic and associated policy measures impact society more broadly, for example regarding mental health, employment, food supplies, housing and so on. Further, the context is forever shifting. Therefore, the suitability, desirability and choice of aims and approaches might alter over time. Nonetheless, overall, if policymaking is not centralised, these developments and policy responses will still require corresponding cooperation within and between epidemiological units to ensure coherency and enable COVID-19 to be addressed effectively. Without at least substantial cooperation, the alternative is either long-term isolation/the division of epidemiological units or incoherent, undermined policy.

RESPONSES ON THE ISLAND OF IRELAND – TERRITORIAL IN TANDEM?

This brings us to the island of Ireland, encompassing both Ireland and Northern Ireland. Before considering the aims and approaches, it is worth highlighting once more that there is an open land border and that the two jurisdictions share overlapping communities, economies, cultures and the like. There are also 'cross-border interdependencies', with individuals crossing the border daily for work, education, shopping and recreation.[45] Whether for plants, animals or humans, the island is a single epidemiological unit.

In light of this and the nature of COVID-19, one option is to close the border entirely, thereby splitting the island into two epidemiological units for the duration of the closure.[46] This measure was undertaken in numerous countries across the world, but it has its own repercussions,[47] in particular for border communities,[48] and is also clearly difficult to achieve 100 per cent in practice. It is easier to achieve in isolated jurisdictions (their own epidemiological units) such as island nations – for instance Tonga, New Zealand or Japan – but even there it can be difficult to guarantee non-transmission.

The alternative, which is considered here, is to recognise and address the existing epidemiological unit through effective cross-

45 O'Connor (n 8 above) 3.

46 This was undertaken for foot and mouth disease on the island of Ireland in the 1990s.

47 E Guild, 'Covid-19 using border controls to fight a pandemic? Reflections from the European Union' (2020) 2 Frontiers in Human Dynamics 606299.

48 O'Connor et al (n 8 above) 2–3.

border management.[49] On this basis, there is strong support for centralising approaches on the island or at least ensuring substantial cooperation.[50] However, other factors must be considered to see where the balance lies, including the overall responses and existing powers of both jurisdictions. This facilitates an evaluation of both the MOU and the subsequent implementation (or lack thereof) of the MOU.

Domestic COVID responses on a shared island – a basis for centralising?

In considering the potential reallocation of powers, it is worth highlighting that both Ireland and Northern Ireland hold core powers for public health. This is despite Ireland's position as an EU member state (health largely remains a national competence) and Northern Ireland's position within the UK. The Devolved Settlements[51] divvy up powers between Westminster/the UK and the devolved administrations. Crucially, the devolved administrations, including Northern Ireland, each hold powers in the areas of human health and other objectives impacted by the public health restrictions such as education and enterprise, enabling Ireland and Northern Ireland to take their own measures and to mirror or at least cooperate with each other.

Indeed, the GFA and the related North/South Ministerial Council highlight the existence of these powers and the importance of cross-border cooperation. The Agreement provided under Strand Two for the Council 'to develop consultation, co-operation and action within the island of Ireland – including through implementation on an all-island and cross-border basis – on matters of mutual interest within the competence of the Administrations, North and South'.[52] Not only is this to cover discussions and information exchange, but also 'best endeavours' to adopt 'common policies'.[53] Health is one of the key areas,

49 This is reflected in Ireland's Shared Island Dialogues on public health, see ('Working together for a healthier island') and the environment and climate ('Environment and climate – addressing shared challenges on the island') as well as all-island approaches to plant and animal diseases (eg All-Island Animal Disease Surveillance Report (Department of Agriculture, Food and the Marine of Ireland, Agri-Food and Bioscience Institute and Animal Health Ireland 2020)) or invasive species (eg Kate Stokes, Kate O'Neill and Robbie McDonald, Invasive Species in Ireland (Environment & Heritage Service and National Parks and Wildlife Service 2004) and National Biodiversity Data Centre.

50 O'Connor et al (n 8 above); and G Scally, 'North and Republic must harmonise Covid-19 response' *Irish Times* (London, 31 March 2020).

51 The Scotland Act 1998, the Government of Wales Acts 1998 and 2006, and the Northern Ireland Act 1998. These are supplemented by the MOUs between the UK and devolved governments. See, generally, R Hazell and R Rawlings (eds), *Devolution, Law Making and the Constitution* (Inprint Academic 2005).

52 Strand Two, para 1.

53 Para 5.

including 'accident and emergency planning', 'major emergencies', 'co-operation on high technology equipment' and 'health promotion'.[54] Although not targeted at COVID-19, the foundations are there (in international law and as an exemplar) for substantial cooperation and some degree of centralisation.

Further, in their responses, the two jurisdictions have demonstrated similar attitudes and aims to the pandemic. For instance, the two governments shared the overall approach of 'flattening the curve',[55] similar attitudes to social restrictions,[56] intentions to support workers and businesses,[57] and a desire to keep the Irish border open. Indeed, the governments could be seen to influence each other (whether positively or negatively) throughout the pandemic, as noted below.

This similarity is also reflected in approaches to domestic decision-making, including centralisation and the type of measures chosen, although the timing, detail and extent of measures have varied. Ireland internally demonstrated a centralised approach to the pandemic, with the National Public Health Emergency Team playing a key role throughout the pandemic, alongside the Health Service Executive (HSE) and the Government.[58] This applied to lockdowns, social restrictions, criteria for opening up, vaccines, and so on. This also entailed both national and localised approaches, including, for instance, county lockdowns depending on the rate of infections, or restrictions on visiting care/nursing homes. Effectively, these were treated as individual epidemiological units within the country. Households, and later bubbles, were likewise treated as epidemiological units. Similarly, the approach to tracing and close contacts reflected the central focus on such units, but also the fluid nature of some units and their potential to overlap. Thus, the rules, criteria and enforcement measures were centralised, but the targets for restrictions were on a national, local and/or individual basis. Furthermore, the Government determined, for instance, the core financial supports and criteria for individuals and businesses, and restrictions (or not) on evictions.[59]

54 North/South Ministerial Council, 'Health'.

55 Besides being implicit in measures across the island, see eg '"We are beginning to flatten the curve" – CMO' (*RTE* 25 January 2021); and M-L Connolly, 'Coronavirus: NI outlook positive as curve "flattens"' (*BBC News NI* 21 April 2020).

56 Eg A Nolan et al, 'Obstacles to public health that even pandemics cannot overcome: the politics of COVID-19 on the island of Ireland' (2021) 32(2) Irish Studies in International Affairs, Analysing and Researching Ireland, North and South 225.

57 Eg 'COVID-19 cross border workers' (EURES Cross Border Partnership, 27 March 2020).

58 Eg Delaney (n 1 above).

59 Eg the Residential Tenancies and Valuation Act 2020.

Very little flexibility was available to local decision-makers, whether county councils, other public bodies or educational institutions, to act out of line with the national policy, for example through opening or shutting a facility other than in accordance with national criteria, or deeming someone to be a close contact unless confirmed as such by the HSE. It was still open to individuals and local authorities to act within their existing powers to, for instance, provide outdoor activity spaces, adapt roads and other public areas for enhanced cycling, pedestrian access or dining, and such like.[60] However, while these powers were essential, they would be insufficient to provide the more targeted or nuanced support discussed in a 2020 report from the Organisation for Economic Co-operation and Development (OECD).[61] Instead, the broad stroke of the national Government was applied across the country, reflecting perhaps the time pressure initially and the political difficulties in adjusting supports in particular after they have been announced or experienced.

Northern Ireland largely took similar approaches across the two years, including centralising measures, flattening the curve, local and national lockdowns, travel restrictions, social restrictions and so on. Variations have arisen regarding the specific details (eg limits on distance from home or limits on the number of excursions) or timing of measures, but the fundamentals remain common.[62] Further, whilst politics was a significant feature at times, many of the variations can be understood due to differences in prevalence of the disease, as well as healthcare capacity.

In light of these similarities and the shared island (entailing an epidemiological unit), either centralisation of decision-making or very substantial cooperation would appear suitable and necessary.[63] The basis for doing so already existed within the GFA and the North/South Ministerial Council, but it remained too vague and general. Further,

60 NB decision-makers were still obliged to comply with their legal obligations, including under EU law. Changes to a road, including making it one-way and expanding cycle lanes, without undertaking necessary environmental assessments were considered a breach of EU law: J Kilraine, 'Residents win legal challenge against two-way cycle lane' (*RTE* 30 July 2021).

61 D Allain-Dupré et al, 'The territorial impact of COVID-19: managing the crisis across levels of government' (OECD November 2020).

62 Nolan et al (n 56 above); and O'Connor et al (n 8 above).

63 O'Connor et al (n 8 above) 9. See also n 49 above. As mentioned, the alternative is to close the border and thereby split the island into two epidemiological units, at least temporarily. This was done to a large extent with foot-and-mouth disease previously, but the context has changed considerably since then (post-Troubles, but now with Brexit and Protocol tensions): this is a human disease and it is airborne – all of which impact on the nature of buffers needed and the desirability of such measures.

whilst much work continued behind the scenes, due to the collapse of the Northern Irish Government there was no plenary meeting after November 2016 until July 2020.[64] There was a need for something more tailored for the pandemic.

Memorandum of Understanding

From before even the first confirmed case on the island, the two Ministers for Health indicated their intentions 'to work closely together'.[65] This approach was confirmed by the two Ministers, as well as Northern Ireland's First Minister and Deputy First Minister and Ireland's Taoiseach and Tánaiste in March, who announced that they would do 'everything possible' to coordinate and cooperate in dealing with the virus.[66] Yet, it must be noted that then Taoiseach Leo Varadkar announced the first lockdown in Ireland on 12 March 2020 from Washington, without first having briefed the Northern Executive, stating in the speech that they 'will be briefed'.[67] Swift action was required, but this would not have prevented at least providing the information in advance of an announcement on a global stage.

However, in April 2020, the respective Departments of Health in Northern Ireland and Ireland signed the COVID-19 MOU, acknowledging the need for cross-border cooperation and collaboration in dealing with the pandemic.[68] Indeed, the MOU notes that, as the pandemic 'does not respect borders … there is a compelling case for *strong cooperation* including information-sharing and, where appropriate, *a common approach* to action in both jurisdictions' (emphasis added).[69] Thus, the two Health Ministers 'affirmed that: "*Everything possible will be done in co-ordination and cooperation*"'.[70]

The MOU expressly was building upon existing cooperation between the two jurisdictions in the area of health reflected in the GFA and, for instance, in the provision of hospital treatments to residents from each other's jurisdictions. It was to entail sharing of information, regular engagement between the relevant parties, reporting and so on. Building upon the underpinning principles in section 3 (agility,

64 North/South Ministerial Council, 'Publications'. An institutional meeting did take place in March 2016.

65 'Ministers for Health Simon Harris and Robin Swann Speak on Covid-19' (*Gov.ie* 27 February 2020).

66 'Meeting of Irish Government and Northern Ireland Executive Ministers concerning North South cooperation to deal with Covid-19' (*Gov.ie* 214 March 2020).

67 'Statement by the Taoiseach on measures to tackle Covid-19' (*Gov.ie* 12 March 2020).

68 See MOU (n 13 above) pt 1.1.

69 Ibid pt 1.2.

70 Ibid pt 1.3.

openness, consistency and trust), section 4 outlined the 'commitments' under the MOU related to areas of modelling; public health and non-pharmaceutical measures (eg social distancing); common public messages; behavioural change; research; ethics (including collaborating on decision-making frameworks); and supporting cooperation (including regarding procurement). However, it is worth noting that, despite the principle of consistency, section 7 provides for the possibility to take different approaches in the two jurisdictions. Specifically, 'for justifiable reasons the public health approach and measures adopted in the respective jurisdictions may not always mirror each other in identical fashion'. Common approaches therefore are not guaranteed. However, it continues by noting that 'strong collaborative arrangements, including good information-sharing, should help to mitigate possible negative consequences'.

Whilst not amounting to centralising powers, the MOU is therefore quite wide-sweeping and the rhetoric weighs heavily in favour of strong cooperation, collaboration and indeed coordination or common approaches where possible (and appropriate) – something that would appear logical in light of the nature of the pandemic, the practical links between the two jurisdictions and the shared epidemiological unit of the island, even whilst still maintaining claims to sovereignty and political independence. In other words, an approach on the face of it that would seem to comply with subsidiarity.

However, there are four substantial limitations to the MOU. First, although identifying potential areas of cooperation, the MOU remains vague in what it seeks to achieve: where are the details on cooperation, beyond regular communication and sharing information? It is an outline framework that needs to be developed and fleshed out. Second, its scope is unclear and limited. Does it predominately apply to social restrictions and scientific research or also to elements such as border controls, financial supports and the like? Not only is there no substantive content on these issues, but it is unclear whether the MOU even extends to these. Third, the MOU entails a 'gentleman's agreement' rather than a binding document, reflected in its very provisions. Sections 4 and 8 expressly note that the MOU creates no legally binding obligations on any party, despite section 4 outlining the 'commitments' of the parties – these are simply political commitments. This also explains in part the lack of specificity. Without consequences for breach, there is less reason to include specific obligations or, for instance, to include criteria for lockdowns or easing up social restrictions. Fourth, in addressing the Irish border, the MOU does not deal with the very real significance of Brexit, Northern Ireland's position in the UK, or Ireland's EU membership. Overall, at times the MOU is much like a New Year's good resolution: great intentions, but

capable of being cast aside when inconvenient. In particular, the MOU provides little incentive to cooperate at a high level consistently or deterrence from acting unilaterally. The question remains as to how it operates in practice.

Implementing the Memorandum?

There has been considerable debate, anxiety and media reporting regarding public policy responses on the island of Ireland, including regarding the cross-border approach, the degree of similarity with (and/or disparity between) approaches in Northern Ireland and Ireland, and the significance of this.[71] The perception throughout the pandemic has been that, despite general similarities, there have been significant variations in approach, substance and/or timing, with the border being inadequately addressed.[72] These perceptions have been supported, for instance, by the publicity surrounding high rates of incidence in locations such as Donegal, Derry and Monaghan. However, there can be considerable differences between what is reported, perceptions and what actually has occurred.[73] The discussion that follows is based on a composite of existing data compiled by authors such as Nolan et al[74] and O'Connor et al,[75] as well as fresh empirical research focused on key official websites and national newspapers until November 2021.[76]

The starting point must be to acknowledge that there has been some significant ongoing cooperation on the island.[77] This is seen in joint statements to the public.[78] It is further reflected both in commentary in official documents, such as reports to the North/South Ministerial

71 Eg O'Connor et al (n 8 above).
72 Eg ibid 8.
73 Ibid 8; and Nolan et al (n 56 above).
74 Nolan et al (n 56 above).
75 O'Connor et al (n 8 above).
76 Official sites searched included: gov.ie; citizensinformation.ie; executiveoffice-ni.gov.uk; health-ni.gov.uk; irishstatutebook.ie; merrionstreet.ie; nidirect.gov.uk; northernireland.gov.uk. Newspapers included *The Journal*; the *Belfast Telegraph*; the *Irish Times*; and Reuters. Archives of the sites were also examined, as the pages were updated and revised frequently over the two years.
77 Nolan (n 56 above).
78 Eg agreement to make a joint public appeal by both governments for the Easter weekend in April 2020: 'Tanaiste co-chairs Covid 19 joint ministerial conference call' (*Gov.ie* 9 April 2020); and joint statement by the two Chief Medical Officers in January 2021: 'Joint statement: Chief Medical Officers urge everyone to stay home' (*Gov.ie* 15 January 2021).

Council,[79] and also in the similarities and parallels between official policy and announcements North and South.[80] This is not to claim that there has been either substantial coordination or the development of common policies – this largely does not appear to have been the case[81] – but there was at least considerable communication between key actors. Even without reports indicating high levels of communication, it would not be realistic to believe that both jurisdictions would independently decide and announce the same measures on the same day without such advance communication.[82] Further, a subsequent MOU was signed in November 2020 regarding critical care,[83] supplementing the original April 2020 one. Subsequently, there was also collaboration in developing proximity apps and the sharing of data of passengers entering each jurisdiction.[84]

Nonetheless, cooperation has not been ideal[85] and considerable variations have also existed since the MOU's creation in April 2020. O'Connor et al provide a clear timeline of measures and announcements in Northern Ireland and Ireland between March and September 2020.[86] Nolan et al focus on specific issues and also compare UK-level

79 Primarily seen in the health and safety sectoral meetings and subsequent communiqués, as well as the plenary meetings: see North/South Ministerial Council, 'Publications'. Key politicians and the two Chief Medical Officers engage with these, and the reports consistently emphasise the cross-border communication that occurs.

80 Nolan et al (n 56 above).

81 This is reflected across the responses North and South, but also in the continued statements on 'consider[ing] how agreed collaborative approaches can contribute to', seen, for instance, in both the North/South Ministerial Council Twenty-Fifth Plenary Joint Communiqué, 18 December 2020, and the Twenty-Sixth Plenary Joint Communiqué, 30 July 2021.

82 Nolan et al (n 56 above).

83 Memorandum of Understanding, 'Covid-19 response – cooperation on an all-island basis in regard to provision of critical care between the Department of Health, Ireland, and the Department of Health, Northern Ireland'.

84 North/South Ministerial Council, Health and Food Safety Joint Communiqué, 14 October 2021. This, however, mirrors earlier comments by the same groups, indicating that progress is slow when it comes to actually finalising or agreeing substantive measures: North/South Ministerial Council, Health and Food Safety Joint Communiqué, 26 March 2021.

85 Eg the Foreign Affairs Minister and the UK Secretary of State for Northern Ireland agreed the need to intensify contact between the governments on the island, *six months after* the conclusion of the MOU in October 2020: 'Joint statement on Covid-19' (*Gov.ie* 12 October 2020). Further, in February 2021 the governments agreed to adopt similar approaches – something already proposed in the MOU: 'Joint statement following Quad meeting on COVID-19' (*Gov.ie* 1 February 2021).

86 O'Connor et al (n 8 above).

measures during a similar period.[87] These variations continued over the course of the pandemic.[88] In some instances, these may appear minor. For instance, the two jurisdictions have effectively been leap-frogging each other, for example regarding lockdowns and the easing of restrictions.[89] However, although the measures are relatively similar, even small time disparities in when the measures are adopted can be significant, for instance in incentivising cross-border travel by individuals who wish to shop or simply to get to school or work, when their own localities are heavily restricted.[90]

At other times, the variations are more blatant and of substance, for instance, with contrasting policies arising regarding easing up or intensifying restrictions,[91] dining out, international travel,[92] contact tracing,[93] and the role of vaccination certificates.[94] With most variations

87 Nolan et al (n 56 above).

88 As confirmed by the empirical research undertaken for this paper. For instance, between March and October 2021, the two jurisdictions announced general plans for opening up; review periods; the return of students to school; the return of sports matches; socialising between households; and opening up of the hospitality sector.

89 Eg varying dates for different students to return to schools: 'Executive agrees a number of early relaxations to Covid-19 regulations' (*Executive Office* 16 March 2021); 'Letter to school principals 23 February 2021' (*Gov.ie* 24 February 2021); 'Government announce the further reopening of primary schools' (*Irish National Teachers' Organisation* 8 March 2021); and 'Government announces phased easing of public health restrictions' (*Gov.ie* 30 March 2021) This could also indicate a level of competition between the jurisdictions, which can lead to swift and decisive measures or alternatively a 'wait and see' approach – both of which have their advantages and disadvantages in a climate of uncertainty.

90 M McDonagh, 'Covid rules: "People were travelling over the border from Donegal all the time"' *Irish Times* (Dublin, 13 October 2021).

91 Eg at the end of November/early December 2020, Northern Ireland initially introduced further restrictions: 'Executive agrees two-week circuit breaker' (*Executive Office* 19 November 2020); while Ireland relaxed measures 'Dáil speech by the Taoiseach Micheál Martin on COVID-19' (*Gov.ie* 24 November 2020); and 'Special measures for the Christmas period come into effect' (*Gov.ie* 17 December 2020).

92 Eg with Ireland adopting the EU system, 'Ireland to phase in EU "traffic light" travel system from Sunday' (*Reuters* 4 November 2020).

93 K O'Sullivan, 'North and South's diverging Covid systems are harming response to case surges' *Irish Times* (Dublin, 16 October 2020).

94 Eg O'Connor et al (n 8 above). Unlike in Northern Ireland, proof of vaccination was required for dining in restaurants and accessing certain venues in Ireland, as laid out in Health Act 1947 (ss 31AB and 31AD) (COVID-19) (Operation of Certain Indoor Premises) Regulations 2021 (Revised), SI 385/2021. Further, Ireland retained social distancing requirements on public transport and more generally in autumn 2021: 'Measures in place from 22 October' (*Gov.ie* 19 October 2021); in contrast with Northern Ireland, eg 'Statement on Executive decisions – social distancing' (*Executive Office* 27 September 2021).

in policy content, there is an incentive for individuals to travel to avail of laxer conditions (for those who seek them),[95] not to mind providing counter examples of policy measures that may undermine trust and compliance within an individual's own jurisdiction. Although there may have been extensive communication and there may be good reason for the variations, perhaps because of lower or high case numbers in one jurisdiction (or part thereof) and limited or extensive resources, the simple existence of a variation can lead to incoherency and pose cross-border issues.

This brings us to the final point, which is the failure for the main part to address cross-border issues directly. This for instance is seen in the inapplicability of internal travel restrictions in Ireland on those from Northern Ireland for a considerable period of time,[96] the inability of those living in one jurisdiction (subject to lockdown) but working in the other (not subject to lockdown) to avail of payment support, the differing unemployment supports for cross-border workers,[97] or closing one's eyes to the potential for individuals to travel from overseas through one jurisdiction to the other (eg from London via Belfast to Dublin, or from Paris via Dublin to Belfast)[98] despite having different rules on incoming passengers.[99] Further, the situation in some border communities merited joint action, if only due to the very challenging circumstances there: Donegal, for example, was repeatedly in the news in 2020 and 2021 for high case numbers, cross-border travel between Derry and Donegal, and later the low uptake

95 Eg McDonagh (n 90 above).

96 '"The virus does not respect the border" – Community "frustrated" laws cannot be enforced on NI day trippers' *Irish Examiner* (Cork, 26 April 2020).

97 Prior to the MOU, the Irish Government announced that cross-border workers resident in Ireland could be eligible for the PUP (pandemic unemployment payment), but that cross-border workers resident in Northern Ireland would not be: 'Covid-19 cross border frontier workers' (*Gov.ie* 30 March 2020). Northern Ireland provided support for the latter category, but it was considerably lower in Northern Ireland and this situation remained the case after the MOU was signed (see ibid and n 57 above).

98 This was acknowledged at times, but still inadequately addressed: J Power, 'Covid crisis: UK travel ban extended until December 31st' *Irish Times* (Dublin, 22 December 2020).

99 Eg 'COVID-19 (coronavirus)' (*Tourism Ireland* 27 September 2021); and M Fagan, '"Thousands will fly from Belfast next month," Irish travel agents warn' *Irish Examiner* (Cork, 11 May 2021).

of vaccines.[100] Hence, in June 2021 we saw the two Chief Medical Officers call for caution by those crossing the border,[101] but this was a limited and rare proclamation on the border. There is clear need for more consistent, widespread, substantive cooperation, going beyond general communication towards joint action and coordination. One major positive counterexample is the expansion of the EU COVID vaccination certificate to Irish passport holders vaccinated in Northern Ireland.[102] However, this is a cumulative requirement and does not address any others resident in Northern Ireland.[103]

Consequently, the MOU's strengths and limitations on paper are reflected in practice. Communication has typically been strong, with information shared and updates provided between the key scientists, medical officers and politicians. However, communication is the most minimal level of cooperation, without deep collaboration or coordination – common policies have been mentioned and discarded, despite the rhetoric in the MOU and the occasional incoherency of policy on the island. The practice is such as to fall far short of what is desirable in light of subsidiarity, indicating that further detail and legally binding commitments, if not full-blown centralisation, might be necessary.

Contextual factors: challenges for cooperating?

So, if the two governments recognise the need for cooperation, why not commit legally to it and not simply politically? Why not create specific, binding obligations tailored for COVID-19? Or indeed, why not at least keep to the political commitments? Beyond the general dislike of being bound legally and the delays involved in developing international agreements, a number of key reasons arise in this context that may explain the governments' seeming reticence. First, the surrounding uncertainties, including how long the pandemic might last, the economic and broader health implications, and the availability of effective vaccines or treatments, make such agreements challenging to design. What if one government's situation changes or they wish to

100 Eg McDonagh (n 90 above); A Molloy, 'Delta in Donegal – "If there's an outbreak in Derry, it will impact here … the border is irrelevant"' (*Independent.ie* 6 July 2021); M Fagan, 'Interactive map shows Ireland's Covid hotspots as rates of infection accelerate' *Irish Examiner* (Cork, 6 July 2021); 'Covid-19: Republic's case rates highest near Derry border' (*BBC News* 3 July 2021); and P Cullen, 'Covid-19: hard-hit Monaghan, Donegal have lowest inoculation rate' *Irish Times* (Dublin, 8 September 2021).

101 See 'Joint statement' (n 85 above).

102 'EU Digital COVID Certificate Third Country portal launches today in Ireland' (*Gov.ie* 29 September 2021).

103 'Covid-19: EU vaccine cert opens for Irish passport holders in NI' (*BBC NI News* 30 September 2021).

adapt their approach? Second, politics plays a substantial role, whether this is not wanting to be seen to be working with (or bound to) other political groups or indeed simply other countries/jurisdictions.[104] For instance, it does not necessarily sit well with Unionists or their voters to be bound in policymaking to actors in Ireland, especially if this is simultaneously conflicting with policy made in Westminster or generally across the rest of the UK. This makes all-island policy more sensitive for others and challenging to propose or implement. Third, Northern Ireland does not have the power to create legally binding international agreements – this remains a reserved power within the UK.[105] And fourth, both Northern Ireland and Ireland have close links with other territories, including most obviously GB and also the EU, reflected in the Common Travel Area between Ireland and the UK, and the free movement of persons in the EU. People, animals and goods are travelling overseas regularly, in particular between the island of Ireland and GB. However, to take a joint approach and treat the island as one unit for the purposes of the pandemic might lead to travel restrictions within the UK (between GB and Northern Ireland) or within the EU (between Ireland and the rest of the EU) to safeguard the island and/or to safeguard the rest of the UK or the EU, reflecting the challenges of Brexit and the Northern Ireland Protocol for the border.

The first point is a practical issue that could be addressed in the design of the documents, whether in providing for review clauses or otherwise. However, the remaining three reasons centre largely on Northern Ireland's (and to a lesser extent Ireland's) relationship with GB, and on Ireland's (and to a lesser extent Northern Ireland's) relationship with the EU. While the UK Government could in principle conclude an agreement on behalf of Northern Ireland, it still does not address the other embedded elements. Thus, the legal, political, cultural and economic aspects impact the application of subsidiarity and raise the question of whether the island is the appropriate level for situating policymaking powers.

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104 Further, by avoiding legal commitments and being willing to break or at least bend the political ones, there was the potential for political one-upmanship whether by individual politicians, parties or governments (since both governments involve more than one political party) – as highlighted by the competitive aspects noted above. This, however, is a double-edged sword and is also not something that will be argued as a reason to avoid making commitments – it is therefore less likely to pose a fundamental constraint by itself.

105 Whilst Ireland is also bound by EU law, this does not prevent the conclusion of such agreements where they do not conflict with EU law; as mentioned, health is largely a national competence, so this would seem initially to facilitate independent action.

A TWO-ISLAND APPROACH?

A key alternative approach to that of focusing solely on the island of Ireland is to focus on what has been referred to as a 'two-island approach' or, more accurately, on an approach for Ireland and the UK. This has been mooted by political commentators, scientists, journalists and even the politicians themselves, with varying degrees of approbation.[106] It is also something that the GFA could facilitate, as Strand Three addresses the relationship between the UK and Ireland and provides mechanisms for engagement between various British and Irish institutions, including the British–Irish Intergovernmental Conference and the British–Irish Council.[107]

There are clear advantages to such an approach that relate directly to many of the challenges for an all-island approach. From a legal perspective, the power to negotiate international agreements (including therefore with Ireland regarding public health cooperation) rests with the UK Government rather than devolved administrations,[108] enabling for strengthening approaches relative to those found within the MOU. Furthermore, it is the UK Government that determines the funding available to the devolved administrations,[109] including funding for developing public capacity, for providing support for businesses and individuals whilst restrictions are in place and in the aftermath of the pandemic, and for purchasing PPE and/or vaccines. Without this funding, public health policies may simply be empty words.

From a political perspective, individuals in Northern Ireland in particular may be more amenable to adopting an approach that is agreed in a collaborative manner between the UK (including the devolved administrations) and Ireland and applies uniformly across

106 As early as March 2020, key politicians (Tánaiste, First Minister, Deputy First Minister, Secretary of State for Northern Ireland and the two Health Ministers) on the island noted a 'compelling case' for cooperation between North and South, but also between Ireland and the UK as a whole: 'Statement on response to COVID-19 on the island of Ireland' (*Gov.ie* 31 March 2020); 'DUP says a two-island approach to international travel is worth "exploring"' (*The Journal* 14 February 2021).

107 See Hough (n 6 above).

108 Eg D Torrance, 'Reserved matters in the United Kingdom' (House of Commons Library, CBP 8544, 5 April 2019); and Memorandum of Understanding and Supplementary Agreements between the United Kingdom Government, the Scottish Ministers, the Welsh Ministers and the Northern Ireland Executive Committee (October 2013) 8.

109 This is typically according to the Barnett formula. M Keep, 'The Barnett Formula' (House of Commons Library, CBP 7386, 23 January 2020) s 1.2.

the two islands, rather than following either Ireland or England to the exclusion of the other.[110]

Further, economically and culturally, the links are not simply present between Northern Ireland and Ireland, but also between both of these and GB and within all of GB. This is reflected in the Common Travel Area as noted, but also for instance in the level of economic interdependence between Ireland and the UK even after Brexit in that GB and then Ireland are the primary markets for NI produce such as agri-food produce, and goods and workers cross the borders daily (in all directions). The combination of these factors is reflected in the reluctance to impose restrictions on people travelling between GB and the island of Ireland, not to mind the fuzziness of restrictions when individuals could travel from GB to Northern Ireland without isolating and also from Northern Ireland to Ireland, but not GB to Ireland. Consequently, not only is there a case to be made that the jurisdictions comprise a single epidemiological unit, or at least two with overlapping boundaries, but also the political and legal relationships would indicate that this might be a viable alternative and appropriate in light of subsidiarity.

This would not necessitate an identical or a joint approach, but could entail substantial cooperation, including communication, collaboration and coordination on the nature of restrictions, border controls, vaccination programmes and the sharing of resources to facilitate all of the above. If common approaches are not always the case, at least cooperation could avoid conflicts. The eventual aim would be to create a single epidemiological unit encompassing the two jurisdictions that has either eradicated COVID-19 or has developed sufficient resistance within the population (through vaccination and/or antibodies) to ensure herd immunity, with measures in the meantime to protect the vulnerable, slow the spread of the disease and ensure the functioning capacity of the health system (to address existing needs and those posed by the pandemic).

However, key interrelated challenges arise relating to overlapping boundaries once more and also ideologies. These include the complexities of UK constitutional law and devolution; membership of the EU and Brexit; politics/political relations on the two islands; conflicting aims and approaches regarding COVID-19, including underpinning ideologies; and globalisation, which has been addressed above.[111]

First, UK constitutional law and the relationship between the UK Government and the devolved nations is complicated. Whilst the UK

110 See *The Journal* (n 106 above).

111 This factor affects Ireland, Northern Ireland and Great Britain differently, but a deeper investigation of this point is beyond the scope of this article.

Government retains the powers to conclude international agreements, controls funding to the devolved administrations and, ultimately, there is (Westminster) parliamentary sovereignty,[112] nonetheless devolution exists and the devolved nations have their own views and voices.[113] This has been reflected in varying approaches at times to COVID-19 across the UK.[114] Further, the UK Government is also dependent on the devolved administrations to implement and uphold UK-wide policy or agreements. Overall, logically there should be a preference for collaborative approaches between the devolved and centralised administrations to developing policy, as reflected in the development of common frameworks for post-Brexit,[115] but in practice these can be slow and difficult to achieve even where similar aims are supposedly held.[116]

Second, Ireland and the UK/devolved administrations are not the only actors involved. In particular, the EU and Brexit must be considered.[117] Ireland remains an EU member state, whereas the UK is no longer one, despite the halfway-house status of Northern Ireland due to the Northern Ireland Protocol.[118] Ireland must abide by EU law, including for instance facilitating the free movement of goods and persons. It must also protect the borders of the EU because, for example, Ireland (and Northern Ireland) is bound to impose sanitary and phytosanitary checks on imported animals and plant products and controls on the importation of medicines and medical devices. The corollary is that Ireland garners the benefits of EU membership, including here access to medical equipment or vaccines procured by the

112 M Elliott and R Thomas, *Public Law* 4th edn (Oxford University Press 2020) 5 and 77ff. The limits of devolution vis-à-vis parliamentary sovereignty are reflected in the Sewel Convention (HL Deb 21 July 1998, vol 592, col 791) and *The UK Withdrawal from the European Union (Legal Continuity) (Scotland) Bill* [2018] UKSC 64.

113 G Anthony, 'Devolution issues, legislative power, and legal sovereignty' (2015) Le Droit Public Britannique: État des Lieux et Perspectives 95.

114 J Sargeant and A Nice, 'Coronavirus lockdown rules in each part of the UK' (*Institute for Government* 19 October 2021).

115 Joint Ministerial Committee (EU Negotiations), 'Communiqué – Common Frameworks: Definition and Principles' (16 October 2017).

116 House of Lords, Common Frameworks Scrutiny Committee, 'Common frameworks: building a cooperative union' (First Report of Session 2019–21, HL Paper 259, 31 March 2021).

117 Eg M Dayan, 'How will Brexit affect the UK's response to coronavirus?' (Nuffield Trust October 2020) 13–14.

118 McCrudden (n 5 above). To avoid a hard border on Ireland and ensure peace, the Northern Ireland Protocol treats Northern Ireland somewhat as part of the EU single market and requires NI to comply with some EU laws – Dobbs and Gravey (n 5 above). The Trade and Cooperation Agreement is of limited relevance to the discussion here.

EU on behalf of the member states, as well as recognition of vaccination status. Although early on each member state was taking its own approaches when it came to restrictions (or the lack thereof), there are now some elements of harmonisation[119] including the EU vaccination certificate.[120] Whilst Ireland and the UK can share resources and cooperate to a large degree regarding COVID-19, the distinction created by EU (non-)membership[121] creates too great hurdles at times for full centralisation, for instance access to the EU Digital COVID certificate for the purposes of travel.[122] EU–UK data-sharing, which is of considerable significance, highlights these differences and also the potential for (temporary) resolutions that facilitate cooperation.[123]

Third, as with an all-island of Ireland approach or considerations of devolution, nationalism and unionism, a two-island approach raises political issues and not simply legal ones. A collaborative approach might be broadly acceptable, but if there were centralisation, where would the decision on behalf of everyone be made? Are devolved nations to have an equal say as Westminster and Dublin? Are Westminster and Dublin to have an equal say? What would the optics be? Each grouping would be seeking to not appear as if they were adopting policies or approaches determined or even heavily influenced by others and simultaneously might also need to not appear to be dictating policy for others. For example, Dublin would not wish to appear weak vis-à-vis Westminster or stepping on toes when it comes to Northern Ireland; Westminster would not wish to appear weak vis-à-vis Dublin or the devolved administrations (for the sake of their own electorates), but would also wish to not step on the toes too much of the devolved administrations (for the sake of the union). Furthermore, in the context of Brexit, 'taking back power' and the desire to reclaim sovereignty, it will be important for the UK Government in particular not to seem overly swayed by Dublin or indirectly by the EU.

Finally, there is simply the difficulty that the fundamental aims of the various administrations are not consistently the same or compatible. In particular, England, which accounts for approximately 82 per cent of the population in the UK and approximately 75 per cent of the

119 Pacces and Weimer (n 2 above); and Renda and Castro (n 2 above).

120 European Commission, 'EU digital COVID certificate'.

121 Eg Dayan (n 117 above). ,

122 'The EU vaccine "passport" and what it means for travel' (*BBC News* 6 August 2021).

123 Eg Commission implementing decision pursuant to Regulation (EU) 2016/679 of the European Parliament and of the Council on the adequate protection of personal data by the United Kingdom, Brussels, C(2021)4800final. This remains conditional on the UK at least maintaining equivalence with the EU's standards: N O'Leary, 'EU warns over post-Brexit data agreement with UK' *Irish Times* (Dublin, 26 August 2001).

population across the two islands, has shifted its aims on occasion. Early statements and behaviour indicated that the UK Government was seeking to develop herd immunity by letting the disease spread, whilst providing some protection to the identified vulnerable population.[124] Whilst the UK Government abandoned this, switching to the 'flatten the curve' approach, it appears that herd immunity may have become the underpinning aim once more – via a combination of enabling the spread and vaccination – with a considerable easing-up of restrictions, emphasis on individual responsibility and acknowledgment of the inevitable increase in deaths.[125] This raises numerous concerns, including that vulnerable people may not yet be sufficiently vaccinated (or even identified as vulnerable), the number with 'long-COVID' will increase, hospitals may become swiftly overburdened, and new variants may continue to develop.[126] Further, from a governance perspective, it raises the question of how this will impact or be impacted by contrasting policies in the rest of GB or in Northern Ireland or Ireland. The populations are not fixed and it is questionable whether herd immunity will be achieved in the short or long term in England[127] and also whether this will lead to the further spread of the disease across the islands – especially if individuals might be incentivised to travel to England to enjoy looser controls, before returning to Wales, Scotland, Northern Ireland or Ireland.[128]

Each of these elements makes a two-island approach much more complex than it might first appear. Of the hurdles examined, the most challenging elements are not the legal restrictions but the political (not wishing to be seen to be influenced or controlled by others, or aligning with or going against specific bodies), economic (the financial costs of the restrictions, whether and how resources should be shared and the significance of cross-border travel) and ideological (whether herd immunity should be facilitated by allowing the spread of the disease or not). In principle, if each part of the UK and Ireland succeeds in developing herd immunity through spread of the disease and/or vaccinations and boosters, then the aims will no longer be in conflict with each other and a more centralised approach would be possible.

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124 Eg C O'Grady, 'The UK backed off on herd immunity. To beat COVID-19, we'll ultimately need it' (*National Geographic* 29 March 2020).

125 'Guidance: moving to step 4 of the roadmap' (*Gov.uk* 27 August 2021).

126 'Covid: why are UK cases so high?' (*BBC News* 22 October 2021); and A Kleczkowski, 'Relaxing restrictions hasn't made COVID cases spike – but this doesn't mean herd immunity has arrived' (*The Conversation* 15 October 2021).

127 While those recovered from COVID-19 have antibodies that provide some protection, it is now clear that individuals can contract the disease a second time. Further, new variants are emerging and will continue to do so.

128 Or in other directions if approaches shift.

However, even the vaccines are shown to already require boosters for new variants and uptake is slowing down, whereas immunity from contracting the disease does not last indefinitely. Consequently, for the foreseeable future a centralised or joint approach is not feasible where aims conflict. A choice is left: segregate the jurisdictions indefinitely, change aims to mirror each other or engage in strong cooperation to help ensure coherency and avoid aims being undermined. Thus, strong cooperation becomes increasingly challenging, but also fundamental to any jurisdiction seeking to tread its own path.

CONCLUSION: COOPERATION AND COORDINATION IN A FRAGMENTED, GLOBALISED WORLD?

Subsidiarity appears complex, but is simply a logical tool that argues for centralisation or at least cooperation where questions of efficiency and difficulties of negative externalities demand it. The complexity is the natural mirror of the situation at hand, exemplified by pandemics.

The nature of a pandemic, as well as globalisation with shifting populations and long supply-chains, means that decision-making needs to look beyond the existing territories to epidemiological units. An approach is needed that recognises the overlapping of these units – as broad, coherent and cooperative as possible – not just for restrictions, but also for resources, vaccinations, food supplies and so on.[129] From the perspective of efficiency and effectiveness, this could entail decision-making ideally at a global level or at least on the basis of epidemiological units, preferably through centralisation or at least substantial cooperation.[130]

However, subsidiarity also takes into account contextual factors, including current legal, political, economic and cultural conditions and relationships. Relevant powers are not currently fully centralised or on the basis of epidemiological units, but instead are primarily aligned to fragmented jurisdictional boundaries. Subsidiarity does not necessitate dispensing with existing territories or allocations of powers, but it requires the recognition of the limits of individual, artificial boundaries to deal with pandemics. The choice could be to map the territories (whether via centralisation or substantial cooperation) onto the epidemiological units or to somehow impose restrictions on the

129 Eg S Scarpetta, 'Access to COVID-19 vaccines: global approaches in a global crisis' (OECD 18 March 2021).

130 Cf Allain-Dupré et al (n 61 above) OECD report.

epidemiological units to map them onto the territories, for instance through isolating country A from B.[131]

The island of Ireland exemplifies both the value of and challenges for centralising, or even substantial cooperation. There is clear merit in a cross-border or all-island approach – whether through centralising or substantial cooperation – reflected in its single epidemiological unit status, links on numerous fronts and provision in the GFA for cooperation on public health, as recognised in political discourse on the pandemic. Yet, the current MOU is clearly insufficient in nature and substance, reflected in its limited implementation and lack of focus on border communities. A revised MOU would benefit from greater specificity and binding commitments, including perhaps being bolstered by a binding agreement between the UK and Ireland (with Northern Ireland's accord). Alternatively, or alongside this, Ireland and Northern Ireland could establish mirroring policy and legislation, with a cross-border body tasked with ensuring they function smoothly in parallel. This is legally possible under domestic and EU law (within limits) and is supported by the GFA.

However, when examining potential reasons for the current MOU's limitations, the thread starts unravelling. Legal issues are only one factor, with political, economic and cultural aspects also key. This has been exacerbated more recently with the continuing conflicts over the Northern Ireland Protocol, and building all-island cooperation (without GB also) currently[132] seems increasingly unlikely. It becomes clear that the existing context, including the very relationships between Ireland, Northern Ireland and the UK as a whole, make the implementation of subsidiarity sufficiently challenging that it might be necessary to rethink the appropriate *loci* for powers or who should be cooperating.

Consequently, it might be necessary to include GB alongside Ireland and Northern Ireland in a two-island approach instead, reflecting the more complex (legal, political, and economic) relationships across the island and the overlapping epidemiological units. This could resolve several of the challenges to cooperation on the island of Ireland and, if possible, would still be an appropriate application of subsidiarity. However, new challenges arise there once more due to the context, including internal UK politics, Ireland and the UK's contrasting relationships with the EU, relationships globally and, most fundamentally, potentially conflicting aims or core approaches to COVID-19. Although complex, if Ireland and all of the constituent parts

131 The latter may be desirable temporarily where conditions are significantly different (eg COVID-19 is present in one part, but not yet the other) or long-term where the fundamental aims conflict.

132 This flags the importance of developing general foundations for cooperation (beyond the limited ones in the GFA) when conditions are most favourable.

of the UK could resolve their differences regarding the underpinning aims and approaches to COVID-19, this would make a two-island approach both more feasible and more appropriate. Without resolving these differences, cooperation is simultaneously more challenging and more important.

However, the story does not end there and Ireland and the UK must look beyond their territories once more and engage globally if there is to be an effective, long-term resolution to this pandemic or others in the future.[133] An all-island or even two-island approach, in a globalised world where there is significant widespread disparity in resources and the capacity to respond to the pandemic, can only be an effective strategy in the short term. Resource-sharing and equitable treatment is required not merely for the sake of fairness and human rights, but also to ensure herd immunity (through vaccination or otherwise) or eradication globally.

This analysis of the island of Ireland also provides insights into subsidiarity's application. The initial evaluation of COVID-19 was premised largely on the nature of a pandemic, taking into account the potential for limited resources or conflicting aims. Despite some caveats, it demonstrated a clear need for centralising powers or at least substantial cooperation within a single epidemiological unit. However, applying the concept to specific jurisdictions demonstrates that the context can have a major impact on the initial identification of power *loci* and also demand a review of the original conclusions. For instance, contextual factors may indicate that other fundamental beliefs and aims (eg sovereignty and identity) should weigh on the considerations of democracy and homogeneity/heterogeneity (subsidiarity's step 1), despite being less directly relevant to COVID-19; some contextual factors may arise that are too challenging to amend (at least in the short-term) and may affect the efficiency and effectiveness (subsidiarity's step 2); and thereby, together affect the balance of whether (de)centralisation or alternative forms of cooperation should occur or are even possible. Thus, a clear conflict may arise in subsidiarity's application, between what ought to arise in a relative vacuum and what ought to arise in context.

Finally, the island of Ireland highlights that the desirability under subsidiarity to centralise powers or at least have substantial cooperation with other *loci* is not limited to just one level or space. For instance, for Ireland, while the most obvious focus is centralising or cooperating with Northern Ireland, it is necessary also to consider the UK and the EU due to the overlapping relationships and indeed effectively overlapping epidemiological units. The context could also change the desirability of

133 Dobbs (n 3 above); and UN Economic and Social Council (n 31 above).

which *loci* to consider cooperating or centralising with. What if Ireland and Northern Ireland had fundamentally opposing aims vis-à-vis the pandemic and they decided to close the border, thereby attempting to divide the island into two epidemiological units? Whom might each cooperate with instead? Nobody or those with whom they have close relationships, shared aims and could perhaps create new units within a globalised world? The natural choice for Northern Ireland would remain GB/the UK, provided the context permitted. For Ireland, the natural choice of the EU is complicated by the variations in aims that arose across the EU member states.

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COVID-19 restrictions in Ireland and Northern Ireland: a comparison of the legal framing of reasonableness

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ABSTRACT

In 2020, Ireland and Northern Ireland implemented separate legislative strategies to tackle COVID-19, despite the island comprising a single epidemiological unit. This article evaluates and contrasts the framing of 'reasonable excuses' in the regulations adopted by Ireland and Northern Ireland between March and December of 2020. It submits that the rejection of an 'all-Ireland' approach, side by side lack of effective regulatory coordination and enforcement, likely had implications for transmission in each state.

The regulations have entailed far-reaching incursions on civil liberties, often without providing the public with a clear evidence base. The complexity of the legislation as well as conflicting government guidance, contributed to a climate of public confusion, which created subsequent difficulties for enforcement, notably in the border regions. Insufficient coordination undermined measures by allowing for loopholes to be exploited. The article reflects on the human rights implications thereof, focusing on transparency and proportionality.

Keywords: COVID-19; Ireland; Northern Ireland; European Convention on Human Rights; reasonableness; human rights; free movement; article 8; foreseeability.

INTRODUCTION

The island of Ireland is comprised of two separate jurisdictions, one sovereign and one part of the United Kingdom (UK), but both are closely connected for the purposes of public health and an area

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of North–South Cooperation.[1] As the border is free from physical crossings courtesy of the Common Travel Area (CTA), the two jurisdictions can furthermore be considered a single epidemiological unit.[2] Yet, at the outset of the COVID-19 pandemic, the respective legislatures adopted curious 'one island, two strategies' legislative approaches. In other words, the Northern Ireland Assembly rejected an all-Ireland approach to coronavirus restrictions, yet neither nation imposed border controls.

The Irish/Northern Irish decision to maintain its invisible border is distinct from other European Union (EU) countries. While borderless travel has become an expectation for many Europeans, in 2020, EU member states closed borders or restricted entry to bring the pandemic under control. This included countries subject to the Schengen agreement with (like Ireland and Northern Ireland) historically fluid borders and close cultural ties, such as Denmark and Sweden, Denmark and Northern Germany, Sweden and Norway, and Austria and Germany.[3] Furthermore, given the eventual imposition of border checks on the Irish side of the border in February 2021, nearly one year after the beginning of pandemic restrictions, the attempt to keep the border invisible while not coordinating restrictions may ultimately be regarded as a failed experiment.[4]

Although the Brexit negotiations have heightened international interest in the border, the variations in the restrictions in Ireland and Northern Ireland in response to the COVID-19 pandemic have received limited legal analysis. Nolan et al explore the public health restrictions in both jurisdictions from a political perspective but do not explore the legal nuances.[5] Legal literature analyses the respective regulations separately, for example, the Northern Irish regulations,[6] the difference

1 Jess Sergeant, 'North–South cooperation on the island of Ireland' (*Institute for Government* 1 July 2020). For the purposes of animal health, the island is a single epidemiological unit.

2 For an analysis of the Common Travel Area, see Graham Butler and Gavin Barrett, 'Europe's "other" open-border zone: the Common Travel Area under the shadow of Brexit' (2018) 20 Cambridge Yearbook of European Legal Studies 252–286.

3 For an update on temporary restrictions, see European Commission, 'Temporary reintroduction of border control'.

4 SI 168/2021, Health Act 1947 (Section 31A – Temporary Restrictions) (COVID-19) Regulations 2021, s 4.

5 Ann Nolan, et al, 'Obstacles to public health that even pandemics cannot overcome: the politics of COVID-19 on the island of Ireland' (2021) 32(2) Irish Studies in International Affairs 225–246.

6 Daniel Holder, 'From special powers to legislating the lockdown: the Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020' 71(4) (2020) Northern Ireland Legal Quarterly 537–555.

between the regulations in the four nations of the UK,[7] and aspects of the Irish Government's response to COVID-19.[8]

In this article, we seek to fill this gap by analysing and comparing COVID-19 restrictions on movement in Ireland and Northern Ireland. In the forthcoming analysis, we explore the regulations on movement applied in both jurisdictions, highlighting inconsistencies. We consider that, because of the invisible border, legislative differences can have an impact on the effectiveness of the restrictions, not least because of limits on enforcement mechanisms. It is logical that less restrictive measures in a neighbouring borderless jurisdiction, without public health justification, will have implications on transmission.[9] At the same time, we recognise that these differences fall within the discretion of the legislature and that, as COVID-19 was a novel virus, countries often pursued a trial and error approach, not driven by a strong evidence base. Furthermore, public health is not immune to ethno-nationalist politics, which have undoubtedly played a role in both responses. As the pandemic continues, we highlight, firstly, lessons the two legislatures can learn from each other's regulations and, secondly, that a disparate approach can undermine the effectiveness of public health legislation on a borderless island. We focus on 2020, given that the regulations are frequently amended.

Ireland and the UK are party to several relevant international treaties, including the European Convention on Human Rights (ECHR), which has been incorporated through the Human Rights Act 1998 (UK) and the European Convention on Human Rights Act 2003 (which applies in Ireland). Several rights have been restricted by the regulations discussed in this article, spanning article 8 (respect for private and family life), article 9 (freedom of religion) and article 11 (freedom of assembly and association). Notably, the UK has not ratified the Fourth Protocol of the ECHR on free movement, while Ireland has done so

7 Akash Paun, Jess Sargeant and Alex Nice, 'A four-nation exit strategy, how the UK and devolved governments should approach coronavirus' (*Institute for Government* 6 May 2020). Tom Hickman QC, Emma Dixon and Rachel Jones, 'Coronavirus and civil liberties in the UK, judicial review' (2020) 25(2) 151–170. See also Barry Colfer, 'Herd-immunity across intangible borders: public policy responses to COVID-19 in Ireland and the UK' (2020) 6(2) European Policy Analysis 203–225.

8 Eoin Carolan and Ailbhe O'Neill, 'Ireland: legal response to COVID-19' in Jeff King and Octávio L M Ferraz et al (eds), *The Oxford Compendium of National Legal Responses to COVID-19* (Oxford University Press 2021). See also Conor Casey, Oran Doyle, David Kenny and Donna Lyons, 'Ireland's emergency powers during the COVID-19 pandemic' (*Irish Human Rights and Equality Commission* 24 February 2021).

9 Emeline Han et al, 'Lessons learnt from easing COVID-19 restrictions: an analysis of countries and regions in Asia Pacific and Europe' (2020) 396(10261) The Lancet 1525–1534.

and incorporated same in schedule 3 of the 2003 Act. Neither state derogated from the ECHR during the COVID-19 pandemic.[10]

Introduction to the Irish and Northern Irish responses

Although Ireland and Northern Ireland have adopted broadly similar approaches to tackling the pandemic, they have not acted in coordination. Ireland implemented a lockdown following the first coronavirus death, while the UK, including Northern Ireland, was slower to introduce restrictions.[11] Northern Ireland has largely followed the UK's approach, which has been criticised for initial delays,[12] dismissing experts and ignoring warning signs.[13] Ireland instead acted more promptly and often followed advice from leading actors in global health, including the World Health Organization (WHO) and the European Centre for Disease Prevention and Control when making regulatory decisions.[14] On the other hand, the Irish Government has been criticised for non-transparent decision-making and its relationship with the National Public Health Emergency Team (NPHET).[15] The North–South differences are recognisable not only in their approaches to expert advice, but also in their testing capacity, contact tracing and timing of school closures. The legal approach of both countries has been driven by use of statutory instruments (regulations) made by the respective Minister/Ministry of Health pursuant to the relevant legislation; in Ireland, the Health Act 1947 (No 28 of 1947) (as amended by the Health (Preservation and Protection and other Emergency Measures in the Public Interest) Act 2020 (No 1 of 2020)); in Northern Ireland, the Public Health Act (Northern Ireland) 1967.

Health is devolved to Northern Ireland, yet, due to the haste of the situation, the Northern Irish Assembly initially opted to be included in the English approach.[16] On 28 March 2020, Northern Ireland made its own regulations, which were first amended on 24 April. On 12 May

10 Council of Europe, 'Derogations COVID-19'.

11 A timeline of these events is found in Ann Nolan et al (n 5 above).

12 Allyson M Pollock et al, 'COVID-19: why is the UK Government ignoring WHO's advice?' (2020) British Medical Journal 368.

13 Richard Horton, 'Coronavirus is the greatest global science policy failure in a generation' *The Guardian* (London, 9 April 2020).

14 Health Service Executive (HSE), 'COVID-19 operations reports and policies'.

15 See further Conor Casey, David Kenny and Andrea Mulligan, 'Public health governance: the role of NPHET' in Alan Eustace, Sarah Hamill and Andrea Mulligan (eds), *Public Health Law during the COVID-19 Pandemic in Ireland* (COVID-19 Legal Observatory, Trinity College Dublin, 2021).

16 Anne-Maree Farrell and Patrick Hann, 'Mental health and capacity laws in Northern Ireland and the COVID-19 pandemic: examining powers, procedures and protections under emergency legislation' (2020) 71 International Journal of Law and Psychiatry 101602.

2020, the Northern Irish Executive published a five-stage recovery plan for the easing of the ongoing restrictions. The initial Health Protection Regulations were amended 11 times before being revoked. Thereafter, the Northern Ireland Department of Health made the Health Protection (Coronavirus Restrictions) Regulations No 2 (Northern Ireland) 2020 on 23 July, which were amended 25 times in the period between July and December 2020.

In Ireland, the first regulation made was the Health Act 1947 (Section 31A – Temporary Restrictions) (COVID-19) Regulations 2020, coming into operation on 8 April. The Minister of Health made approximately 10 different sets of statutory regulations with a total of 13 amendments throughout 2020.[17] Ireland also established a recovery plan on 15 September called the 'Resilience and Recovery 2020–2021: Plan for Living with COVID-19', which included a 'Framework for restrictive measures' comprised of five different levels.[18]

Recognising the benefits of coordination, in April 2020, the Irish and Northern Irish Ministers of Health entered into a political, non-binding Memorandum of Understanding on the COVID-19 response.[19] The Ministers agreed to, in the interests of consistency, adopt regular public messaging, including for vulnerable groups. The Agreement sets a loose policy agenda, noting that the public health approaches in the jurisdictions will not always mirror each other but good information sharing should 'help to mitigate negative consequences'. However, as discussed in this article, this loose agreement has often failed to materialise into effective regulatory coordination, resulting in gaps.

From the outset, schools and retail outlets in the South were ordered to close while neighbouring counties in the North remained free of such restrictions for a week longer, despite being mere minutes apart.[20] Northern Ireland's testing rate was also lower than Ireland.[21] In terms of quarantine upon arrival, Northern Ireland largely followed the UK approach, initially including a significant number of countries in 'travel corridors'.[22] At one point, Northern Ireland had 'opened up'

17 Numerous statutory instruments have been in place, but for our purposes, we will focus on restrictions on movement.

18 Government of Ireland, 'Resilience and recovery 2020–2021: plan for living with COVID-19' (2020).

19 Northern Ireland Executive, 'Memorandum of Understanding' (2020).

20 'The Irish Times view on Covid-19 restrictions: an all-island approach is vital' *Irish Times* (Dublin, 15 October 2020).

21 Farrell and Hann (n 16 above).

22 NI Direct, 'Coronavirus (COVID-19): travel advice' (2020).

to 58 countries, whilst Ireland only allowed entry from 15 without self-isolation.[23]

The decision to take separate approaches while maintaining an open border has been criticised.[24] In Ireland, high case numbers in border counties has been a cause of concern in light of Northern Ireland's initially less restrictive approach. There have been concerns that tighter restrictions in either jurisdiction would lead consumers to cross the border, thus causing spikes in the less restrictive jurisdiction or importing cases.[25] While it is unproven whether the spike in cases in border counties can be attributed to these divergent policies, Northern Ireland public health doctor, Dr Gabriel Scally, claimed this was 'the most likely explanation'.[26] Another aspect is that workers resident in Northern Ireland but working in Ireland were not able to avail of pandemic financial support in Ireland.[27]

Yet, in 2020, the Irish Government was resolute that closing the border between Ireland and Northern Ireland was not an option.[28] Ireland even opted to diverge from EU measures restricting travel from third countries to ensure that the land border remained open.[29] The Irish approach appeared to be that, with regular border crossings from those with family, work and schooling commitments in both countries, it would present extensive practical and operational challenges to implement, notwithstanding the inevitable political difficulties. Furthermore, the backdrop of the contentious Brexit negotiations loomed large, undermining both cooperation and border controls. Meanwhile, for political reasons, the Northern Irish Assembly preferred to chart its own course or follow the English approach where perceived necessary.

In the forthcoming analysis, we focus on the differences in the reasonable excuses that citizens in each jurisdiction could rely on to leave home under the respective regulations in 2020.

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23 Marie O'Halloran, 'Martin adopts "passive stance" on all-Ireland health, claims McDonald' *Irish Times* (Dublin, 29 July 2020).

24 Sergeant (n 1 above).

25 Shawn Pogatchnik, 'Ireland's divided coronavirus policies' (*Politico* 27 November 2020).

26 Paul Cullen, 'Coronavirus: border county case spike unlikely to be "spillover" from North, says Holohan' *Irish Times* (Dublin, 28 April 2020).

27 Colin Murray, 'The COVID-19 crisis across the Irish border' (*UK in a Changing Europe* 14 May 2020).

28 Ibid 21.

29 Ibid.

REASONABLE EXCUSES

Both jurisdictions imposed a restrictive approach, ordering individuals to remain at home, unless the reason for leaving fell under reasonable excuses. Here we highlight differences in the approaches, focusing on exercise, essential items, cocooning/shielding recommendations, obtaining money, the care and welfare of animals, attending places of worship, and visiting cemeteries/ graves. These statutory instruments (regulations) restrict various rights protected under the ECHR, which will also be integrated in the ensuing discussion. Generally, we find an absence of clarity in the restrictions, which is a central aspect of the requirement that restrictions be 'in accordance with the law'.

Exercise

On 27 March 2020, the Taoiseach announced that everyone in the state should stay at home until 12 April 2020 unless they had a reasonable excuse, which included physical exercise, to leave their home. The use of the word 'include' in the list of excuses confirms that the list is non-exhaustive. Exercise was, however, limited to a two-kilometre radius from 'home' and was only permitted either alone or with other persons residing in the relevant residence.[30] The legal basis for these restrictions was not published until 8 April 2020, meaning that they remained advisory until that point. The guidance was eventually codified in the Health Act 1947 (Section 31A – Temporary Restrictions) (COVID-19) Regulations 2020, made by the Minister for Health. The time between the Government announcing the guidelines and the restrictions coming into force was delayed, which was likely as a result of government lawyers taking time to closely review the regulations given the unprecedented circumstances.[31]

The Irish regulations have at various times imposed limitations on kilometre radius, the persons with whom, and places where, it is permitted to exercise. The two-kilometre radius remained in place until 5 May 2020, when the radius increased to five kilometres.[32] A further change on 18 May included a provision providing that exercise could be undertaken outdoors with a maximum of three other persons who do not reside in the relevant residence (still within the five kilometre radius).[33] On 8 June, the regulations changed to allow for

30 Health Act 1947 (Section 31A – Temporary Restrictions) (COVID-19), Regulations 2020, s 4(2)(i).

31 Paul Cullen and Conor Gallagher, 'Coronavirus: minister signs regulations giving Gardaí powers to enforce lockdown' *Irish Times* (Dublin, 7 April 2020).

32 The Health Act 1947 (Section 31A – Temporary Restrictions) (COVID-19), (Amendment) (No 2) Regulations 2020, s 3(b).

33 Health Act 1947 (Section 31A – Temporary Restrictions) (COVID-19), (Amendment) (No 3) Regulations 2020, s 5(c).

organised outdoor activities to occur with up to 14 other people. It was recommended that one stay within their own county or within a 20-kilometre radius.[34] On 22 October, the regulations reverted back to the five-kilometre radius for a period of six weeks as the country went back into Level Five, with no reference as to whether exercise had to occur alone or with members of the relevant household.[35] From 1 December, there was a staggered easing out of lockdown restrictions until 17 December.[36] Over the Christmas period, restrictions were further relaxed to allow for household mixing.[37]

Northern Ireland took a different approach to restrictions on exercise. The Department of Health made the Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020 on 28 March without the draft being laid before and approved by the Assembly, due to the perceived urgency. Section 5 contained provisions relating to restrictions on movement, imposing limitations as to when individuals could leave their home. Exercise was included as one of the 'reasonable excuses' that could be relied upon in order to leave home. Once again, the list can be considered non-exhaustive due to the use of the word 'includes'. The regulation did not impose a kilometre radius on exercise, but did restrict with whom one could exercise to 'either alone or with other members of (one's) household'. This rule remained in place until 23 July when the requirement for a reasonable excuse to leave home was removed from the regulations.[38] Thereafter, Northern Ireland put in place a two-week 'circuit breaker' lockdown from the end of November. During this time, the Government advanced a strong stay at home message, urging the public to stay indoors unless for essential purposes, including to exercise. The regulations were amended on 27 November[39] to permit 'outdoor exercise if the participants are one individual or are members of one household'.

Although the Northern Ireland regulation did not indicate how often exercise could be taken nor how far individuals were allowed to travel to exercise, government guidance suggested that if one left one's

34 Health Act 1947 (Section 31A – Temporary Restrictions) (COVID-19) (No 2) Regulations 2020, s 5.

35 Health Act 1947 (Section 31A - Temporary Restrictions) (COVID-19) (No 8) Regulations 2020, part 2, s 5(2)(x).

36 Health Act 1947 (Section 31A – Temporary Restrictions) (Covid-19) (No 9) Regulations 2020.

37 Department of the Taoiseach, 'Briefing on the Government's response to COVID-19' (*Gov.ie* 22 December 2020).

38 Health Protection (Coronavirus, Restrictions) No 2 Regulations (Northern Ireland) 2020.

39 Health Protection (Coronavirus, Restrictions) (No 2) (Amendment No 17) Regulations (Northern Ireland) 2020, s 2(4)(c).

residence to exercise this could be done only once a day.[40] Further recommendations suggested to stay close to home to exercise.[41] Some exceptions to this guidance included that, if the individual or their child had a medical need such as a learning disability, then exercise was allowed more than once per day.[42] The Police Service of Northern Ireland (PSNI) advised that 'as the vast majority of people can exercise from their home, travel to exercise may not be deemed necessary'.[43] In a post on the PSNI Facebook page an Assistant Chief Constable stated that when enforcing the regulations regarding restrictions on movement, 'we understand it is not possible to be definitive in each case, but officers will treat each case on its own merits and in a professional and proportionate manner'.[44] Public confusion regarding the rules around exercise also prompted the Northern Ireland Executive to make a public statement to clarify the restrictions.[45] The statement noted that, 'for example, a drive to a safe space or facility would be permitted. However, taking a long drive to get to a beach, or resort where numbers of people may gather is unlikely to be regarded as reasonable, even for exercise.' It can be deduced from this statement that, when carrying out exercise, discretion was left to police to determine what was appropriate and reasonable in the circumstances. Whilst offering greater flexibility, this could create subsequent enforcement problems and pose difficulty for individuals' ability to act within the law.

Although the Irish approach adopted a greater level of clarity in comparison to Northern Ireland, in Ireland there has also been confusion. Some wrongly interpreted the radius to apply to all reasonable excuses under the regulations, not only exercise, leading the Taoiseach to tweet a clarification.[46] Furthermore, the approach to exercise in Ireland can be criticised for being far-reaching and lacking a clear evidence base. Evidence suggests that outdoor transmission of Covid-19 is rare.[47] We therefore question whether the kilometre radius restriction was proportionate and underpinned by clear public health benefit. Furthermore, there remain concerns as to how flexible

40 'Lockdown: what are the rules?' (*Community Development and Health Network* 1 May 2020).

41 Ibid.

42 Ibid.

43 Ibid.

44 PSNI, 'ACC Todd Update' via Facebook (16 April 2020).

45 Amanda Ferguson, 'PSNI welcomes move to clarify rules on exercising during pandemic' *Irish Times* (Dublin, 25 April 2020).

46 Justin Treacy, '2km radius – how far is that exactly?' (*RTE* 28 March 2020).

47 Tommaso Celeste Bulfone et al, 'Outdoor transmission of SARS-CoV-2 and other respiratory viruses: a systemic review' (2021) 223(4) Journal of Infectious Diseases 550–561. See also Hua Qian et al, 'Indoor transmission of SARS-CoV-2' (2020) 31(3) Indoor Air 639–645.

the exercise rules were in terms of the length of the period of exercise. In other words, when would the reasonable excuse to exercise 'expire'? Could an individual remain outdoors all day and rely on the reasonable excuse of exercise? In other European countries, such as France, proof was required when leaving home.[48] In both Ireland and Northern Ireland, proof of a reasonable excuse by way of a form was never required.

A key issue for Northern Ireland relates to the guidance stemming from Westminster, especially at the beginning of the COVID-19 pandemic. According to a report from the Joint Select Committee on Human Rights, there have been discrepancies between government guidance and the underpinning regulations.[49] The example given in the report relates to exercise. Guidance recommended that persons only exercise once a day despite regulations in both England and Northern Ireland not imposing a limit on the number of times an individual could exercise.[50] In May, the UK Prime Minister announced that individuals could exercise for 'an unlimited amount', despite no changes to the regulations regarding frequency of daily exercise.[51] This fuelled public confusion,[52] especially among the devolved regions. The London School of Economics and Political Science highlighted this confusion through a small study conducted with 200 participants in May 2020. When asked whether the UK Government or the devolved administrations were in charge of lockdown measures, half of all respondents incorrectly said it was the UK Government.[53]

Exercise is not expressly protected as a human right. However, the restrictions amount to limitations on the right to private life and, in the case of Ireland, freedom of movement. Such inferences must be in accordance with law and necessary (in this case, for the protection of health). The European Court of Human Rights has repeatedly held that laws must be 'accessible and foreseeable'.[54] The Northern Irish restrictions do not appear to meet these requirements. Furthermore, we question whether near total prohibitions on exercise under these

48 'This is how France's new coronavirus lockdown permission form works' (*The Local Europe* 25 March 2020).

49 Joint Committee on Human Rights, 'The government's response to COVID-19: human rights implications' (*Parliament.uk* 21 September 2020), paras 45–46.

50 Ibid.

51 Institute for Government, 'Written evidence from the Institute for Government (RCC 12t)' (June 2020)

52 Vikram Dodd and Helen Pidd, 'Police acknowledge confusion over UK lockdown rules' *The Guardian* (London, 27 March 2020).

53 Stephen Cushion et al, 'Different lockdown rules in the four nations are confusing the public' (*London School of Economics* 22 May 2020).

54 *Sunday Times v The United Kingdom* App no 6538/74 (ECHR, 26 April 1979), para 49.

circumstances were necessary, that is, proportionate to the aim pursued.

The restrictive approach to exercise suggests that governments may have viewed this necessary purpose with suspicion or as an 'easy' means of bypassing the regulations unless strictly curtailed. This approach seems ironic given that governments generally encourage citizens to exercise for the good of their health. From a human rights and public health perspective, a less restrictive approach that builds trust through outlining the potential risks of exercising in groups may be more successful in achieving the desired result and avoiding increases in sedentary behaviour.

Essential items

Furthermore, individuals were permitted to leave home for the purpose of obtaining essential items. However, the phrasing of the regulations again differed between the two jurisdictions.

The Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020, section 5 allowed obtaining 'basic necessities', described as including 'food and medical supplies for those in the same household or for vulnerable persons' as a reasonable excuse for leaving home. The use of the word 'including' suggests that the definition of a basic necessity was not strictly limited to food and medical supplies. In addition, the regulation added 'to obtain supplies for the essential upkeep, maintenance and functioning of the household, or the household of a vulnerable person' as a reasonable excuse. On 11 June,[55] the list of reasonable excuses was amended to include 'to obtain goods from any businesses that are open'. This implies that, rather than obtaining a specific item, the legal basis underlying the purpose of the trip related instead to the list of essential businesses that were allowed to open at the time.

In Ireland, the public was advised not to leave their homes unless they had to shop for essential food, beverages and household goods, to collect a meal or collect medicines and other health products among other reasonable excuses. The aforementioned kilometre radius limit did not apply to individuals seeking to access essential services.[56] Once the advice had been codified, the wording changed to state that a reasonable excuse included,[57] 'to go to an essential retail outlet for the purpose of obtaining items or accessing services in the outlet for

55 Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020 (Amendment 6), s 4.

56 Department of Taoiseach, 'Briefing on the government's response to COVID-19 - Saturday 28 March 2020' (*Gov.ie* 28 March 2020).

57 Health Act 1947 (Section 31A – Temporary Restrictions) (COVID-19) (No 8) Regulations 2020, s 4.

yourself or others in the residence or for a vulnerable person'. Rather than describing items as essential, the regulation suggested that the retail outlet being open implied the items in it were, by definition, essential.

The regulations did make explicit reference to what items could be obtained, including: food, beverages, fuel, medicinal products, medical devices or appliances, other medical or health supplies or products, essential items for the health and welfare of animals, or supplies for the essential upkeep and functioning of the person's place of residence. During Ireland's second lockdown, retailers were urged to separate essential and non-essential goods such as food and clothing.[58] Under new rules, stores were restricted to selling products necessary for the 'essential upkeep and functioning of places of residence and businesses'.

The key difference between Northern Ireland and Ireland's approach was the wording of the text, with Northern Irish regulations using the term 'basic necessities' and Irish regulations referring to 'items from essential retail outlets'. The initial list under the Irish regulations appears to have had greater flexibility since items did not have to be regarded as 'a necessity'. The rules also had greater clarity by providing a non-exhaustive list of potential items to ease confusion. It could be said that the Northern Irish rules provided equal flexibility as basic necessities could be broadly interpreted. However, this raises questions as to whether items not classed as food or medical supplies can be considered as necessities and from whose perspective. For example, what a young woman and an older man consider essential is likely to differ. Furthermore, in parts of the UK and Ireland, police were accused of interrogating shoppers over the necessity of their purchases.[59] Pictures from Dublin show the Gardaí stopping individuals on the street and inspecting their shopping bags,[60] despite lacking legal powers to do so.

Another issue arising once again relates to the expiry of said excuse.[61] Would an individual be obliged to return home immediately after the purchase of necessities? How long was reasonable for a trip to an essential outlet? In the UK, the confusion led to a clarification of the regulations to establish that there must be a reasonable excuse

58 Conor Pope, 'Large retailers modify stores and block off non-essential products' *Irish Times* (Dublin, 27 October 2020).

59 Cherry Wilson, 'Coronavirus: shoppers face "essential items" confusion' (*BBC News* 2 April 2020).

60 Zoe Drewett, 'Police threaten to search shopping trolleys to check you're only buying essentials' *Metro* (London, 9 April 2020).

61 House of Commons, Public Administration and Constitutional Affairs Committee, *Parliamentary Scrutiny of the Government's Handling of Covid-19: Fourth Report of Session, 2019–21* (10 September 2020) 14–15.

for leaving home and for *remaining* outside of the home – changing the wording to require an excuse to both 'leave' and 'be outside of' your residence.[62] In situations where the wording of legislation is ambiguous, the use of general terms should be interpreted in a way that safeguards basic rights of the individual.[63] To do otherwise and interpret such rules in a way that curtails personal liberty would be contrary to the long-standing principle of legality.[64] Legislation passed in both Ireland and Northern Ireland risked falling into the latter category, in the sense that powers were being exercised in a much broader manner than originally intended.

Cocooning/shielding recommendations

In both countries, older persons and those considered 'vulnerable' were advised to stay at home. In Ireland, the Government advised those considered vulnerable to remain at home and limit their social contacts, a phenomenon dubbed 'cocooning'. Whilst the regulations did not make reference to specific age groups, a vulnerable person was defined as someone who required assistance because he or she was 'particularly susceptible to the risk posed to health by Covid-19, or not in a position to leave his or her place of residence due to reasons related to the spread of Covid-19 or otherwise'.

Guidance from the Health Service split the level of risk into 'very high risk' and 'high risk', with those over 70 classified as very high risk. Those falling within this category were advised that 'you need to stay home as much as possible'. Despite providing detailed advice on what to do in certain situations as a very high-risk individual, ultimately, the guidance was advisory. The Health Service website advised citizens to 'use your best judgement' to avoid higher-risk situations.[65] This mixed messaging through the use of the words 'need' and 'should' likely caused public confusion around the nature and enforceability of the recommendations.[66] While these recommendations were not subject to legal challenge, the High Court has noted that, while the Executive is entitled to provide health advice, such advice could be subject to judicial review where it portrays recommendations as having legal status.[67]

62 Health Protection (Coronavirus, Restrictions) (England) (Amendment) Regulations 2020.

63 *R v Secretary of State for the Home Department, ex parte Simms* [2000] 2 AC 115, 131

64 Ibid.

65 HSE, 'Staying safe if you are at very high risk – advice for people at very high risk from COVID-19' (31 December 2020).

66 Katharina Ó Cathaoir and Ida Gundersby, 'The rights of elders in Ireland during COVID-19' (2021) 28(1) European Journal of Health Law 81–101.

67 *Ryanair DAC v An Taoiseach & Others* [2020] IEHC 461.

In Northern Ireland, similar recommendations were present from 23 March 2020, although the term 'shielding' was used. The definition of vulnerable persons was split into two categories,[68] 'vulnerable' and 'clinically extremely vulnerable (CEV)'. People over the age of 70 were classified as vulnerable. Unlike Ireland, Northern Ireland paused its shielding recommendations from 31 July 2020.[69] Yet, advice from 26 December for those clinically extremely vulnerable was that they should not attend the workplace even if they were unable to work from home.[70] Prior to this, CEV individuals were advised that it was safe to attend work if 'proper measures to ensure social distancing are in operation in the workplace'. The Health Service website made clear that 'this is advice only' and that 'people are free to make their own judgements'. Despite the clear reference to the advisory nature of the guidance, confusion could have arisen given the reference to shielding being paused alongside the introduction of more stringent advice on entering the workplace. This advice could appear contradictory and confusing to the public and, ultimately, infringe the requirement of a valid legal basis under article 8 ECHR.[71]

Obtaining money

Whilst both Ireland and Northern Ireland included 'obtaining money' as a reasonable excuse to leave home, each country enacted this provision at different times. In Ireland, 'to obtain money for yourself, someone in the residence or a vulnerable person' was included in the list of reasonable excuses in the initial regulation on 8 April 2020.[72] Whereas in Northern Ireland, leaving home to obtain money was not added until 15 May,[73] nearly two months after lockdown began. This possible oversight had the potential to adversely affect certain groups who use cash at higher rates, such as the elderly or marginalised groups. Throughout the pandemic, there has been concern that a move away from cash for hygiene purposes could adversely affect certain groups.[74]

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68 NI Direct Government Services, 'Coronavirus (COVID-19): definitions of "clinically extremely vulnerable" and "vulnerable"'.

69 Department of Health for Northern Ireland, 'Live life COVID-aware'.

70 See n 68 above.

71 Ibid.

72 Health Act 1947 (Section 31a – Temporary Restrictions) (COVID-19) Regulations 2020, s 4.

73 Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020 (Amendment 2), s 5(2).

74 Siran Kale, '"You can't pay cash here": how our newly cashless society harms the most vulnerable' *The Guardian* (London, 24 June 2020).

The care and welfare of animals

Similarly, each country took a different approach to the inclusion of care and welfare of animals as a reasonable excuse. In Ireland, the initial government advice included 'farming purposes', described as either food production or the care of animals, as a reasonable excuse.[75] However, when the initial regulations were published on 8 April 2020, 'farming purposes' was not included in the list of exceptions. There was, however, reference to being able to leave home to obtain items from an essential retail outlet,[76] including 'essential items for the health and welfare of animals'. Farming was also listed as an essential service under schedule 2 and seeking veterinary assistance was included as an exception under section 4. Whether the culmination of these provisions was what was meant by 'farming purposes' in the government briefing on 28 March is unclear. In Northern Ireland, the phrase 'farming purposes' was not referred to in the regulations. Reference to 'the care and welfare of animals' was not added as a reasonable excuse until 7 June.[77] It is unclear whether individuals were fined or warned for caring for animals during the pandemic. The absence of such a reasonable excuse could suggest a deprioritisation of animal welfare or that a level of flexibility was exercised for some purposes, but not for others (such as exercise).

Attending places of worship

During the initial lockdown in Northern Ireland, attending a place of worship was not considered a reasonable excuse until 19 May 2020.[78] This could likely be defined as attending a place of worship for individual prayer, as places of worship did remain open for certain events such as weddings in accordance with the guidelines. In-person religious services resumed from 29 June 2020.[79] During the second lockdown, the Executive initially decided to keep places of worship open only for weddings, civil partnerships and funerals. However, backlash from religious leaders led to a revision of the rules,[80] allowing churches to

75 See n 56 above.

76 Health Act 1947 (Section 31A – Temporary Restrictions) (COVID-19) (No 8) Regulations 2020, s 4.

77 Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020 (Amendment 5), s 3.

78 Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020 (Amendment 3), s 5(2).

79 Naomi Holland, 'Coronavirus: what will church services look like in the "new normal"?' (*BBC News* 28 June 2020).

80 Jayne McCormack, 'Coronavirus: NI churches to remain open for individual prayer' (*BBC News* 24 November 2020). See also Peter Moore, 'Church leaders express disappointment at places of worship shutting under latest COVID-19 restrictions' (*Q Radio* 22 November 2020).

remain open for individual prayer over the two-week lockdown from 27 November.

In contrast, in a Post Cabinet statement on 24 March,[81] the Deputy Prime Minister of Ireland stated that, 'all places of worship are to restrict numbers entering at any one time to ensure adequate physical distancing'. These measures were in reference to lawful gatherings such as weddings or funerals as well as individual prayer. For public prayer or attending services, churches were closed until 20 July 2020,[82] but remained open for individual prayer subject to health and safety measures.[83] Places of worship then closed again following additional lockdown measures and public services were moved online.

These restrictions amount to a limitation on freedom of religion. At the same time, high transmission rates may justify closure of places of worship, particularly if distance requirements and adequate hygiene standards cannot be guaranteed. A 2021 judicial review petition before the Scottish Court of Session confirms the illegality of the enforced closure of places of worship during the pandemic.[84] The court held that the closure was unlawful as it amounted to a disproportionate infringement of the petitioner's human rights under article 9 of the ECHR given that less intrusive measures could have been used.[85] In Lord Braid's opinion, the respondents had not 'fully appreciated' the importance of article 9 rights in the drafting of the regulations.[86]

Whilst an in-depth examination of the role of the courts in upholding qualified rights is outside the scope of this article, some consideration must be given to the dichotomy between the courts and the Executive in times of a political turmoil. The *Dolan*[87] case provides a clear example of the judiciary taking a different approach to the Scottish Court of Session and deferring to the Government upon concluding the matter to be of political nature. In the context of COVID-19, where scientific knowledge was limited at the beginning of the pandemic, the court held that the Government had taken decisions to reduce the risk of transmission based on expert advice, making judicial intervention inappropriate. This is in similar vein to cases related to national

81 Irish Government News Service, 'Post Cabinet statement, an Taoiseach, Leo Varadkar' (24 March 2020).

82 Patsy McGarry, 'Coronavirus: church leaders urge people to stay resolute amid pandemic restrictions' *Irish Times* (Dublin, 4 May 2020).

83 Charles Collins, 'N Ireland leaders welcome move to open churches for private prayer' (*Crux* 19 May 2020).

84 *Judicial Review of the Closure of Places of Worship in Scotland, Opinion of Lord Braid* [2021] CSOH 32.

85 Ibid para 127.

86 Ibid para 120.

87 *Dolan and Others v Secretary of State for Health and Social Care* [2020] EWCA Civ 1605.

security, whereby the courts have traditionally taken a more passive approach. Yet, arguably, the difference for our purposes is the collective element (the rights of an entire population in contrast to individual breaches) and extensiveness (the spectrum of rights triggered) of the infringements, with freedom of religion accounting for only part of this.

Visiting cemeteries/graves

Initially, visiting a grave or cemetery was not included in the list of reasonable purposes in either jurisdiction. From 24 April 2020, Northern Ireland included visiting cemeteries as a necessary purpose,[88] aligning with England. In Ireland, the regulations did not order cemeteries to close during the lockdowns but travelling thereto was not a reasonable excuse.

In a speech, the Deputy First Minister, Michelle O'Neill, stated that the Executive was 'very mindful of people's mental health at this time and recognise the comfort that visiting the graveside of a loved one brings'.[89] Yet, the logic behind the delay in adding visiting gravesites to the list of reasonable excuses is unclear. The issue caused tension within the Northern Ireland Executive, with the Democratic Unionist Party and Ulster Unionist Party suggesting that cemeteries could reopen on a controlled basis whilst Sinn Féin and Alliance opposed the suggestion.

The Executive claimed that the eventual policy change was an attempt to strike a balance between protecting public health and preventing further mental suffering being inflicted on individuals. It has been described as a 'proportionate' and 'low risk' decision.[90] According to the BBC, the change in the regulations was a result of pressure from the public.[91] Deputy First Minister, Michelle O'Neill, stated she had 'listened carefully' to calls from the public.[92] Church leaders reacted positively to the new regulations, deeming them to be 'sensible and compassionate'.[93]

Ireland took a different approach. Cemeteries were not ordered to close (this decision was at the discretion of the local authorities), however, visits thereto were also not listed as reasonable purposes.

88 Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020, s 4(a).

89 Northern Ireland Executive, 'Executive approves opening of cemeteries on restricted basis' (24 April 2020).

90 'Coronavirus: first cemeteries reopen following policy change' (*BBC News* 25 April 2020).

91 Ibid.

92 Ibid.

93 Ibid.

According to then Health Minister, Simon Harris, if the cemetery in question was within the individual's kilometre radius, visiting was permitted.[94] This seems incorrect. Instead, an individual visiting a cemetery within their kilometre radius would have to be doing so for exercise (or other permitted purposes). Later, visiting graves was added to the government website, though not the regulation itself.[95]

The public health basis for excluding cemetery visits from COVID restriction exceptions is unclear. As the Northern Irish Executive noted, the activity is low risk given it takes place outdoors and offers the ability to adhere to social distancing. Funerals were still permitted throughout the lockdowns in both countries, albeit with limited numbers. It is furthermore a ritual of comfort at the time of an unsettling pandemic, where mental health is being negatively impacted. It was reported that one individual was impaled on a fence in an attempt to access a cemetery to visit his wife's grave.[96] We therefore question whether the Irish approach was a proportionate restriction on the right to private and family life given the limited public health gain.

Having introduced the main reasonable excuses, we now comment on enforcement thereof.

ENFORCEMENT

The enactment of the regulations to combat COVID-19 across Ireland and Northern Ireland led to a meaningful increase in police powers, which must be utilised in accordance with human rights and civil liberties. In a report on policing performance of the Gardaí, the Policing Authority highlighted that

> These powers quite significantly infringe on our rights to liberty, assembly and association and for many, the right to a family life. However, it is of great national importance, and indeed a matter of life and death, that the spread of the virus is limited to the greatest extent possible.[97]

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94 William Dunne, 'Simon Harris confirms beaches and graveyards are open but public need to "cop on"' *Irish Mirror* (Dublin, 18 May 2020).

95 Department of Taoiseach, 'Your guide to upcoming changes' (*Gov.ie* 15 September 2020).

96 Phillip Bradfield, 'Coronavirus: pensioner impales himself on cemetery railings trying to visit wife's grave during Covid-19 lockdown' (*Belfast News Letter* 21 April 2020).

97 Policing Authority, 'Policing performance by the Garda Síochána in relation to COVID-19 regulations. Report on the exercising of powers under the Health Act 1947 (Section 31 – Temporary Restrictions) (COVID-19) Regulations 2020' (May 2020) 3.

The criminalisation of previously normal and legal conduct requires scrutiny given the potential for disparate application of rules, disproportionate responses and discrimination.

Enforcement of regulations must be reasonable, necessary and proportionate.[98] In both Ireland and Northern Ireland, police were ordered to implement regulations in accordance with the 'four E's' – engage, explain, encourage and enforce.[99] Both Policing Authorities committed to a 'policing by consent' approach and emphasised that enforcement should only be used if necessary. The Gardaí were afforded five powers under emergency legislation: to direct a person to comply with the regulations; to arrest for failure to comply with such a direction; to demand a person's name and address; to arrest for failure to comply with the demand for name and address; and, finally, to arrest for failure to comply with the regulations.[100] In Northern Ireland, police officers 'may take such action as is necessary to enforce any requirement imposed by regulation 3, 4 or 6'.[101] This may include directing a person to return home, removing a person to their home, dispersing a gathering or arresting an individual for breaching regulations.[102]

The powers given to the police in terms of enforceable penalties have changed throughout the course of the pandemic, with both countries increasing the level of fines towards the end of 2020. In Northern Ireland, the least stringent form of penalty was a warning, otherwise known as a 'Community Resolution Notice'. Until March 2021, police had issued around 1795 of these warnings, most likely for non-serious breaches or potential breaches of the regulations.[103] Police could also issue fines to individuals over the age of 18 starting from £200 and rising to £1000 for breaches such as failure to isolate or attending a gathering that exceeds the allowed number of individuals.[104] As of March 2021, police had issued around 1758 of these penalties. In 2020, if unpaid, these types of notices could also be punishable by summary conviction with a fine of up to £5000.[105]

98 Ibid.

99 Minister of Justice Statement, Ad Hoc Committee Meeting (6 January 2020), 4. See also, Policing Authority, 'Report on policing performance by the Garda Síochána during the COVID-19 Health crisis' (18 December 2020) 3.

100 Ibid 3. See also, Health Act 1947, s 31(a).

101 Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020, s 7(1).

102 Northern Ireland Policing Board, 'Report on the thematic review of policing response to COVID-19' (2020).

103 NI Direct Government Services, 'Coronavirus (COVID-19) Regulations: compliance and penalties'.

104 Ibid.

105 Ibid.

In Ireland, police had access to the aforementioned powers from 8 April until 8 June 2020 when restrictions were eased and some of the penal provisions were revoked.[106] Subsequently, further provisions were enacted and sanctions included a fine of up to €2500 and/or up to six months' imprisonment under the 1947 Health Act. From 22 October 2020, when the country moved into Level Five lockdown, amendments to legislation meant that a new system of 'tiered fines' came into place, including on-the-spot fines of up to €500.[107] According to a report from the Policing Authority, the Gardaí relied on their enforcement powers 859 times between 8 April and 5 December 2020.[108]

One can question whether these fines were proportionate. In *Lacatus v Switzerland*, the European Court of Human Rights found that penalties imposed for begging violated article 8. The applicant was fined 500 CHF, which she could not pay. As a result, a custodial sentence of five days was imposed. The court found that, under the circumstances, the sentence was almost inevitable given the applicant's 'precarious and vulnerable situation'.[109] It concluded that the penalty was not proportionate as the state had not established that 'less restrictive measures would not have achieved the same or a comparable result'.[110] While the UK Joint Committee on Human Rights has criticised the UK fixed penalty notice system as 'two tiered' and potentially disproportionate,[111] the Irish fine system can lead to a criminal conviction for failure to pay, similar to the *Lacatus* case. Although the contexts differ, the *Lacatus* judgment opens up the possibility that a fine and criminal sentence might breach article 8 if, for example, the individual were destitute with no means of paying and this was not taken into account.

The Irish police force also made use of a large number of roadblocks as part of its wider COVID response. From 11 May to October 2020, over 120,000 checkpoints were set up. Whilst most of these took place during the initial lockdown period, during the Level Five lockdown there were around 6000 checkpoints per week.[112] Throughout the pandemic, there have been tailbacks on the motorways in bordering counties, especially around the Donegal area, with drivers seeking

106 The Health Act 1947 (Section 31A – Temporary Restrictions) (COVID-19), (Amendment) (No 2) Regulations 2020.

107 Department of Health, 'Press release on additional enforcement powers for breaches of COVID-19 regulations' (*Gov.ie* 20 October 2020).

108 Ibid.

109 *Lacatus v Switzerland* App no 14065/15 (ECHR, 22 February 2021), para 109.

110 Ibid para 114.

111 Human Rights (Joint Committee), 'The government's response to Covid-19: human rights implications of long lockdown' (27 April 2021).

112 Department of Health (n 107 above).

to avoid checks by taking backroads.[113] Yet, the effectiveness of the checkpoints is questionable, with the vast majority of road users appearing to have a reasonable excuse for travelling.[114] For example, a checkpoint at a motorway on 1 May 2020 found that only two vehicles had made non-essential journeys out of a total of 3300 that were checked.[115] This can call into question the proportionality of the measure, given that individuals were required to account for their apparently legal behaviour. At the same time, the roadblocks may have had a deterrent effect, which is more difficult to measure.

Ireland's use of armed police at checkpoints raises questions as to whether the policing strategy can be reconciled with broader policy aims to avoid engaging in enforcement practices if possible. The Police Commissioner addressed these concerns and stated that the use of armed officers was to enable the continued policing of serious crimes, further stating that armed officers have uncovered criminals at checkpoints.[116] Adopting checkpoints that were introduced to enforce COVID regulations for other policing purposes appears to be an inappropriate repurposing of the initial objective of the checkpoints. This illustrates rules intended to prevent the spread of COVID-19 being used as a proxy for broader policing objectives and becomes more troubling when considered alongside the lack of consultation and debate regarding the regulations.

The Garda Síochána Ombudsman Commission (GSOC) had received over 169 complaints by 8 June 2020 from the public on the enforcement of COVID regulations by police.[117] A Police Ombudsman Statutory Report Investigation into policing in Northern Ireland established that there had been 136 complaints made by the public relating to the police and COVID regulations between 28 March and 31 October 2020.[118] Almost a quarter of all complaints received by the Police Ombudsman related to enforcement concerns in the context of gatherings at funerals as well as queuing outside of shops.[119]

A significant barrier to the fair and effective enforcement of COVID regulations is the coherence of the rules. Legislation that creates new criminal sanctions must be laid out in a clear and transparent manner;

113 Orla Ryan, 'Long tailbacks reported as Operation Fanacht gets underway' (*The Journal* 7 October 2020).

114 See n 102 above, 7.

115 Ibid.

116 Ibid 12.

117 Garda Ombudsman, 'Update on complaints relating to COVID 19' (8 June 2020).

118 Police Ombudsman for Northern Ireland, 'Public statement by the Police Ombudsman pursuant to section 62 of the Police (Northern Ireland) Act 1998, an investigation into police policy and practice of protests in Northern Ireland' (22 December 2020) 3–5.

119 Ibid.

this is especially true for legislation that creates offences for what would, ordinarily, be considered perfectly normal behaviour. Ensuring that an individual has fair warning that what they are about to do could constitute committing a crime is a fundamental aspect of the rule of law.[120] For this reason, the state has a duty to create regulations that are both accessible and reasonably straightforward to interpret – as echoed in recommendations from the Northern Ireland Policing Board.[121] In both Ireland and Northern Ireland, the regulations were brought in as emergency legislation. The lack of opportunity for legislative scrutiny, combined with the rate of amendments made to the regulations, generates a climate of uncertainty and contributes to difficulties with enforcement. As a result, there must be scope to excuse a reasonable amount of ignorance and not place an unfair burden on citizens when exercising and enforcing such powers.[122]

The speed of amendments presents challenges for how regulations are understood and applied in practice, with police seemingly given no advance notice of approaching changes. The Northern Ireland Department of Health's Chief Environmental Health Officer stated, 'we do share with the PSNI … information on changes that have been made as soon as possible afterwards, usually the following day if the changes to the legislation were made in the evening'.[123] The Policing Board in Northern Ireland wrote to the Minister of Health, stating that

> it is … unequivocal that you have a duty to provide clarity (underpinned by legal advice) as to how Regulation 5 should be interpreted. It is imperative that both the PSNI and the public are provided with clear, comprehensive and unambiguous guidance as to what constitutes unlawful behaviour under the Regulations.[124]

In addition, mixed messaging from the Government on the wording of the regulations and official guidance may have contributed to widespread confusion and undermined public confidence in the regulations. The regulations are lengthy and somewhat unclear, potentially contributing to flawed interpretation by police. Whilst a non-exhaustive list provides for instances when an excuse is considered reasonable, it could imply that only the activities listed are permissible, resulting in confusion for both the police and the public.

In the early stages of the pandemic, the police service in Northern Ireland was criticised for its approach to enforcement, with some

120 Andrew Ashworth, 'Ignorance of the criminal law, and duties to avoid it' (2011) 74(1) Modern Law Review 4–7.

121 Ibid.

122 Ibid.

123 Northern Ireland Assembly, Committee for Health, 'Official report: minutes of evidence, Committee for Health, meeting on Thursday 18 June' (18 June 2020).

124 See n 102 above.

suggesting it was going further than provided for by the legislation. One report displayed examples of police ordering a woman to leave her front garden and go indoors, whilst another individual was instructed to return home by police whilst driving her autistic son to a familiar park for exercise.[125] As a result of inconsistent policing approaches and continued ambiguity, senior officers in Northern Ireland contacted the Department of Health to seek clarity on the regulations in order to enable fairer enforcement.[126]

Further, the nature of the regulations requires probing from police to determine whether members of the public are breaching rules; it is not immediately clear whether those outside of their residence have a reasonable excuse. Without any requirement to provide evidentiary proof or to rely on a listed excuse, police are left with a significant degree of discretion in deciding what can or cannot be classified as reasonable. In England and Wales, the Crown Prosecution Service determined that all of the 44 individuals initially charged with breaches of the regulations were incorrectly charged.[127] If the onus on how to interpret regulations remains with police, greater coordination and transparency is required to prevent arbitrary penalties being applied. Ultimately, incorporating a more transparent public health approach could potentially assist in addressing these issues by directing attention to vectors of transmission rather than policing individuals participating in low-risk activities.

ANALYSIS OF LEGAL LOOPHOLES ACROSS THE BORDER

The porous nature of the border side by side a two-Ireland approach has resulted in certain challenges and legal loopholes. Whilst increased border regulation has become a major strategy in the suppression of the virus across the world, including countries with similarly fluid borders, tensions surrounding these discussions are uniquely palpable in Ireland. The issue of the Irish land border remains politically charged and, when closures have been suggested as an available tool to control the spread of the virus, it has generated both societal and operational concerns.[128]

An initial dilemma was coined the 'Dublin loophole', whereby passengers were able to evade quarantine rules in the UK by rerouting

125 Sam McBride, 'Sam McBride: the police's made-up Coronavirus law ought to unsettle anyone who understands democracy' (*Belfast News Letter* 18 April 2020).

126 See n 94 above.

127 Crown Prosecution Service, 'CPS announces review findings for first 200 cases under coronavirus laws' (15 May 2020).

128 Murray (n 27 above).

their return journey through Dublin airport.[129] This was then addressed in Northern Irish regulations, ensuring that self-isolation must be followed by anyone who had been outside of the CTA in the last 14 days, regardless of whether the flight was routed via Dublin airport.[130] However, the so-called 'Belfast loophole' remained, whereby arrivals from Britain into Northern Ireland with onward journeys to Ireland were able to avoid self-isolation recommendations. Furthermore, rather than having an arrangement in place requiring only one form for arrival on the island of Ireland, each country created its own passenger locator form. Despite repeated calls from Northern Ireland for the states to share information,[131] the Tánaiste responded that there were some formatting issues and details to work out before this could be done but gave assurances that it would be resolved. Since then, the Irish Government has agreed to provide data from the passenger locator forms to Northern Ireland.[132]

Moreover, in 2020, if police identified an individual resident in the neighbouring jurisdiction in breach of regulations, they could not enforce sanctions. For example, if an individual from the North travelled to the South without reasonable excuse, the Gardaí could only advise them to turn back. In other words, no effective enforcement mechanisms, pecuniary or otherwise, were available. The General Secretary of the Association of Garda Sergeants and Inspectors, Antoinette Cunningham, highlighted that this was of particular concern to the Gardaí, who were left with limited means of combating breaches of the regulations in border regions from those travelling to the South for the day.[133] As of February 2021, the Gardaí were empowered to enforce fines against those travelling into the country from the North in breach of travel rules. The new system allowed for fines of up to €100 to be sent to an individual's home address in the North. The fines could apply to those who are 'not ordinarily resident in the State' who are travelling in the state 'without reasonable excuse'.[134] The new powers

129 Holder (n 6 above) 537–555.

130 Committee on the Administration of Justice, 'Passenger quarantine and the Common Travel Area (CTA): the Health Protection (Coronavirus, International Travel) Regulations (Northern Ireland) 2020' CAJ Briefing Note No 2 (June 2020).

131 '"Really regrettable" Irish Government is not sharing passenger information – O'Neill' (*RTE* 18 January 2021).

132 Pat Leahy, 'Why is there no serious engagement on joint North–South approach to Covid?' *Irish Times* (Dublin, 28 January 2021).

133 Conor Lally, 'Covid-19: restrictions mismatch "difficult" for gardaí meeting North daytrippers' *Irish Times* (Dublin, 26 April 2020).

134 Health Act 1947 (Section 31A – Temporary Restrictions) (COVID-19) (No 10) (Amendment) (No 2) Regulations 2021, s 4(a).

did not extend to forcibly returning someone across the border nor to ordering them across the border.

CONCLUSION

In 2020, Ireland and Northern Ireland adopted separate approaches to COVID-19, while keeping their shared land border open. Both jurisdictions adopted legal approaches that in many ways mirrored those of England, Wales and Scotland: frequently amended regulations, often backed up by fines or criminal sanctions that imposed a legal obligation on individuals to stay at home unless their purpose fell within certain exceptions. These restrictions amounted to far-reaching incursions on numerous rights, including the right to family and private life, freedom of movement and freedom of religion.

This article has reviewed the reasonable purposes allowed for in both jurisdictions and identified discrepancies. While Nolan et al concluded that there was 'significant public health policy alignment' during the first wave, we have identified several areas of legislative non-alignment.[135] By comparing the approaches, we have questioned whether the restrictions in some cases were proportionate with reference to the ECHR. We echo the recommendation of Casey et al that human rights expertise should be mainstreamed in pandemic decision-making.[136] For example, in relation to exercise, we recognise that the Irish approach was clearer and easier for citizens to orientate themselves regarding compliance. Yet, we have not found that the Government put forth a compelling case for why exercise within a kilometre radius was necessary and proportionate to the public health aim. Similar questions can be asked with regards to the visiting of graves; did the public health benefit outweigh the limitation on movement and private life? Other purposes were left out at various stages, such as obtaining money or the care and welfare of animals, perhaps highlighting the haste with which the regulations were enacted. We posit that with better coordination between the two jurisdictions, some of these gaps could have been avoided as they seem to mainly have been oversights, not conscious political choices or prioritisation. The absence of a one-island approach further led to several legal loopholes in terms of enforcement, which may have undermined the effectiveness of both countries' restrictions.

In general, the lack of clarity as to the rules in both jurisdictions has been criticised. Both states have mixed guidance and legal requirements, sometimes framing the former in terms of orders like 'must'. At times,

135 Nolan et al (n 5 above) 246.
136 Casey et al (n 15 above) 102.

the governments and the police forces have acted in a manner that suggests they misunderstood the regulations. Furthermore, the use of social media to correct the public's understanding of the law can also be questioned with reference to foreseeability. The potential for confusion is especially problematic from the standpoint of proportionality in light of the far-reaching nature of the interferences, and the fact that they were often underwritten by criminal sanctions. In the UK generally, fixed penalty notices were often used, which an individual cannot appeal, meaning that individuals may have paid fines even where they did not in fact breach the law.

Ultimately, this article submits that a more coordinated public health response was required to effectively combat the challenge presented by COVID-19 on the island of Ireland. Failure to do so resulted in restrictions on numerous human rights that were not always accompanied by sound legal or public health reasoning. The ambiguity surrounding these provisions generated a climate of unpredictable policing practices, with no clear public health rationale. All of these issues share a common thread, namely the role that borders can play in responding to a global, viral threat. In considering these points, it is fair to conclude that the response on the island of Ireland often lacked clarity, transparency and sometimes explicit justifications with regards to protecting public health.

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Procuring in a pandemic: assessing the use of the EU Public Procurement Directives, the Joint Procurement Agreement and advance purchase agreements

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ABSTRACT

Since the COVID-19 pandemic began, public procurers have faced an uphill battle to secure urgently required medical countermeasures. Contracting authorities in the face of extreme urgency at the start of the pandemic relied heavily on emergency provisions to deactivate procedural requirements and conclude contracts on the basis of direct negotiation. Additional procurements were conducted at a European Union (EU) level, leveraging the buying power of member states to rapidly secure the acquisitions of medical equipment, medicines, vaccines, booster shots and more recently COVID-19 therapeutics. The article offers an analysis of the use of the negotiation procedures and the European coordinated efforts to conclude COVID-19-related contracts. As we optimistically move towards the final stages of the pandemic, this article argues that it is time to retire the use of emergency procurements. It contends that such emergency provisions are no longer available for use and procurers, if not already, must return to the use of fully transparent and competitive procurement procedures. Furthermore, it suggests that the EU should build on the success of the coordinated approach of competitive tendering and extend the use of the Joint Procurement Agreement to prepare for future cross-border health crises and acquire in-demand medical countermeasures.

Keywords: EU public procurement; Joint Procurement Agreement; advance purchase agreements; COVID-19.

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INTRODUCTION

Public procurement has and is continuing to play an important role supporting healthcare systems during the COVID-19 pandemic. At the start of the pandemic, procurers scrambled to secure access to medical supplies, such as personal protective equipment (PPE), medical equipment and medicines. During the middle of the pandemic, the race began to secure the rapid acquisition of newly developed vaccines and booster jabs. As we hopefully and optimistically move into the final stages of the pandemic, procurers are now tasked with purchasing sufficient quantities of the new innovative COVID-19 therapeutics to treat those who are infected.

Under normal circumstances, the process for procuring affordable medical supplies is timely and administratively burdensome, and heavily dependent on market competition.[1] However, time and supply is a luxury that procurers do not enjoy. This article reflects on how contracting authorities in Ireland and the United Kingdom (UK) concluded public supplies and services contracts during the pandemic. Firstly, it reviews how contracting authorities availed of the flexibility in the current European Union (EU) public procurement framework to deactivate procedural requirements in the face of extreme urgency. Secondly, it analyses the unprecedented and ongoing joint procurement efforts co-ordinated by the European Commission. This paper argues that it is time to phase out the use of emergency procurement and re-assert the importance of upholding the principles of transparency and competition in procurement activities.

BACKGROUND TO THE EU PUBLIC PROCUREMENT DIRECTIVES

In the EU, the Public Procurement Directives[2] set out the procedures public bodies must follow when concluding public supplies and services contracts. The Council Directives are in place, harmonising contract tender procedures to facilitate cross-border trade in the internal

1 A Erridge and S Hennigan, 'Sustainable procurement in health and social care in Northern Ireland' (2012) 32(5) Public Money and Management 363; Y Askfors and H Fornstedt, 'The clash of managerial and professional logics in public procurement: implications for innovation in the health-care sector' (2018) 34(1) Scandinavian Journal of Management 78.

2 Council Directive 2014/24/EU of 26 February 2014 on public procurement and repealing Directive 2004/18/EC (Public Sector Directive) OJ 2014 No L94/65; Council Directive 2014/25/EU of 26 February 2014 on procurement by entities operating in the water, energy, transport and postal services sectors and repealing Directive 2004/17/EC OJ 2014 No L94/243.

market.[3] In addition to the promotion of cross-border trade, public procurement is regulated to prevent public procurers purchasing in a reckless or discriminatory manner. When carrying out calls for tenders, public bodies must conform to the principles derived from the fundamental freedoms, including the principles of transparency,[4] mutual recognition,[5] proportionality,[6] non-discrimination[7] and equal treatment.[8]

While the rules complement and reflect broader EU policies and legislative developments, the Council Directives have been criticised harshly for being overly complex and administratively burdensome.[9] In particular, the Council Directives have been criticised for pursuing two competing sets of objectives: namely, a set of economic objectives and a set of social objectives.[10] Sánchez-Graells, in particular, argues that the '*ultimate*' purpose of the rules is to secure '*economic efficiency from undistorted competition*'.[11] This interpretation suggests that competition-orientated public markets result in the minimum

3 Council Directive 2004/18/EC (Public Sector Directive); Council Directive 2014/25/EU. Other directives in place not discussed in this article include: Directive 2014/23/EU on the award of concession contracts (2014) OJ L 94/1 (Concessions Directive); Directive 2009/81/EC on the coordination of procedures for the award of certain works contracts, supply contracts and service contracts by contracting authorities or entities in the fields of defence and security, and amending Directives 2004/17/EC and 2004/18/EC (2014) OJ L 216/76; and the Remedies Directive 2007/66/EC.

4 Case C-324/98 *Telaustria Verlags GmbH and Telefonadress GmbH v Telekom Austria AG* [2000] ECR I-10745.

5 Case T-258/06 *Federal Republic of Germany v European Commission* [2010] ECR-2027.

6 Case C-376/08 *Serrantoni Srl i Consorzio stabile edili Scrl v Comune di Milano* [2009] ECR I-12169.

7 Case C-225/98 *Commission v France ('Nord-pas-de-Calais')* [2000] ECR I-7445.

8 Case C-13/63 *Italy v Commission* [1963] ECR 165 at para III, (4)(a); Case C-306/93 *SMW Winzersekt v Land Rheinland-Pfalz* [1994] ECR I-5555 at para 30.

9 A Cox and P Furlong, 'European procurement rules and national preference: explaining the local sourcing of public works contracts in the EU in 1993' (1995) 1(2) Journal of Construction Procurement 87; C J Gelderman, W T Paul and M J Brugman, 'Public procurement and EU tendering directives – explaining non-compliance' (2006) 19 International Journal of Public Sector Management 702–714.

10 P Trepte, *Regulating Procurement: Understanding the Ends and Means of Public Procurement Regulation* (Oxford University Press 2004) 123; S Arrowsmith and P Kunzlik, *Social and Environmental Policies in EC Procurement Law: New Directives and New Directions* (Cambridge University Press 2009); C Bovis (ed), *Research Handbook on EU Public Procurement Law* (Edward Elgar 2016).

11 A Sánchez-Graells, *Public Procurement and the EU Competition Rules* 2nd edn (Bloomsbury 2015) 9 (emphasis added).

distortion of private sector activities, thus allowing for tenderers to submit competitive costs.[12] This approach places competition at the heart of the procurement actions.

Arrowsmith rejects this interpretation, submitting that revisions made to the Council Directives in 2014 have not elevated '*competition*' as a fundamental principle, and alternatively suggests that the fundamental purpose of the rules is to prevent preferential treatment, to remove barriers to trade for suppliers and support the sustainability of competitive public markets.[13] This approach suggests that alongside securing the best value for tax payers' money, public procurers should also consider the wider societal impact of the procurement spend. Alongside assessing submitted bids from interested economic operators on the grounds of costs, quality and performance criteria, procurers should also take into account considerations relating to labour equality, sustainable supply chains and the facilitation of small businesses in public contracts.[14]

Debate has long prevailed as to whether procurement rules should mandate the use of procurement spend to achieve policy goals. However, it is widely accepted that it is necessary to regulate public procurement activities to prevent the mismanagement of funds and prevent corrupt and collusive behaviour.[15] Open and transparent competitions are required to inform the market of contract opportunities and contract awards, facilitate competition and support review processes.[16] Contracting authorities at a minimum are required to advertise calls for competition notices:

> ... for the benefit of any potential tenderer, a degree of advertising sufficient to enable the services market to be opened up to competition and the impartiality of the procedures to be reviewed.[17]

Despite the concerns raised that the revised rules are directing contracting authorities to purchase in a strategic manner, the rules do not dictate what purchasers should buy and instead set out procedures which must be followed to facilitate cross-border tendering in the internal market.

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12 Case C-240/83 *Waste Oils* [1985] ECR 531 9; Case C-55/06 *Arcor v Germany* [2008] ECR I-2931 Opinion of Advocate General Poires Maduro, para 49.

13 Public Sector Directive, recital 93.

14 S Arrowsmith, 'The purpose of the EU procurement directives: ends, means and the implications for national regulatory space for commercial and horizontal procurement policies' (2012) 14 Cambridge Yearbook of European Legal Studies 1.

15 A Jones, 'Combatting corruption and collusion in UK public procurement: proposals for post-Brexit reform' (2021) 84(4) Modern Law Review 667.

16 Case C-19/00 *SIAC Construction* [2001] ECR I-7725, para 35.

17 Case C-324/98 *Telaustria*, para 62.

When COVID-19 cases began to rise in member states, the Commission quickly directed public bodies to rely on the emergency provisions set out in the Council Directives, again merely indicating how purchasers should engage with the market.[18] It was the World Health Organization (WHO) that established guidelines outlining the specific medical countermeasures required for managing the pandemic.[19] For contracting authorities responsible for procuring health-related products and services, their procurement objectives changed from attempting to secure the optimum combination of whole-life costs and quality to securing supplies '*at all costs*'.[20] The Commission recognised this change of priorities and objectives, noting that contracting authorities may derogate from the basic principle of the Treaty on the Functioning of the European Union (TFEU) concerning transparency when rapidly purchasing medical supplies from an increasingly disrupted supply chain.[21] Although, in the same guidance note, the Commission continued to call for contracting authorities to comply with the broader policy objectives of the rules, rallying purchasers where possible to:

> ... take into account [also] strategic public procurement aspects, where environmental, innovative and social requirements, including accessibility to any services procured, are integrated in the procurement process.[22]

Contracting authorities were placed in a very difficult position, they were tasked with procuring scarce supplies while ensuring the efficient use of public spend. This article aims to offer an overview of the key legislative provisions available for use during the pandemic and questions if it is time to phase out the use of emergency procurement. The next section of the paper will review the emergency provisions relied on by contracting authorities to conclude public supplies and services contracts and will swiftly move on to reviewing the joint procurement actions taken by the Commission on behalf of member states.

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18 Joint Communication to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, Communication on the Global EU response to COVID-18 [2020] JOIN/2020/11 final.

19 World Health Organization, 'Operational support and logistics disease commodity packages' [2020] V4 WHO/2019-nCoV/DCPv3/2020.4.

20 V Clarke and M Wall, 'Donnelly defends HSE over ventilator procurement after only 465 of 2,200 pre-paid machines delivered' *Irish Times* (Dublin, 1 September 2021) (emphasis added).

21 Guidance from the European Commission on using the public procurement framework in the emergency situation related to the COVID-19 crisis OJ C108I/1.

22 Ibid.

PUBLIC PROCUREMENT LEGISLATIVE RESPONSES TO THE COVID-19 PANDEMIC

When the WHO declared the COVID-19 outbreak a pandemic, the EU swiftly coordinated a regional health response supported by various financial mechanisms.[23] In April 2020, the Commission published a guidance communication outlining the 'options and flexibilities available under the EU public procurement framework for the purchase of the supplies, services, and works needed to address the crisis'.[24] Similar advisory notes were issued in Ireland and Northern Ireland. The European Union (Award of Public Authority Contracts) Regulations 2016 (SI No 2016/284) implements Directive 2014/24/EU into Irish law. Public procurement is considered a transferred matter under the Northern Ireland Act 1998 as the UK Public Contracts and Utilities Contracts Regulations were adopted prior to the restoration of a devolved administration in Northern Ireland. As such, public procurement law in Northern Ireland falls within the scope of the UK procurement regulations, the Public Contracts Regulations 2015 implemented in England, Wales and Northern Ireland by Council Directive 2014/24/EU.[25]

Both the EU and national COVID-19 guidance notes reaffirmed that the procurement rules and policies were not relaxed in their entirety. Prior to engaging in any additional procurements, contracting authorities were firstly encouraged to exploit ongoing contracts with suppliers to increase supplies or extend concluded contracts. Procurers were encouraged to make purchases under existing contracts or conduct competitions under established 'framework agreements'.[26] If contracting authorities were unable to secure adequate supplies using or modifying contracts in place, procurers were encouraged to temporarily rely on the accelerated procedures and, as a last resort, direct awards.

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23 Primarily a rescEU stockpile of medical equipment was introduced and the EU4Health initiative was adopted. The European Civil Protection Mechanism aims to strengthen cooperation between the EU member states, and participating states, in the field of civil protection, with a view to improving prevention, preparedness and response to disasters. See European Commission, 'Strengthening EU disaster management: rescEU solidarity with responsibility' COM (2017) 773 final; Press Release (EC), 'COVID-19: Commission creates first ever rescEU stockpile of medical equipment' (19 March 2020).

24 European Commission OJ C108I/1 (n 21 above).

25 As amended Public Contracts Regulations 2015 amended by Public Procurement (Amendment etc) (EU Exit) Regulations 2020 (SI 2020/1319).

26 Framework agreements are generally attached to the concluded contracts, allowing national, regional and local contracting authorities to purchase from the framework agreements using the stated and agreed-upon form of mini-competition or purchasing method.

INDIVIDUAL PROCUREMENT ACTIONS: ACCELERATED PROCEDURES AND DIRECT AWARDS

There are a number of 'flexible' options available under the Council Directives that procurers may rely on to secure 'urgently' required supplies and services. Provisions are in place to allow procurers to substantially reduce tendering deadlines in cases of urgency.[27] In cases of 'duly justified urgency', the deadline for submission of tenders under the commonly used 'open procedure' may be reduced to 15 days.[28] Similarly, the deadline to submit a request to participate under the 'restricted procedure' may be reduced to 15 days, with the deadline for tender submissions reduced to 10 days.[29] The Commission noted that the use of the accelerated open or restricted procedures must comply 'with the principles of equal treatment and transparency and ensures competition even in the cases of urgency'.[30] It appears that the accelerated procedures could be used to procure urgently required supplies and services while promoting the central objectives of the rules, although these procedures did not offer an immediate solution to the emerging COVID-19 crisis. Hospitals, in particular, required immediate access to PPE, ventilators, and other medical equipment and pharmaceuticals.

In circumstances where it is not appropriate to rely on the accelerated open or restricted procedures, contracting authorities may consider using a 'negotiated procedure without publication'.[31] Using this procedure, procurers are able to negotiate directly with suppliers. Unlike the accelerated open or restricted procedures, there are no set rules, time limits or procedural requirements attached to the negotiated procedure without publication.[32] This process allows procurers to conclude contracts immediately. Contracting authorities may rely on this procedure:

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27 When conducting a competition using the most straightforward 'open procedure', procurers are required to advertise the competition for a minimum of 35 days. Under the 'restricted procedure', interested economic operators must be provided with a minimum of 30 days to submit a tender. This procedure is carried out in two stages, with the second stage requiring an additional 30 days' submission requirement. Council Directive, art 27, art 28.

28 Ibid art 27(3).

29 Ibid art 28(3).

30 C-275/08, *Commission v Germany*, and C-352/12, *Consiglio Nazionale degli Ingegneri*, and Council Directive, art 32(2)(c).

31 Council Directive, art 32.

32 M Burnett, 'The new rules for competitive dialogue and the competitive procedure with negotiation in Directive 2014/24 – what might they mean for PPP?' (2015) 10(2) European Procurement and Public Private Partnership Law Review 62.

> insofar as is strictly necessary where, for reasons of extreme urgency brought about by events unforeseeable by the contracting authority, the time limits for the open or restricted procedures or competitive procedures with negotiation cannot be complied with. The circumstances invoked to justify extreme urgency shall not in any event be attributable to the contracting authority.[33]

The conditions must be strictly met to prevent the misuse of public funds and non-compliance with the basic transparency principle of the Treaty.[34] However, it is obvious that the impact of the COVID-19 pandemic on the healthcare systems was an unforeseeable event for public bodies and contracting authorities could easily meet the set conditions when attempting to secure medical supplies.[35] Theoretically, procurers could use this procedure to finalise a contract within a number of hours, but the practical issues posed a greater problem, namely the lack of supply and increased costs.[36]

In response to lack of supply concerns, the Communication from the Commission on using public procurement procedures during the pandemic suggested that procurers should consider contacting or directly meeting with existing and potential contractors to confirm immediate delivery of available stocks.[37] Additionally, procurers were encouraged to accept tenders from companies and innovators that were willing to design solutions to solve the pressing challenges raised by COVID-19.[38] While the Communication aimed to assist procurers in accessing supplies and services to manage the pandemic, it additionally acted as a reminder to encourage procurers to integrate accessibility, environmental, innovative and social considerations in the procurement procedures.[39] All procurement activities not affected by the pandemic were required to respect the applicable requirements laid out in the Council Directives. Overall, the use of the accelerated and negotiated procedures for urgent medical supplies and medicines provided contracting authorities with the flexibility to conclude public contracts in a simplified and speedy manner.[40] However, allowing for

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33 Council Directive, art 32(2)(c)

34 C-275/08 *Commission v Germany* and C-352/12 *Consiglio Nazionale degli Ingegneri*, and Council Directive.

35 European Commission, 'Public procurement in healthcare systems' (2021) Opinion of the Expert Panel on effective ways of investing in Health (EXPH).

36 N Hawkes, 'Pfizer is fined £84m for "exploiting opportunity" to hike price of phenytoin' (2016) British Medical Journal 355.

37 European Commission OJ C108I/1 (n 21 above).

38 D Mwesiumo, R Glavee-Geo, K M Olsen and G A Svenning, 'Improving public purchaser attitudes towards public procurement of innovations' (2021) Technovation 102.

39 European Commission OJ C108I/1 (n 21 above).

40 Once they met the strict requirements laid out in 32(2)(c) of the Directive.

the use of the emergency provisions did not ease procurers' difficulties in acquiring scarce PPE, ventilators and additional hospital and intensive care infrastructure.

JOINT PROCUREMENT ACTIONS

Separately to the easing of the public procurement procedures, the Commission accelerated the use of the Joint Procurement Agreement (JPA).[41] Similarly, and not unsurprisingly, the previous H1N1 influenza pandemic in 2009 caused serious disruptions to supply chains. During the 'swine flu' outbreak member states competed against each other, often unsuccessfully, for scarce medical supplies, which led to price hikes, stock hoarding and inflated demand.[42] Consequently, the European Council sought to improve solidarity in times of emergencies and requested the Commission to introduce measures to support the use of joint procurement to prepare for future pandemics.[43] Subsequently, Decision 1082/2013/EU, on the basis of article 168(5) of the TFEU,[44] was introduced to prepare for serious cross-border threats to health. A specific provision is contained in that Decision to allow the EU institutions and the member states to engage in a joint procurement mechanism to enable 'the advance purchase of medical countermeasures for serious cross-border threats to health'.[45]

It is worth noting that the JPA itself is not a pure EU legal Act, it is merely a budgetary implementing measure of Decision 1082/2013/EU.[46] Therefore, article 5 is not the JPA's legal basis as the public law powers related to health policy are conferred under article 168

41 See European Commission, 'Explanatory note on the joint procurement mechanism' (December 2015).

42 N Azzopardi-Muscat, P Schroder-Bäck and H Brand, 'The European Union Joint Procurement Agreement for cross-border health threats: what is the potential for this new mechanism of health system collaboration?' (2017) 12(1) Health Economics, Policy and Law 43–59.

43 Ibid.

44 Art 5 provides for participating member states to engage in a joint procurement procedure conducted pursuant to the third subparagraph of art 104(1) of Regulation (EU, Euratom) No 966/2012 on the financial rules applicable to the general budget of the Union and pursuant to art 133 of Commission Delegated Regulation (EU) No 1268/2012 on the rules of application of Regulation (EU, Euratom) No 966/2012 on the financial rules applicable to the general budget of the Union, with a view to the advance purchase of medical countermeasures for serious cross-border threats to health.

45 Decision 1082/2013/EU OJ 2013 L 293/1, art 5.

46 A Sánchez-Graells, 'Procurement in the time of COVID-19' (2020) 71(1) Northern Ireland Legal Quarterly 81–87.

TFEU.[47] The JPA is a *sui generis* legal instrument rooted in article 168 TFEU that allows member states to pool their resources to secure medical countermeasures in preparation for and during instances of cross-border health crises.[48] 'Medical countermeasures' refer to any medicines, medical devices, or any other related goods or services that are aimed at combating serious cross-border threats to health.[49] Since its introduction in 2014, the JPA has been used to procure and in some cases stockpile, vaccines, antivirals and other medical countermeasures in preparation for serious cross-border health emergencies.[50] However, the previous agreements concluded did not assist signatories adequately in preparation for the COVID-19 pandemic.

An initial procurement competition conducted under the agreement for PPE in February 2020 was unsuccessful. After a rocky start, the use of the JPA gained momentum and five competitions for the provision of ventilators, goggles, face shields and masks, laboratory equipment, testing kits and intensive care unit medicines were successfully concluded.[51] As noted by Sánchez-Graells, the success of the JPA is heavily reliant on competition in the marketplace.[52] Despite the disruptions in the global supply chain, the Commission successfully organised the procurements for critically needed medical supplies. The supplies were allocated on a needs basis, responding to signatories' immediate needs to prevent their healthcare systems from collapsing or becoming overwhelmed by surges of infections.[53]

It is important to note that the JPA mechanism is not subject to the same objectives and aims as the Council Directives. The JPA mechanism should be conducted in light of the aim of Decision 1082/2013/EU which is to assist coordinated approaches to improve

47 Art 168(5) TFEU allows for the adoption of 'incentive measures designed to protect and improve human health and in particular to combat the major cross-border health scourges, measures concerning monitoring, early warning of and combating serious cross-border threats to health …'.

48 It is important to note that the JPA is fully governed by EU law and under the jurisdiction of the CJEU.

49 Separately, cross-border health crises are defined as: a life-threatening or otherwise serious hazard to health of biological, chemical, environmental or unknown origin which spreads or entails a significant risk of spreading across the national borders of Member States, and which may necessitate coordination at Union level in order to ensure a high level of human health protection. Article 3 (lett g) of the Decision.

50 The first procurement competition conducted under the JPA for the provision of Botulinum anti-toxin was carried out in 2016.

51 European Commission, 'COVID-19 Response – Public Health'.

52 Sánchez-Graells (n 46 above).

53 L D Dąbrowski, 'Poland and EU cooperation – mechanism of joint public procurement (COVID-19)' in J Menkes and Magdalena Suska (eds), *The Economic and Legal Impact of COVID-19* (Routledge 2021) 53.

the prevention and control of the spread of diseases and other serious cross-border threats to health.[54] The JPA is therefore not concerned with ensuring the non-discriminatory completion of competitive public contracts. However, it appears from the outset that the procurement competitions organised under the JPA respected the Treaty principle of transparency. Call for competition notices were openly published in the Official Journal (OJ) outlining the procurement selection and award criteria. Additionally, contract award notices were published naming the preferred candidates.[55] If the successful use of the JPA is heavily reliant on competition in the marketplace, it is timely for the Commission to assess the JPA's objectives and responsibility for the promotion of sustainable competition in the global market.

In comparison with the successful use of the JPA to secure medical countermeasures, the EU's response for acquiring vaccines was more controversial and, arguably, less effective and tainted by political motives. Vaccines are society's best defence to fighting and protecting against pandemics and over the last 18 months states have scrambled to inoculate society to protect vulnerable members from illness and stabilise fluctuating economies.[56] Traditional procurement procedures are not appropriate for the purchase of vaccines under development as the product is not readily available on the market.[57] As such, the accelerated open or restricted procedures or the negotiated procedure without publication would not have secured timely acquisitions of vaccines once they became readily *available*. The JPA, in the same way, was also an inappropriate approach to take as the agreement is used to conclude contracts for the provision and supply of available medical countermeasures.

On the basis of Regulation (EU) 2016/369 (the ESI Regulation),[58] Decision 4192/2020/EU allows for the Commission to procure COVID-19 vaccines on behalf of the member states. Advance purchase agreements (APAs) were signed with vaccine manufacturers for the

54 Although art 5(2)(c) of Decision 1082/2013/EU specifically states that joint procurement does not affect the internal market, does not constitute discrimination or a restriction of trade or does not cause distortion of competition.

55 See Contract Award Notices: 2020/S 051-119976 of 12 March 2020; 2020/S 100-238632.

56 A S Rutschman, 'The COVID-19 vaccine race: intellectual property, collaboration(s), nationalism and misinformation' (2021) 64 Washington University Journal of Law and Policy 167–202, 'Introduction' 167.

57 Following the COVID-19 outbreak in 2020, the Council adopted Regulation (EU) 2020/521 activating emergency support measures under the ESI Regulation. The activation period was from 1 February 2020 to 31 January 2022.

58 Art 4, para 5, point (b) of the ESI Regulation provides that the Commission may grant emergency support in the form of procurement on behalf of the member states based on an agreement between the Commission and member states.

development, production and supply of COVID-19 vaccines.[59] This form of agreement requires initial financial support, which was provided for through the 'emergency support instrument' (ESI).[60] Upfront finances were provided for under the ESI to secure large volumes of vaccines '*in a given timeframe and at a given price*'.[61] The aim of the process as outlined in the 'EU Vaccines Strategy', is to 'ensure the production in Europe of qualitative, safe and efficacious vaccines, and to secure swift access to them for Member States and their populations'.[62] Moreover, the process was designed to reflect procedures often relied on to purchase pharmaceuticals from a limited and often closed market.[63] Procurement of pharmaceuticals and medical countermeasures, in particular, patented medicines and medical devices, often rely on prolonged negotiated procedures resulting in member states paying different costs for the same products.[64]

After a delayed start, the Commission succeeded in securing vaccines from several suppliers. Initial contracts were agreed with; BioNTech-Pfizer for up to 600 million doses; AstraZeneca for up to 400 million doses; Sanofi-GSK for up to 300 million doses; Johnson and Johnson (J&J) for up to 400 million doses; CureVac for up to 405 million doses; Moderna for up to 160 million doses; Novavax for up to 200 million doses; and Valneva for up to 60 million doses.[65] Originally, the Commission refused to publish information on the concluded agreements, suggesting that this was to protect sensitive financial information and information relating to product developments.[66] Furthermore, it was stated that:

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59 Decision 4192/2020/EU provides for the Commission to procure COVID-19 vaccines on behalf of the member states.

60 OJ L 70, 16 March 2016, p 1, as amended by Council Regulation (EU) 2020/521 of 14 April 2020 activating the emergency support under the ESI Regulation, and amending its provisions taking into account the COVID-19 outbreak, OJ L 117, 15.4.2020, 3.

61 European Ombudsman's Decision in the joint cases *85/2021/MIG* and *86/2021/MIG* (emphasis added).

62 European Commission, 'Coronavirus: towards a common vaccination strategy' (17 October 2021).

63 WHO Regional Office for Europe, *How Can Voluntary Cross-Border Collaboration in Public Procurement Improve Access to Health Technologies in Europe?* (WHO Regional Office for Europe Publications 2016).

64 M L Johnson, J Belin, F Dorandeu and M Guille, 'Strengthening the cost effectiveness of medical countermeasure development against rare biological threats: the Ebola outbreak' (2017) 31(6) Pharmaceutical Medicine 423–426.

65 European Commission Communication, 'EU strategy of COVID-19 vaccines' (2020).

66 European Ombudsman's Decision (n 61 above)

> Disclosing sensitive business information would also undermine the tendering process and have potentially far-reaching consequences for the ability of the Commission to carry out its tasks as set out in the legal instruments that form the basis of the negotiations.[67]

However, following the European Ombudsman's Decision in the joint cases *85/2021/MIG* and *86/2021/MIG*, the Commission has agreed to increase 'transparency' in future procurement processes for the supply and provisions of COVID-19 vaccines.[68] The Commission has since published redacted versions of all concluded APAs on its official website. Furthermore, the Commission agreed to review the documents on an ongoing basis with the view of removing redactions where possible.[69] Further commitment to improving transparency in the process can be seen in the recent compliance with freedom of information (FoI) requests from media outlets. Media outlets have been publishing vaccines costs retrieved from Commission Communications.[70] This is a somewhat unusual move, as pharmaceutical prices are rarely disclosed.[71] This is, however, a welcome move, as it will assist other non-EU countries with leveraging power when negotiating for future contracts.

Separately, the UK was more successful in securing COVID-19 vaccines in a compressed timeframe. The UK's mass vaccination plans were implemented 'before confirmation of the first Covid-19 case' was reported.[72] In a more aggressive manner than the EU, the UK concluded its first negotiated contract for the provision of 100 million doses of the Oxford-AstraZeneca vaccine in June 2020. Separate contracts were also negotiated for the provision of the Pfizer-BioNTech vaccine.[73] Alongside the use of the APAs to procure vaccines, member states conducted individual contracts to buy additional vaccines. While the use of the APAs might have been problematic, the upfront funding

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67 Ibid.

68 These cases arose over concerns filed by the not-for-profit company, Corporate Europe Observatory regarding the Commission's refusal to fully comply with two FoI requests regarding the vaccine's procurement procedures.

69 See European Commission, 'EU vaccines strategy'.

70 D P Mancini, H Kuchler, M Khan, 'Pfizer and Moderna ramp up EU COVID vaccine prices' *Irish Times* (Dublin, 1 August 2021). It was reported that the unit price for a Pfizer shot has increased from €15.50 to €19.50, and Moderna prices have increased from €21.49 to €24.02.

71 S G Morgan, H S Bathula and S Moon, 'Pricing of pharmaceuticals is becoming a major challenge for health systems' (2020) British Medical Journal. 368.

72 Department of Health and Social Care, 'UK COVID-19 vaccines delivery plan' 11 January 2021.

73 K Bingham, 'The UK Government's Vaccine Taskforce: strategy for protecting the UK and the world' (2021) 397(10268) The Lancet 68–70.

offered to the pharmaceutical companies significantly supported the rapid development and testing of the COVID-19 vaccines.

PROCURING IN A POST-PANDEMIC SOCIETY

An initial objective of this paper was to identify how the public procurement legislative framework supported the management of the pandemic. This section of the article summarises the key lessons learnt and offers some suggestions on how procurement should operate in a post-pandemic era. The findings are threefold. Firstly, the article argues that it is no longer appropriate for contracting authorities to rely on the accelerated procedures or directly awarded contracts. Secondly, the findings suggest that the process used to conclude the APAs for the supply of vaccines lacked transparency and need to be reviewed. Finally, on foot of previous research, the paper recognises the success of the JPA and calls for the further use of centralised procurement to obtain medical countermeasures, including COVID-19 vaccines and eventual therapeutics.[74] The paper concludes by suggesting that further research is needed to assess the importance of 'competition' as a fundamental objective of the Council Directives and coordinated joint procurement mechanisms.[75] Previous literature has questioned the elevation of competition as a fundamental principle of the Council Directives, however, as we enter this new post-pandemic stage, competition needs to be at the heart of procurement as global supply chains remain in a disrupted state and economies are fragile. The economic and social importance of public procurement was often overlooked in the past, but the pandemic has highlighted the significance of the activity and it is now the perfect time to review its objectives and potential to foster a sustainable, innovative, competitive and socially inclusive society.

Emergency provisions

During the early stages of the pandemic, contracting authorities, in the first instance, were able to rely on emergency 'accelerated' procedures or direct contracts to fast-track the purchase of PPE and medical equipment.[76] For the most part, these negotiations resulted in the timely acquisition of emergency supplies in Ireland and Northern

74 E McEvoy and D Ferri, 'The role of the Joint Procurement Agreement during the COVID-19 pandemic: assessing its usefulness and discussing its potential to support a European Health Union' (2020) 11(4) European Journal of Risk Regulation 851.

75 Building on the extensive and insightful scholarship conducted by Albert Sánchez-Graells, see A Sánchez-Graells, *Public Procurement and the EU Competition Rules* (Hart 2011). See also, Sánchez-Graells (n 11 above) 9.

76 See Council Directive 2014/24/EU, art 1(2).

Ireland.[77] Although, the reliance on the negotiated procedure without prior publication to deactivate procedural requirements quickly led to nationalistic purchasing actions.[78] Unsurprisingly, the unprecedented global demand for medical countermeasures quickly led to price hikes and supply shortages.[79] Recent reviews and audits of the public sector's early response to the pandemic have further shown that use of the accelerated contracts resulted in the purchase of PPE and supplies that have fallen short of expected standards.[80] The use of the accelerated procedures, particularly the negotiated procedure, without publication in the UK and Ireland resulted in high costs, non-delivery of pre-paid items, and the acquisition of poor or inferior products.[81] Additionally, there was evidence of poor management and non-compliance with internal policies when conducting accelerated procedures.[82]

There have been many examples of poor procurement actions, which illustrate the procurers' desperation to conclude risky contracts for the provision of medical supplies. In Ireland, a Health Service Executive (HSE) internal auditor's report harshly criticised the processes used to conclude contracts for the supply of ventilators.[83] It noted that the HSE pre-paid for the supply and delivery of 2200 ventilators, only 465 of which were delivered to date. None of the delivered 465 ventilators were put into use. The HSE defended its actions acknowledging that the procurement was conducted;

> ... in a volatile and effectively closed market where we had to secure equipment in extremely high demand, in an expedited timeframe and under considerable pressure, in the face of a global pandemic.[84]

Despite these justifications, significant sums of public money were misspent and wasted. Furthermore, safety tests completed by the

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77 K Burnett, S Martin, C Goudy, J Barron, L O'Hare, P Wilson, G Fleming and M Scott, 'Ensuring the quality and quantity of personal protective equipment (PPE) by enhancing the procurement process in Northern Ireland during the COVID-19 pandemic: challenges in the procurement process for PPE in NI' (2021) 27(1) Journal of Patient Safety and Risk Management 42–49.

78 European Commission, 'Coronavirus: European solidarity in action' (2020)

79 M Eßig, C von Deimling and A Glas, 'Challenges in public procurement before, during, and after the COVID-19 crisis: selected theses on a competency-based approach'(2020) 3 European Journal of Public Procurement Markets 65–80.

80 S Sian and S Smyth, 'Supreme emergencies and public accountability: the case of procurement in the UK during the COVID-19 pandemic' (2021) 35(1) Accounting, Auditing and Accountability Journal 146–157.

81 Ibid.

82 Ibid. See also Clarke and Wall (n 20 above). 'Donnelly defends HSE over ventilator procurement after only 465 of 2,200 pre-paid machines delivered' *Irish Times* (Dublin, 1 September 2021).

83 Clarke and Wall (n 20 above).

84 Ibid. The article included the HSE's response to the internal audit findings.

HSE found that the first 100 ventilators received had a 41 per cent failure rate.[85] The auditor's report further found that the HSE pre-paid €81 million to 10 new suppliers that had no previous experience of supplying ventilators to the state. The HSE's willingness to conclude high-risk contracts highlights the extreme urgency faced during this particular period and the political pressure placed on procurers 'to get these ventilators in at all costs'.[86] The UK's procurement actions have also been subject to scrutiny and criticism. A recent government report noted that large quantities of PPE procured during the pandemic did not meet contractual specifications or relevant safety standards, including 50 million face masks and 10 million surgical gowns.[87]

In his ongoing blog discussion of procurement during the pandemic, Telles has repeatedly questioned the lawfulness of the use of the negotiated procedure without prior publication via article 32(2)(c) of Directive 2014/24/EU and regulation 32(2)(c) to finalise the 'vast majority of contracts' in the UK in 2020.[88] Telles has consistently argued that the contracts concluded were unlawful due to the 'unnecessary discrimination they entail'. This argument is somewhat supported by the recent ruling in *R (Good Law Project and EveryDoctor) v Secretary of State for Health and Social Care*, which found that the UK Government was obliged to comply with the principles of equal treatment and transparency when relying on the emergency provisions to conclude 'High Priority Lane' COVID-19 response contracts in 2020.[89] While the High Court found that the fundamental principles were not lawfully displaced for these particular contracts, it confirmed that the public procurers were entitled to rely on regulation 32(2)(c) to directly award contracts, based on the facts that the global pandemic was unforeseeable and there was extreme urgency to acquire supplies.[90]

This ruling acts as a reminder to public procurers that the use of regulation 32(2)(c) is only lawful in exceptional circumstances, where the procurer can cumulatively meet the criteria set out in the regulation

85 KPMG, internal audit conducted on behalf of the HSE summarising procurement spend during the pandemic. This report has not been made available to the public. Certain information has been retrieved by the *Irish Times* through FoI requests.

86 Minister for Health, Stephen Donnelly's response to the internal audit. See Clarke and Wall (n 20 above).

87 Nicholas Barrett and Anthony Reuben, 'What is going on with government COVID contracts?' (*BBC News* 30 June 2021).

88 Pedro Telles, 'High Court rules (some) VIP route contract as unlawful' (*Telles.eu* 12 January 2022). See also 'Why those UK PPE contracts from 2020 are illegal' (*Telles.eu* 25 May 2021).

89 *R (Good Law Project and EveryDoctor) v Secretary of State for Health and Social Care* [2022] EWHC 46 (TCC).

90 Ibid 329–338.

and in cases C-275/08 *Commission v Germany* and C-352/12 *Consiglio Nazionale degli Ingegneri*. It is difficult to see how procurers can lawfully displace the principles of equal treatment and transparency at this stage of the pandemic, as it can no longer be described as an unforeseen and extremely urgent situation. Sánchez-Graells warns that procurers may be tempted to use simplified negotiated practices during this stage of the pandemic to pursue specific economic goals or use procurement to channel additional public spend to revitalise national economies.[91] But the recent rise in procurement litigation and findings from government audits would indicate that procurers should avoid any form of uncompetitive tendering, as the closed procurements conducted over the course of the pandemic have resulted in inefficient and at times reckless spending.[92] While the use of emergency procurement is strongly discouraged at this stage of the pandemic, the availability and use of the accelerated procedures and negotiated procedure without prior publication was arguably one of the core legislative supports available to governments in early 2020.[93] European joint procurement efforts equally assisted member states navigating this extremely difficult stage of the pandemic.

Coordinated procurement at a European level

Prior to the COVID-19 pandemic, individual member states in an effort to improve purchasing power engaged in joint procurement activities to secure medical supplies. Member states, in their individual capacity, often struggle to secure competitive prices or access to patented or innovative medicines and technologies.[94] There are various examples, with varying degrees of successes, of states forming alliances to improve their access to required medical supplies, such as the failed joint procurement for the provision of the BCG vaccine undertaken by Latvia,

91 Sánchez-Graells (n 46 above)

92 A Sánchez-Graells, 'COVID-19 PPE extremely urgent procurement in England: a cautionary tale for an overheating public governance' in Dave Cowan and Ann Mumford (eds), *Pandemic Legalities: Legal Responses to COVID-19 – Justice and Social Responsibility* (Bristol University Press 2021) 93.

93 M Kubak, P Nemec and M Vološin, 'On the competition and transparency in public procurement during COVID-19 pandemic in European Union' (2021).

94 Johnson et al (n 64 above).

Estonia and Lithuania under the Baltic Partnership Agreement.[95] The H1N1 'swine flu' pandemic sounded the sirens that member states cannot manage cross-border health crises individually and paved the way for the introduction of the JPA.[96] Unfortunately, the JPA was not activated fully and the Commission did not have appropriate supplies or measures put in place to immediately support countries when the first wave crashed onto the Italian shores. The JPA was only used to its full potential when COVID-19 was surging through countries. This article argues that the use of the JPA, when activated, was one of the strongest and most effective (*voluntary*) legislative mechanisms relied on to fight the pandemic. Countries, such as the UK and Ireland, as noted above, struggled in an individual capacity to secure appropriate and cost-effective PPE, ventilators and other medicines and equipment during the first wave of the pandemic.[97] The JPA provided the lifeline for healthcare authorities by securing significant volumes of PPE.[98] In recognising the success of the JPA, the Commission plans to increase the use of collaborated health actions, including joint procurement, to support the creation and development of a European Health Union.[99]

However, the coordinated approach for the production and development of vaccines has been less than desirable.[100] The procurement procedures and concluded agreements were shrouded

95 Since 2012, other collaborative activities for innovative medicines and medical devices have been conducted, including: a BeNeLuxA Agreement between Belgium, Netherlands, Luxembourg and Austria; the Nordic Pharmaceuticals Forum between Denmark, Iceland, Norway and Sweden; Southern European initiative between Greece, Bulgaria, Spain, Cyprus, Malta, Italy and Portugal; and Central Eastern European and South Eastern European Countries Initiative between Romania, Bulgaria, Croatia, Latvia, Poland, Serbia, Slovakia, Slovenia, Republic of Moldova and FYR Macedonia.

96 S Ponzio, 'Joint procurement and innovation in the new EU Directive and in some EU-funded projects' (2014) Ius Publicum Network Review.

97 R Beetsma, B Burgoon, F Nicoli, A de Ruijter and F Vandenbroucke, 'Public support for European cooperation in the procurement, stockpiling and distribution of medicines' (2021) 31(2) European Journal of Public Health 253–258.

98 European Commission, 'Overview of the Commission's response' (7 July 2020). See also S Baute and A De Ruijter, 'EU health solidarity in times of crisis: explaining public preferences towards EU risk pooling for medicines' (2021) Journal of European Public Policy 1–23.

99 European Commission, 'Building a European Health Union: reinforcing the EU's resilience for cross-border health threats' (2020) COM 724 final; N Fahy, T Hervey, M Dayan, M Flear, M Galsworthy, S Greer, H Jarman and M McKee, 'Assessing the potential impact on health of the UK's future relationship agreement with the EU: analysis of the negotiating positions' (2021) 16(3) Health Economics, Policy and Law 290–307.

100 E Schanze, 'Best efforts in the taxonomy of obligation – the case of the EU vaccine contracts' (2021) 22(6) German Law Journal 1133–1145.

in secrecy.[101] When problems arose regarding delivery and safety of the vaccines, the Commission adopted a strong defensive stance.[102] Improvements have been made with the Commission recognising the need to improve transparency in the process.[103] Redacted versions of all concluded contracts are publicly available for perusal and review. However, when the current contracts come to an end in 2022, the Commission should consider retiring the APAs and return to using the JPA mechanism for procuring vaccines.

On a more general note, the WHO warns that large-scale centralised procurement can inadvertently result in the distortion of competition or a restriction in trade.[104] This is particularly evident in circumstances where exclusivity agreements are relied on as exclusivity restrictions during times of crisis can create unfair barriers to trade and hinder countries' access to critical medical supplies.[105] The concluded APAs have included exclusivity restrictions, and it is unknown at this stage what impact these inclusions are having on the equitable global distribution of COVID-19 vaccines.[106] Even though there were flaws, overall, the speedy development, testing, formal approval and supply of the COVID-19 vaccines was extraordinary. Additionally, the EU has significantly contributed to the COVAX Facility. The Facility is co-led by Gavi, the Vaccine Alliance, the Coalition for Epidemic Preparedness Innovations and the WHO and is driven by the purpose 'to accelerate the development and manufacture of COVID-19 vaccines and to guarantee fair and equitable access for every country in the world'.[107] Alongside these measures, the Commission, when designing future and extended

101 R Hyde, 'von der Leyen admits to COVID-19 vaccine failures' (2021) 397(10275) Lancet 655.

102 European Commission, 'Belgian Court orders AstraZeneca to deliver vaccine doses to the EU' (19 June 2021).

103 European Commission, 'Speech by President von der Leyen at the European Parliament plenary on the state of play of the EU's COVID-19 vaccination strategy' (10 February 2021).

104 WHO (n 63 above)

105 A McMahon, 'Patents, access to health and COVID-19: the role of compulsory and government-use licensing in Ireland' (2020) 71(3) Northern Ireland Legal Quarterly 331–359; C L Atkinson, C McCue, E Prier and A M Atkinson, 'Supply chain manipulation, misrepresentation, and magical thinking during the COVID-19 pandemic' (2020) (50) American Review of Public Administration 6; Z Yu, A Razzaq, A Rehman, A Shah, K Jameel and R S Mor, 'Disruption in global supply chain and socio-economic shocks: a lesson from COVID-19 for sustainable production and consumption' (2021) Operations Management Research 1.

106 E Brooks and R Geyer, 'The development of EU health policy and the COVID-19 pandemic: trends and implications' (2020) 42(8) Journal of European Integration 1057–1076.

107 European Commission, 'Coronavirus global response: Commission joins the COVID-19 Vaccine Global Access Facility (COVAX)' (1 September 2021)

use of the JPA or APAs, must take into account any potential adverse impact the planned procurements could have on global supply.

Review of procurement objectives

As mentioned at the start of this article, the Council Directives have a number of primary economic objectives and secondary horizontal policy goals. An underpinning goal of the EU public procurement rules is to promote cross-border trade in the internal market by harmonising the use of transparent tendering processes.[108] These objectives were quickly side-lined when procurers were tasked with securing COVID-19-related contracts. Contracting authorities in Ireland and Northern Ireland were continuously reminded to ensure that their procurement processes secure 'value for money, transparency and equal treatment' in circumstances where the procurement was unaffected by COVID-19-related issues.[109] However, these objectives may prove difficult to achieve as procurers are no longer facing just the health crisis and are now additionally facing a global supply chain crisis.[110] There are several reasons for this emerging global supply chain crisis. Temporary and continued closures of factories in Asia due to COVID-19 outbreaks, shortages of shipping containers and personnel, the impact of Brexit and the consequences of the Suez Canal blockage in March 2021 have all contributed to the current disruption to the supply chain.[111]

As procurement will only yield cost savings, efficiencies and generate social impact when the market is competitive, it is timely for procurers to re-evaluate the relationship between competition and procurement. Bovis reminds us that competition and public procurement law are two separate doctrines, acknowledging that EU competition law is underpinned by a principle of uniformity and possesses a corrective characteristic whereas public procurement rules allow for member state discretions and have an underlying convergence character.[112]

108 European Commission, *Proposal for a Directive of the European Parliament and of the Council on Public Procurement* (2011) COD 0438.

109 Department of Finance, 'Procurement guidance note 01/20: supplier relief due to COVID-19'.

110 P Haren and D Simchi-Levi, 'How coronavirus could impact the global supply chain by mid-March' (2020) Harvard Business Review 28; P Chowdhury, S K Paul, S Kaisar and M A Moktadir, 'COVID-19 pandemic related supply chain studies: a systematic review: transportation research part E' (2021) Logistics and Transportation Review 102271.

111 Ibid.

112 C Bovis, 'The social dimension of EU public procurement and the "social market economy"' in D Ferri and F Cortese (eds), *The EU Social Market Economy and the Law: Theoretical Perspectives and Practical Challenges for the EU* (Routledge 2018) 105; A Heinemann, 'Social considerations in EU competition law: the protection of competition as a cornerstone of the social market economy' in ibid 129.

This convergence nature suggests that public procurement seeks to harmonise 'behavioural norms' including legal efficiency, simplification and cross-border trade through the use of harmonised procedures and rules.[113] Furthermore, Bovis confirms that public procurement 'serves as a negation agent to state aid and competition regulation', which is firstly concerned with the promotion of a cross-border competition by respecting the fundamental freedoms and principles.[114]

While the two legal doctrines sit separately, competition and procurement are naturally interlinked activities. Sánchez-Graells suggests that a standalone 'principle of competition' is embedded in the Council Directives. This view implies that 'contracting entities must refrain from any procurement practices that prevent, restrict or distort competition'. This view has been similarly expressed by the Court of Justice of the European Union (CJEU) in the *Commission and Germany*: 'the principal objective of the Community rules on public procurement, that is, the free movement of services and the opening-up of undistorted competition in all the Member States'.[115] It is still disputed as to whether 'competition' is a standalone principle of the Council Directives in the same manner as the fundamental Treaty principles of transparency, equal treatment and non-discrimination. However, as contracting authorities continue to procure from disrupted supply chains and the Commission plans to extend the use of coordinated procurement actions, public bodies must properly assess their role and responsibilities for engaging in activities that will not distort market competition. This is particularly important for large cross-border procurement healthcare projects concluded using the JPA or APAs, as such contracts have the potential to generate significant cost-savings through competitive tendering and price convergence.[116]

Currently, Decision 1082/2013/EU and Decision 4192/2020/EU do not instruct the JPA or APAs to be conducted in a transparent manner that promotes sustainable competition. Sánchez-Graells suggests that it is time to overhaul the legislation to harness the 'potential for digital technologies to accelerate' the use of procurement to effectively respond to future emergencies, in particular, future climate change-related emergencies.[117] Perhaps it is also timely to review if voluntary coordinated JPA and APA mechanisms should mirror the long-term strategic objectives of the Council Directives. In the meantime, as

113 Bovis (n 112 above). See also Trepte (n 10 above)123.

114 Bovis (n 112 above) 106.

115 Case C-480/06 *Commission v Germany*, EU:C:2009:357, [47].

116 Bovis (n 10 above) ix.

117 A Sánchez-Graells, 'Procurement and Commissioning during COVID-19: reflections and (early) lessons' (2020) 71(3) Northern Ireland Legal Quarterly 523–530.

supply chains are forecast to remain in a state of fluctuation for the remainder of 2022, contracting authorities should continue to make best use of the 'competitive procedure with negotiation', the 'innovation partnerships' and other forms of innovative procurements.[118] Contracting authorities should maintain or develop relationships with suppliers and potential suppliers to identify or develop solutions to any supply issues.

CONCLUDING REMARKS

It is time for procurement to return to normal. It is no longer appropriate for contracting authorities to rely on the emergency 'accelerated' provisions set out in the Council Directives to purchase medical supplies and other goods and services required to navigate the pandemic in Ireland and Northern Ireland. Fortunately, the threat of COVID-19 overwhelming health systems is dwindling and national emergency response measures are being gradually reduced. In line with these reductions, procurement procedures for medical equipment, such as PPE and ventilators, should resume as normal if they have not already done so. And for the most part these activities have returned to normal. However, if the virus makes a resurgence these provisions may be relied on again.

A more difficult question should be asked: should the rules be simplified in general? As briefly discussed above, prior to the COVID-19 pandemic, the Council Directives were subject to a number of criticisms. The objectives of the rules are often unclear and the procedures set out are often cited as being overly complex resulting in expensive and administratively burdensome tendering processes. The use of the emergency and direct award procedures during the first wave of the pandemic offered an unplanned experiment of simplified negotiated practices. The results of this experiment were mixed. Initially, Ireland and Northern Ireland struggled to purchase medical equipment due to global supply-chain disruptions. When the contracting authorities did secure the supplies, significant quantities did not meet the required health and safety standards. There was evidence of poor contract management, misspent funds and irregular practices being followed. There is limited evidence or research conducted to suggest that the rules should be relaxed to allow for continued use of the negotiated procedure without publication or direct

118 For a further discussion on innovative procurement see: L Georghiou, J Edler, E Uyarra and J Yeow, 'Policy instruments for public procurement of innovation: choice, design and assessment' (2014) 86 Technological Forecasting and Social Change 1–12.

awards for current contracts related to the pandemic.[119] Additionally, there is no evidence to suggest that there is a need to review the use of direct awards for non-COVID-related contracts to address these criticisms. However, the UK has indicated that, when it implements national procurement legislation to replace the Council Directives, it 'does not want to go beyond the minimal provisions of the WTO's Agreement on Government Procurement'.[120] It is hoped that the new rules will promote competitive tendering without placing burdensome administrative responsibilities on contracting authorities.

While it is time for procurement to return to normal, it is also pertinent for researchers and policymakers to assess the role of coordinated joint procurement actions. The use of the APAs to secure COVID-19 vaccines was less than desirable, the negotiation processes were conducted in secrecy and the contracts appear poorly managed, and in some cases, poorly executed. This research suggests that it is time to retire the use of APAs, and instead the Commission should consider relying on the JPA mechanism to purchase future vaccines and medical countermeasures. Moving forward, the EU should build on the success of the coordinated approach of competitive tendering and extend the use of the JPA to prepare for future cross-border health crises. Finally, as we move into a post-pandemic stage, it is timely for public bodies and the Commission to assess their roles and responsibilities for engaging in procurement activities that will not distort market competition and that will facilitate sustainable competition in the UK and the internal market.

119 There are several provisions contained in the rules to ease administrative burden, such as the use of electronic procurement to speed up timeframes.

120 Fahy et al (n 99 above).

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Digital technology and privacy attitudes in times of COVID-19: formal legality versus legal reality in Ireland

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ABSTRACT

The adoption of digital technologies to counteract the spread of COVID-19 has resulted in a major exposure of our rights to privacy and data protection. An empirical study conducted in Ireland by the Science Foundation Ireland-funded project PRIVATT demonstrates that privacy attitudes have shifted, resulting in a greater willingness to share personal data in order to combat the pandemic, while, at the same time, upholding a persistent mistrust in the public and private institutions overseeing this global health crisis. This article interprets these findings from a socio-legal perspective, arguing that people tend to overlook the inalienable nature of the essence of their rights to privacy and data protection, the compression of which is not admissible under EU law. Moreover, the widespread mistrust of public and private actors evidences a divergence between the formal legality of the technological solutions adopted and the legal reality that brings about the Irish public's perception of government measures as potentially infringing their fundamental rights. These considerations will prompt recommendations in pursuit of enhancing transparency, involvement in decision-making processes and data protection literacy amongst the population.

Keywords: COVID-19; digital technology; privacy and data protection; efficiency; essence of fundamental rights; formal legality; legal reality; transparency; fundamental rights literacy.

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INTRODUCTION

The outbreak of the COVID-19 pandemic in 2020 has led the media to evoke the deadly 1918 influenza pandemic, which, spread by troops fighting in the First World War, killed 20 million people worldwide.[1] Black and white photos of people wearing masks have illustrated that many of the public health measures currently in place to fight the spread of coronavirus are not new.[2] Social distancing, travel restrictions, coughing and sneezing etiquettes had all already been put in place over a century ago.[3] However, among the main differences between the COVID-19 pandemic and the 1918 pandemic, one can certainly mention the widespread use of digital technology to limit the diffusion of the virus.

Indeed, in the COVID-19 pandemic, digital technology has played a crucial role. Pre-existing digital technology tools have been adapted to the fight against the virus. New digital solutions have been introduced to maximise the efficiency of containment measures imposed by state and health authorities. The coronavirus has been elevated to the ranks of the main public enemy, often leading to the decision to prioritise public health over our liberties. However, one cannot underestimate the risks that the misuse of digital technologies may have on our fundamental rights, particularly on the rights to privacy and data protection. Most of the digital technology tools introduced to limit contagions significantly interfere with our personal life, and often process sensitive personal data, increasing the risks associated with our 'digital selves'.

The project PRIVATT (Assessing Irish Attitudes to Privacy in Times of COVID), funded by Science Foundation Ireland, aimed to assess whether the introduction of digital technology tools to fight the pandemic in Ireland had also been accompanied by a change of attitude regarding privacy and data protection preferences. Our hypothesis was that, in general, the adoption of digital technology tools that might be more privacy intrusive and riskier from a data protection perspective is also accompanied by a major complacency within the population. A survey conducted on Irish residents showed that people had effectively changed their privacy attitudes in light of the current pandemic, becoming now more willing to share their data to counteract the spread of the virus, but that a significant portion did not trust the technological tools introduced by the Government, despite their formal legality.

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1 Stephen Dowling, 'Coronavirus: what can we learn from the Spanish Flu?' (*BBC News* 3 March 2020).

2 Hannah Devlin, 'Four lessons the Spanish flu can teach us about coronavirus' *The Guardian* (London, 3 March 2020).

3 Nina Strochlic, 'How they flattened the curve during the 1918 Spanish flu' (*National Geographic* 27 March 2020).

This article does not include a detailed analysis of the hypotheses, methodology and full results of the survey conducted in the context of the PRIVATT project, which have been covered in other works in detail.[4] Instead, it aims to contextualise and critically assess the findings of the PRIVATT project from a socio-legal point of view. For this reason, following this introduction, in the second section we will start by providing an overview of the results of the survey. The third section will then illustrate the main privacy and data protection implications of the use of digital technology to counteract the spread of COVID-19, focusing on the risks associated to both public and private actors. In the fourth section, we will show that in some Asian countries, despite these threats, a duty of fully sacrificing privacy and data protection in favour of ensuring the most efficient use of the digital technology adopted to fight the virus has emerged during the pandemic. However, with reference to the recent case law of the Court of Justice of the European Union (CJEU), we will explain how such a rhetoric would not be acceptable in a European context, due to the inalienable nature of the essence of the rights to privacy and data protection. The fifth section will then examine the guidelines adopted in the EU in order to guarantee the introduction of fundamental rights-compliant digital solutions by member states for fighting the pandemic. We will explain that, despite this formal reassurance, a significant mistrust towards digital solutions for combating COVID-19 has been identified among Irish residents. From a socio-legal perspective, such a divergence between the formal legality of technological solutions adopted and the legal reality that brings about the Irish public's perception of government measures as potentially infringing their fundamental rights will be interpreted as evidence of a lack of transparency and involvement of the population in decision-making, as well as literacy related to the legal safeguards offered by fundamental rights in general, and in particular, by the rights to privacy and data protection. The final section will conclude with a series of recommendations for ensuring that digital solutions used to fight the virus are both legally compliant from a formal point of view but also, in view of maximising their efficiency, that they are accepted, understood and endorsed at a social level.

4 See Malika Bendechache et al, 'Public attitudes towards privacy in COVID-19 times in the Republic of Ireland: a pilot study' (2021) 0 Information Security Journal: A Global Perspective 1; Ramona Trestian et al, 'Privacy in a time of COVID-19: how concerned are you?' [2021] IEEE Security and Privacy 2.

COVID-19 AND THE SHIFT OF PRIVACY ATTITUDES IN IRELAND

The PRIVATT project conducted an online survey from 11 November 2020 to 12 January 2021.[5] Targeted at members of the general public over the age of 18 resident in Ireland, the main objective of the survey was to investigate and report on the attitudes to privacy of the residents of Ireland during COVID-19. The main research questions at the basis of the survey were:

i) What is the general attitude towards privacy in times of COVID-19?
ii) Has this attitude changed compared to normal circumstances with the desire to help control the spread of COVID-19?
iii) Do privacy concerns prevent Irish people from using digital technology tools (eg the Health Service Executive (HSE) COVID Tracker app) that may help to manage the crisis?
iv) Are people in Ireland concerned about the long-term effects of these technologies on their privacy beyond the current health crisis?

The questionnaire was therefore structured in three parts: demographics, privacy profiles and privacy attitudes during COVID-19. The first part collected demographic data, while the second part aimed to build a general privacy profile of the respondents and used the Privacy Segmentation Index methodology coined by Alan Westin that classifies individuals into three groups based on their privacy attitude.[6] The third part of the questionnaire aimed to capture the attitudes toward privacy in times of COVID-19. This included questions related to sharing personal data in the interest of saving lives, usage of the COVID tracker app, and possible factors influencing privacy attitudes.

An intermediate step in designing the national survey was represented by a pilot study conducted between 24 August 2020 and 15 September 2020 during which 258 participant responses were collected. The questionnaire used in the pilot study was refined on the basis of participant and stakeholder feedback, and the final survey conducted on a national level was closed in January 2021. It was circulated on mailing lists and on the websites of universities involved, social media, news articles, including the *Irish Times* and *Irish Tech News*,[7] and received 1011 responses.

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5 See Trestian et al (n 4 above); Bendechache et al (n 4 above).

6 Ponnurangam Kumaraguru and Lorrie Faith Cranor, 'Privacy indexes: a survey of Westin's Studies' (Institute for Software Research International, School of Computer Science, Carnegie Mellon University 2005) CMU-ISRI-5-138.

7 See 'Personal privacy vs "we're all in this together": a survey in Covid-19 times' *Irish Times* (Dublin, 11 December 2020); 'Do you trust the Government with your data?' (*Irish Tech News* 2 December 2020).

Of all participants, 48.85 per cent were male and 48.95 per cent were female, 18 people preferred not to say and 4 people were non-binary. We provided four age groups, 18–24, 25–44, 45–64 and over 65 for participants to select. The largest age group was between 25–44 years old, accounting for 50.0 per cent of the total. Regarding the location of participants, 62.3 per cent of the participants came from County Dublin. Participants of the survey were generally well-educated, with 30.3 per cent of the respondents holding a master's degree and 22.2 per cent holding a bachelor's degree. The third largest educational group finished secondary school (16.8 per cent).

In the second part of the survey, participants were asked questions to determine their privacy attitudes based on the Privacy Segmentation Index developed by Westin and were classed accordingly as 'pro-privacy', 'ambivalent' or 'dismissive', to use a terminology which appears as less value judgement-laden.[8]

Pro-privacy persons are termed 'privacy fundamentalists' by Westin and 'are the most protective of their privacy. These consumers feel companies should not be able to acquire personal information for their organizational needs and think that individuals should be proactive in refusing to provide information'.[9] They are also described as supporting 'stronger laws to safeguard an individual's privacy'.[10] Ambivalent persons are termed 'pragmatists' by Westin and 'weigh the potential pros and cons of sharing information; evaluate the protections that are in place and their trust in the company or organization. After this, they decide whether it makes sense for them to share their personal information.'[11] Dismissive persons are termed 'unconcerned' by Westin and 'are the least protective of their privacy – they feel that the benefits they may receive from companies after providing information far outweigh the potential abuses of this information. Further, they do not favour expanded regulation to protect privacy.'[12]

The PRIVATT survey found that 54 per cent of the participants were privacy ambivalent, 17 per cent were privacy dismissive and 29 per cent were pro-privacy. Interestingly, a shift in attitude towards sharing data to combat COVID-19 was demonstrated by responses to the question: 'Would you agree to share your mobile data (data stored or related to your mobile device) with the government and relevant institutions to help defeat COVID-19?' – 61 per cent of respondents chose 'Strongly Agree' and 'Agree' and 47 per cent changed from the 'Disagree' given to questions referring to normal times to 'Neutral'

8 Kumaraguru and Cranor (n 6 above).
9 Ibid 15.
10 Ibid.
11 Ibid.
12 Ibid.

or 'Agree', demonstrating an increase in their willingness to share their data to fight COVID-19 compared to usual circumstances. The greatest change came from the privacy dismissive with a 57 per cent increase, while pro-privacy and ambivalent respondents demonstrated an increase of 46 per cent and 44 per cent respectively. In this article, we will contextualise this finding, arguing that, in the complex times we are living, where public health is threatened by a global pandemic, people often think that they are free to dispose of their rights to privacy and data protection in the pursuit of the public good. However, as we will explain, this argument is untenable in the EU, where the essence of these rights cannot be given up and solutions preserving these rights must always be sought.

We will combine this analysis with a second interesting finding deriving from the survey. Despite the general willingness to share data with the Government to help counteract the virus, a still significant percentage of respondents were concerned by potential misuse of their data by government agencies. Indeed only 12 per cent of the respondents answered that they were not concerned at all in relation to how their personal data would be used by the Government and relevant institutions in order to defeat COVID-19.[13] When asked about specific concerns, the top concerns were 'privacy issues' (582 respondents), 'lack of trust in the Government and the institutions managing the data' (483 respondents), 'security issues' (469 respondents), 'creating a dangerous precedent' (418 respondents), and 'other' (30 respondents). Moreover, when specifically asked about concerns in relation to use of the HSE COVID Tracker App, 28 per cent of respondents reported worries about the implications of using the app for their privacy and data protection; 30 per cent feared that the app could be used as a surveillance tool beyond its primary aim of fighting the spread of COVID-19; and 42 per cent of respondents who are using the HSE COVID Tracker App had concerns about what will happen to their data after they leave the app. These data reveal that people do not fully trust the formal legality of measures adopted by government agencies to counteract the spread of the virus while preserving their privacy. The legal reality indeed shows a different image: individuals who are willing to help fight the pandemic are still not persuaded that their government will not misuse their data.

13 Trestian et al (n 4 above).

DIGITAL TECHNOLOGY AND FUNDAMENTAL RIGHTS IMPLICATIONS

All digital technology instruments introduced to limit the circulation of COVID-19 have fundamental rights implications, in particular on the right to privacy and data protection. Firstly, they all rely on the processing of data related to identifiable individuals in order to achieve their purposes, from contact-tracing to quarantine enforcement.[14] Secondly, they process information related to aspects of our personal and family lives, such as our social interactions, movements and health status. In Europe, as we will explain in the next few sections, the adoption of these technologies is legitimate in so far as data protection principles are respected and the intrusion into our personal and family life is justified, necessary and proportionate to the purpose of solving a global health crisis. Around the world, however, the use of digital technology tools to limit the spread of COVID-19 has produced a series of violations of these fundamental rights. In this section, we will focus in particular on an examination of aspects relating to the rights to privacy and data protection as conceived by European case law, or, using the denomination commonly used in the United States (US), aspects related to data privacy. Without aspiring to provide an exhaustive investigation of the topic, the aim of this overview is to offer an introductory analysis of the fundamental rights implications derived from the use of digital technology tools during the pandemic. In the following section, we will explain how, in Europe, differently from countries in other regions, specific measures have been taken to prevent these risks. This analysis will be used in the final section to highlight the current discrepancy between formal legality of the use of digital tools in Ireland and the persistent fear of the general population that government and private companies may misuse these instruments.

State actors: mass surveillance and mission creep risks

The most concerning scenario is offered by states where government authorities are carrying out a systematic monitoring of location, travel history and contacts between natural persons, using the fight against COVID-19 to justify the implementation of mass surveillance measures. An apparent example is provided by the indiscriminate use by the Chinese Government of the data collected by the Health Code

14 For a comprehensive overview of digital technology instruments used to fight COVID-19, see Trestian and others (n 4 above).

apps.[15] However, some have also observed that measures implemented to halt COVID-19 also emerge as 'extensions of already ongoing moves by democratic states to engage in domestic surveillance'.[16] This appears to be the case in Israel where the Government has employed legal mechanisms intended for counterterrorism purposes in order to use its security services to harness and utilise location and contact data for contact-tracing and to serve isolation orders.[17] In any case, as stated by the European Data Protection Board (EDPB), the use of digital technologies adopted to limit the spread of the virus for mass surveillance purposes represents a 'grave intrusion into people's privacy' and illustrates the risk of mission creep of the use of technology in combating the pandemic.[18]

Indeed, as Eck and Hatz argued, one may fear that 'governments will not be willing to abandon the new surveillance opportunities these apps offer and that personal data will be collected indefinitely and used for unanticipated ends'.[19] These concerns are not unfounded in circumstances where, presently, the Government of the United Kingdom (UK) 'plans to retain the data it collects for up to 20 years and denies individuals an absolute right to have their data deleted upon request',[20] and where such instances have existed in the past, such as surveillance measures implemented in the US in the wake of 9/11 that remain in place today.

Moreover, this mission creep is a grave concern as millions of citizens worldwide entrust their personal data to authorities for the protection of their health and the health of those around them via commonly used digital technology tools such as smartphones. Although many are presently optional, fears remain of the possibility

15 See Fan Liang, 'Covid-19 and Health Code: how digital platforms tackle the pandemic in China' (2020) 6 Social Media and Society 1; Helen Davidson, 'China's coronavirus Health Code apps raise concerns over privacy' *The Guardian* (London, 1 April 2020); Paul Mozur, Raymond Zhong and Aaron Krolik, 'In coronavirus fight, China gives citizens a color code, with red flags' *New York Times* (1 March 2020).

16 Kristine Eck and Sophia Hatz, 'State surveillance and the Covid-19 crisis' (2020) 19 Journal of Human Rights 603, 606.

17 Amir Cahane, 'Counterterrorism measures to counter epidemics: Covid-19 contact tracing in Israel' (*Blog Droit Européen* 18 July 2020); Rachel Noah, 'Using counterterrorism for fighting the pandemic: Israel during the days of Covid-19' (University of Oxford Faculty of Law, 19 June 2020); Dan Williams, 'Israel to halt sweeping Covid-19 cellphone surveillance next month' (*Reuters* 17 December 2020).

18 European Data Protection Board, 'Guidelines 04/2020 on the use of location data and contact tracing tools in the context of the Covid-19 outbreak' (EDPB 21 April 2020).

19 Eck and Hatz (n 16 above) 607.

20 Ibid.

of COVID-19 tracking technologies becoming mandatory in the future through the introduction of their use being 'necessary to access workspaces', or being used as 'a condition of lifting restrictions', as is already occurring in India.[21] This kind of argument has indeed recently become apparent even in the EU, where passenger locator forms currently require travellers to declare their recent cross-country movements as well as prospected national whereabouts,[22] and some member states are requiring a COVID vaccination certificate to access workplaces or perform leisure activities.[23] The European Commission, citing the ePrivacy Directive, emphasises the requirement for necessity, appropriateness and proportionality in the use of these apps that have 'a high degree of intrusiveness', thus recommending that they remain voluntary.[24] This extends both to governments and providers of third-party services, so that 'choosing not to use the app may not adversely affect access to third parties' services, such as shopping malls, public transportation, or workplaces'.[25]

Private companies: function creep and lack of transparency

Similar concerns of a potential function creep of digital solutions developed to limit the spread of the virus have arisen in relation to the involvement of commercial actors. Reuse of data collected by private apps for commercial purposes, such as targeted advertising, often represents a breach of the data minimisation, retention and purpose limitation principles. Companies must collect only data which are necessary to the purposes of the processing, and they must not retain them if they are no longer necessary to those ends. Moreover, companies must not illegally exploit data originally collected for a significantly different purpose.

This apprehension is not groundless considering data controversies that have occurred in the past. For example, Alipay and Wechat have contractually secured the right to keep data collected in China after the

21 Rob Kitchin, 'Civil liberties *or* public health, or civil liberties *and* public health? Using surveillance technologies to tackle the spread of Covid-19' (2020) 24 Space and Polity 362.

22 See eg the European Digital Passenger Locator Form (dPLF); Government of Ireland, COVID-19 Passenger Locator Form.

23 See eg European Commission, EU Digital COVID Certificate; Government of Ireland, Department of the Taoiseach, 'Public health measures in place right now'.

24 European Commission, 'Guidance on apps supporting the fight against Covid 19 pandemic in relation to data protection' (2020/C124 I/01).

25 Klaudia Klonowska and Pieter Bindt, 'The Covid-19 pandemic: two waves of technological responses in the European Union' (Hague Centre for Strategic Studies April 2020).

pandemic.[26] The International Digital Accountability Council found that many apps 'request permissions that have the potential to be invasive if misused' and could 'allow apps to access other shared files on the device that could be used to infer personal information about the user, such as location, through calendar invites, or image metadata'.[27] Many contact-tracing applications, including Ireland's, have employed the Exposure Notification System developed jointly by Apple and Google. Despite their 'public-spirited' presentation, it remains that Apple and Google are private companies whose primary objective is to make profit and share it among their stakeholders. Bradford et al have drawn attention to the system's 'reserved functionality for additional unspecified associated metadata that might be collected later'.[28] It has also been noted that these apps do not operate in isolation on user's devices, and, as stated by Kitchin, 'by opening up location data, either via GPS or Bluetooth, a device is being made trackable by a range of adtech embedded in other apps, enrolling it into the ecosystem of location-based data brokers'.[29]

A further area of concern is the lack of transparency with regards to apps and other technologies developed by private companies to limit the spread of COVID-19. This is particularly true in the EU where full compliance with data protection law requires that data controllers disclose in an intelligible and accessible way the purpose and means of the data processing and that users have the option to exercise their rights, preferably through the app itself.[30] Transparency can ensure not only legal and fundamental rights compliance, but also increase trust in the population. An example of this being successful is Google's COVID-19 Community Mobility Report, which includes aggregated telecom data used by authorities in Ireland for mobility monitoring. This type of data is legally compliant through the use of anonymisation techniques, which allow location data to be processed in an aggregated form to prevent potential re-identification. Through Google's sharing of this aggregated location data with the public, it has been noted to potentially increase trust in the population by proving that private companies are really processing anonymised data and are not misusing personal information for hidden commercial purposes.[31]

26 Laura Bradford, Mateo Aboy and Kathleen Liddell, 'Covid-19 contact tracing apps: a stress test for privacy, the GDPR, and data protection regimes' (2020) 7 Journal of Law and the Biosciences lsaa034.

27 International Digital Accountability Council, 'Privacy in the Age of Covid: An IDAC Investigation of Covid Apps' (5 June 2020)

28 Bradford et al (n 26 above) 5.

29 Kitchin (n 21 above) 369.

30 See Emanuele Ventrella, 'Privacy in emergency circumstances: data protection and the Covid-19 pandemic' (2020) 21 ERA Forum 379.

31 Klonowska and Bindt (n 25 above).

Common risks: anonymisation and data breaches

Common to settings involving both public and private actors are the risks related to the collection of significant amounts of data, such as data breaches. Some measures have been implemented in the development of digital technologies to allow for a greater protection of personal data, such as the use of Bluetooth proximity tracing over GPS location tracking, the use of a decentralised approach over storing data on a centralised server, and processes of anonymisation or pseudonymisation. However, these approaches also appear to be flawed.

The use of Bluetooth proximity technology over GPS location tracking is seen to be more privacy-preserving since it only ascertains whether two devices enter in contact rather than constantly tracking their location. However, this is not a perfect solution. Location may still be tracked by authorities by introducing Bluetooth receivers in open settings, such as squares, roads and other public spaces.[32] The use of decentralised over centralised servers, although more in line with the data minimisation principle, does not reduce the risk of identification of individuals.[33] The possibility of re-identification through technological means and simple human inference also remains with the use of pseudonymous, and sometimes anonymous, data.[34] Indeed, as asserted by Kitchin, 'it is well established in the big data literature that unless the data are fully de-identified it is possible to reverse engineer anonymisation strategies by combing and combining datasets'.[35]

SACRIFICING PRIVACY IN FAVOUR OF PUBLIC HEALTH: COMPARATIVE PERSPECTIVES

Asian countries and the 'war' against the pandemic

In many Asian countries, maximisation of efficiency and effectiveness of public health containment strategies is often cited as one of the aims of the digital solutions used against COVID-19. Consequently, debates on privacy versus public health are often framed as requiring the sacrifice of one for the other.

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32 Hyunghoon Cho, Daphne Ippolito and Yun William Yu, 'Contact tracing mobile apps for Covid-19: privacy considerations and related trade-offs' (2020) Cryptography and Security.

33 Stephanie Rossello and Pierre Dewitte, 'Anonymization by decentralization? The case of Covid-19 contact tracing apps' (*European Law Blog* 25 May 2020).

34 See Bradford (n 26 above).

35 Kitchin (n 21 above) 369.

South Korea's Health Minister Park Neung-hoo described Seoul as a 'COVID-19 war zone': posters with a red germ that looked like a bomb ready to be exploded could be seen on the streets of the South Korean capital city.[36] China's President Xi Jinping vowed to wage a 'people's war'.[37] War metaphors, as we see in the use of expressions such as 'war against pandemic', 'battle plan', 'enemy', 'frontline',[38] and even 'war against stupidity',[39] spread also beyond Asian countries[40] and demonstrate how the discussions on the need to combat COVID-19 were framed, encouraging the public to bring out the big 'artillery' and do 'whatever it takes, fast' or die.[41]

The privileging of the efficiency of public health strategies over privacy led to the favouring of particular technological designs, categories of operational actors and law enforcement regimes to the detriment of fundamental rights, particularly the rights to privacy and data protection. In this section, we analyse three concrete examples of this approach, namely the adoption of centralised approaches in contact tracing, the use of pre-existing commercial apps and the declaration of the state of emergency in order to compel the use of apps.

The debate surrounding contact-tracing apps has primarily focused on centralised versus decentralised systems. Storing data related to people's close contacts, or even location, in a centralised database presents greater risks from a data protection perspective since it increases the chances of security risks, such as data breaches, or potential misuse by the relevant authorities.[42] However, in some countries, centralised approaches remained the preferred option because of the clear efficiency gains. Indeed, privacy and data protection considerations aside, the efficiency of centralised systems is clear. In decentralised systems, health authorities cannot identify users of the apps and instead rely on each individual to act responsibly and report any notification they receive. Individuals may decline or

36 Anthony Kuhn, 'South Korea's Health Minister describes Seoul as a "Covid-19 war zone"' (*NPR* 7 December 2020).

37 Yew Lun Tian, 'In "people's war" on coronavirus, Chinese propaganda faces pushback' (*Reuters* 13 March 2020).

38 Yasmeen Serhan, 'The case against waging "war" on the coronavirus' (*The Atlantic* 31 March 2020).

39 Molly Gamble, '"I'm fighting a war against Covid-19 and a war against stupidity," says CMO of Houston hospital' (*Becker's Hospital Review* 1 August 2020).

40 See eg Lisa McCormick, 'Marking time in lockdown: heroization and ritualization in the UK during the coronavirus pandemic' (2020) 8 American Journal of Cultural Sociology 324.

41 Rosamond Hutt, '"Act fast and do whatever it takes" to fight the Covid-19 crisis, say leading economists' (*World Economic Forum* 23 March 2020).

42 See Yann Sweeney, 'Tracking the debate on Covid-19 surveillance tools' (2020) 2 Nature Machine Intelligence 301; Joseph Duball, 'Centralized vs decentralized: EU's contact tracing privacy conundrum' (*iapp* 28 April 2020).

refuse to voluntarily report themselves to the relevant authorities, thus undermining the whole contact-tracing system. Owing to this reason, developers, such as those of MorChana, a leading contact-tracing app in Thailand and operated by the Digital Government Development Agency, opted for a centralised approach.[43] In their report on COVID-19 and the Right to Privacy in South Korea, authors from the Korean Progressive Network JINBONET and the Institution for Digital Rights said that 'considering the nature of public health authorities, it is highly likely that they focus on the efficiency and medical necessity of enforcement, while they might relatively neglect deliberation on other basic rights including the right to informational self-determination'.[44] From a study by DigitalReach, contact-tracing apps in Southeast Asian states tend to choose centralised approaches over decentralised ones in order to maximise the efficiency of these solutions, even if the option is manifestly 'more vulnerable to being misused, exploited or exposed to a data breach'.[45]

Another strategy used in Asian countries to maximise the efficiency of public health solutions was to allow the simultaneous use of commercial contact-tracing apps, some of which pre-existing and reconverted for COVID purposes. While the Singaporean Government acted swiftly and released the first contact-tracing app deployed to a large public, other governments in Asia were quite slow in contrast.[46] Civil society and private sector initiatives therefore tried to fill this gap, introducing new purpose-built apps. In some cases, existing commercial apps were repurposed for use with COVID-19 response activities, such as SydeKick (tracking individuals) and QueQ (queue management systems for restaurants and hospitals).[47] This phenomenon had both

43 *Blognone,* ทีมงานแอพหมอชนะแจง ไม่ใช้ Apple/Google API เพราะอยากได้พิกัด GPS, เก็บข้อมูลบนเซิร์ฟเวอร์ตลอดเวลา' (translation from Thai: 'MorChana team said it rejects Apple/Google API because they want GPS location and want the data to always be kept on the server') (*Blognone* 21 January 2021).

44 Byoung-il Oh, Yeokyung Chang and SeonHwa Jeong, 'Covid-19 and the right to privacy: an analysis of South Korean experiences' (*JINBONET* 4 December 2020)

45 Digital Reach, 'Digital contact tracing in Southeast Asia: the Summary Report Submitted to ASEAN Intergovernmental Commission on Human Rights (AICHR)' (*Digital Reach* 27 November 2020).

46 However, it is not that other governments came completely unprepared. Taiwan and Hong Kong, for example, relied on their experience with SARS and existing infrastructure for that. Temperature scans were actually a normal practice in Hong Kong airport long before Covid-19, and face masks can be considered a common clothing item on the streets of Taipei. Taiwan also implemented early-stage containment policy, so the in-country contact tracing was probably less necessary at the outset of the pandemic.

47 Norton Rose Fulbright, 'Contact tracing apps in Thailand' (Norton Rose Fulbright 11 May 2020); Jotham Lim, 'Queuing app that acts as social distancing tool' (*The Edge Markets* 20 May 2020).

positive and negative effects. On the one hand, these apps were widely used by the population, thus increasing the spread of contact-tracing solutions. On the other hand, however, many of these apps often did not offer sufficient safeguards for the rights to privacy and data protection. Thailand, for example, saw many COVID-19 apps popping up quickly during the first wave of the virus in March 2020; this effectively helped the work of contact-tracing officers, while at the same time often failing to provide a privacy policy.[48]

One final example of the maximisation of the efficiency of public health solutions and a corresponding compression of fundamental rights in Asian states is the declaration of the state of emergency used to compel the use of contact-tracing apps among populations. Many states across the world declared a state of emergency, which, in most cases, granted governments the power to adopt executive decisions in a quicker and more efficient way in order to respond to the rapidly changing situation.[49] In some Asian countries, these new powers were also used to mandate the population to use contact-tracing apps. In Thailand, for example, the Government used the power granted by the Emergency Decree on Public Administration in the State of Emergency, BE 2548 (2005) to force people in five 'red zone' provinces to install contact-tracing apps.[50] As we have seen, this solution was expressly rejected in Europe as it would have deprived individuals of their ability to fully enjoy their rights to privacy and data protection, including being free to dispose of these rights, and would have allowed government authorities to monitor movements and social interactions of the entire population, with the potential risk of mission creep. Moreover, the state of emergency declared in some Asian countries did not only restrict the population's rights to privacy and data protection, but also had a domino effect on other constitutional guarantees and fundamental freedoms, such as the balance of powers and due process

48 SydeKick, PedKeeper and MorChana apps on Android provide no information on privacy as of 20 April 2020: Location tracking / Contact tracing technology comparisons (COVID-19).

49 See, for example, Suzanne Lynch, 'Trump declares national emergency over coronavirus' *Irish Times* (Dublin, 13 March 2020); Benoit Van Overstraeten and Christian Lowe, 'France declares public health state of emergency over Covid-19' (*Reuters* 14 October 2020); Department of the Prime Minister and Cabinet of New Zealand, 'State of National Emergency and national transition period for Covid-19' (31 July 2020); Rebecca Ratcliffe, 'Malaysia declares Covid state of emergency amid political turmoil' *The Guardian* (London, 12 January 2021); Belén Carreño, 'Spain announces new state of emergency as Covid infections soar' (*Reuters* 25 October 2020); 'Coronavirus: Japan declares nationwide state of emergency' (*BBC News* 16 April 2020).

50 'Position-tracking app required in 5 provinces' *Bangkok Post* (8 January 2021).

51 Joseph Sipalan, Rozanna Latiff and Nick Macfie, 'Explainer: why a state of emergency raises concerns in Malaysia' (*Reuters* 12 January 2021).

rights. Indeed, in some Asian countries, the state of emergency made the regular checks and balances of government powers, such as administrative review, merely an option, and this also had the effect of suspending the right to appeal.[51]

Inalienable nature of privacy and data protection in Europe

Arguments of sacrificing privacy and data protection in favour of preventing the spread of disease have gained momentum across the globe. Even within Europe, one may have a similar impression by reading the words that the Data Protection Commissioner of the Council of Europe and Chair of the Convention 108 stated at the beginning of the COVID-19 pandemic:

> data protection can in no manner be an obstacle to saving lives, and that the applicable principles will always allow for a balancing of the interests at stake.[52]

However, while balancing the right to privacy and data protection against other rights and competing interests is definitively possible, it is important to stress that in the European context a specific limit to this compression exists. Arguments of a substantial derogation of privacy and data protection in order to prevent and slow the spread of COVID-19 are unworkable in Europe owing to the inalienable nature of fundamental rights in EU law. The Charter of Fundamental Rights of the European Union safeguards the rights to privacy (article 7) and data protection (article 8), including the requirement in article 52(1) to 'respect the essence' of all fundamental rights. This last provision is particularly important because, as stated by Lenaerts, it 'defines a sphere of liberty that must always remain free from interference'.[53] This norm is interpreted as that rights protected by the Charter contain a core that cannot be compromised, no matter the strength of the competing interest. Accordingly, although privacy and data protection rights may be relaxed to allow for a greater balancing against other interests, such as the efficiency of measures seeking to reduce the extent of a global pandemic, a compression of the core principles of the rights to privacy and data protection is not possible in the EU. This is an important point to stress, and which probably people should be made more aware of, as we will argue in the next sections. Our perception is indeed, as the PRIVATT survey may empirically demonstrate for Ireland, that individuals, notwithstanding their privacy attitude, can be persuaded that they have the power to dispose of their fundamental

52 Alessandra Pierucci and Jean Phillippe Walter, 'Joint statement on the right to data protection in the context of the Covid-19 pandemic' (Council of Europe, 30 March 2020).

53 Koen Lenaerts, 'Limits on limitations: the essence of fundamental rights in the EU' (2019) 20 German Law Journal 779, 781.

rights to privacy and data protection freely in order to satisfy apparently more important values, such as public health. Conversely, the knowledge of the inalienable nature of their core privacy rights could foster a critical attitude among the general population vis-à-vis digital technology instruments that can potentially be unnecessarily restrictive of fundamental rights. Moreover, an increased awareness of the duty of state authorities to preserve privacy and data protection rights in any circumstance, even in the presence of other important interests to satisfy, could ultimately enhance people's trust in the measures adopted by governmental actors.

The development of the concept of 'essence' of fundamental rights under article 52(1) was first interpreted in a CJEU case that, coincidentally, involved the rights to privacy and data protection and was initiated in Ireland: *Digital Rights Ireland*.[54] On that occasion, the extensive retention of data imposed by the Data Retention Directive was not seen as affecting the essence of the rights to privacy and data protection.[55] Yet, the Directive was eventually invalidated because it represented 'a particularly serious interference with those rights', which was not proportionate to the objectives of investigating, detecting and prosecuting serious crime.[56] While this was the first development of the notion in EU law, the idea of the 'essence' of fundamental rights is present in the constitutional case law of many EU member states and in international human rights treaties, which Brkan notes share the 'purpose' of preventing 'the holder of the fundamental right to be stripped of the inalienable core of her fundamental right'.[57]

The 'essence' of fundamental rights was further developed in *Schrems I*, in which the CJEU stated that US legislation allowing national security authorities to access EU data on a generalised basis compromises the essence of article 7 of the EU Charter of Fundamental Rights enshrining the right to respect for private life. Ojanen posits that the judgment in *Schrems I* represents a concrete judicial implementation of article 52(1) of the Charter by pragmatically explaining that fundamental rights present an inviolable core that

54 *Digital Rights Ireland* [2014] ECJ Joined Cases C-293/12 and C-594/12, ECLI:EU:C:2014:238, paras 39–40.

55 Ibid.

56 Ibid para 39. See Edoardo Celeste, 'The Court of Justice and the ban on bulk data retention: expansive potential and future scenarios' (2019) 15 European Constitutional Law Review 134.

57 Maja Brkan, 'The essence of the fundamental rights to privacy and data protection: finding the way through the maze of the CJEU's constitutional reasoning' (2019) 20 German Law Journal 864, 866; see also Jerome J Shestack, 'The philosophic foundations of human rights' (1998) 20 Human Rights Quarterly 201.

cannot be compressed in any circumstance.[58] *Schrems I* determines that fundamental rights under the Charter are not just 'principles that may be balanced and weighed against other competing principles', but are also 'capable of generating rules that should be applied in an either/or manner'.[59] Therefore, they can prevail against other interests, 'no matter how weighty or pressing the legitimate aims of any restriction are, or any other legal arguments made'.[60] Likened to the inner core of an onion by Brkan, the 'essence' is considered as representing

> the untouchable core or inner circle of a fundamental right that cannot be diminished, restricted or interfered with. An interference with the essence of a fundamental right makes the right lose its value for society and, consequently, for the right holders.[61]

Accordingly, while measures can be implemented to reduce and prevent the spread of COVID-19 through the use of digital technology, the core of the fundamental rights to privacy and data protection cannot be given up, as doing so would interfere with the 'essence' of fundamental rights in the EU.

To conclude this comparative section, it is important to stress that the geographical factor plays a significant role: the concepts of privacy, data protection and consequently the derived notion of the 'essence' of these rights do not receive a univocal definition worldwide, especially in terms of their balancing with other fundamental rights. Therefore, the finding of the PRIVATT survey that highlighted an increased willingness of the Irish population to compress their privacy rights, or to be less privacy-concerned, has to be read within the specific context of Europe and its fundamental rights tradition, as established by decades of case law of the CJEU and the European Court of Human Rights. It is interesting to observe that the starting point of this shift is not a situation where these specific rights are usually considered as subordinate to other interests, but contrariwise a context where their primary relevance has now been consolidated from a legal perspective. This point is particularly telling because it exposes a more significant divergence between the legal dimension and societal perception, an element which the next section will further analyse with reference to a detected mistrust of the Irish population towards the digital technology solutions adopted to counteract the spread of COVID-19.

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58 Tuomas Ojanen, 'Making the essence of fundamental rights real: the Court of Justice of the European Union clarifies the structure of fundamental rights under the Charter: ECJ 6 October 2015, Case C-362/14, Maximillian Schrems v Data Protection Commissioner' (2016) 12 European Constitutional Law Review 318.

59 Ibid 322.

60 Ibid.

61 Maja Brkan, 'The concept of essence of fundamental rights in the EU legal order: peeling the onion to its core' (2018) 14 European Constitutional Law Review 332, 333.

FORMAL LEGALITY VERSUS LEGAL REALITY

Fundamental rights-compliant solutions in the EU

Absent the possibility of sacrificing the core principles of the right to data protection and privacy on the altar of public health, EU authorities and member states began working together to provide guidelines on how to introduce fundamental rights-compliant digital solutions in the EU. During the first wave of the pandemic, in March 2020, one can lament a certain delay in providing a coordinated and adequate response at EU level. Amid internal trepidation, national governments acted as solo actors in search of the right contact-tracing app, hastily organising calls for tenders and heavily relying on private companies and spontaneously emerging scientific consortia. Only on 8 April 2020 did the EU Commission announce the imminent creation of a common toolbox on the use of digital technology to combat the spread of COVID-19, stressing that a lack of coordination in the deployment of similar apps could also significantly impact the functioning of the single market.[62] On 15 April 2020, the eHealth Network adopted a first series of recommendations to design contact-tracing apps in the EU, followed soon after by detailed guidelines from both the European Commission and EDPB.[63]

Reading these different documents together, the response of the EU to fears of incumbent mass surveillance and potential mission creep in Europe is clear. Firstly, these documents recall that the General Data Protection Regulation (GDPR) and the ePrivacy Directive prohibit the bulk collection, access and storage of health data and location data in any circumstance, even in the context of a global pandemic, since this would violate the essence of the fundamental rights to privacy and data protection.[64] What contact-tracing apps in the EU can do therefore is limit their processing to 'proximity data', namely information about the likelihood of virus transmission based on the epidemiological distance and duration of contact between two individuals. Simultaneous processing of other kinds of data is discouraged in order to comply with the principle of data minimisation.[65]

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62 European Commission, 'Commission Recommendation of 8.4.2020 on a common Union toolbox for the use of technology and data to combat and exit from the Covid-19 crisis, in particular concerning mobile applications and the use of anonymised mobility data' C(2020) 2296 final.

63 eHealth Network, 'Mobile applications to support contact tracing in the EU's fight against Covid-19: Common EU Toolbox for Member States' (2020); European Commission (n 24 above); EDPB (n 18 above).

64 See *Digital Rights Ireland* (n 54 above); see also Celeste (n 56 above).

65 EDPB (n 18 above).

Proximity-tracking apps rely on a radio technology such as Bluetooth to estimate the distance between two devices using signal strength, assuming a device is a representation of the existence of a user. In the context of COVID-19 tracking, the app developer can decide that, if two users are in a sufficient proximity for a sufficient period of time, the apps in both devices exchange identifiers. Each app logs an encounter of the other's identifier, which can be later used for contact tracing and notification. The identifier is not necessarily personally identifiable to an actual person, it can only be an identifier of a device. The identifier can also change over time. These implementation details can be different among proximity-tracking apps: for example, Apple and Google's Exposure Notifications change the identifier every 10–20 minutes.[66] The users' locations are not necessary, as the application need only know if the users are sufficiently close together to create a risk of infection. However, some proximity-tracking apps may collect location data as well.[67] Location data can be collected from the sensors present in the device itself (like GPS and WiFi) and from the 'check-in' feature.

While, in general, the design of the proximity-tracking functionality among apps are similar, the mechanisms for keeping logs of contacts and notifying users about infection risk can differ significantly.[68] Some apps rely on central authorities that have privileged access to information about users' devices. With the real contact information provided during the app registration, the central authority can contact people who are at risk through channels outside of the app. Some apps, instead, do not ask for real contact information, and instead are only able to send the notification to the device and ask the user to contact the authority. This last solution was the one embraced by the EU Commission guidance: data about close contacts should not be automatically shared with health authorities, but should be up to the individual user to decide whether to do so. Furthermore, a warning received by the app should not lead to an automatic decision aiming to restrict the fundamental rights of the users in order to avoid the risks of a blind form of automated decision-making, in line with article 22 GDPR. Digital contact-tracing apps can complement, but should not

66 Google, 'Exposure notifications: using technology to help public health authorities fight Covid-19'.

67 Kif Leswing, 'Utah has rejected the Apple-Google approach to tracing coronavirus, and is using an app made by a social media start-up instead' (*CNBC* 13 May 2020); Andrew Clarance, 'Aarogya Setu: why India's Covid-19 contact tracing app is controversial' (*BBC News* 15 May 2020).

68 Andrew Crocker, Kurt Opsahl and Bennett Cyphers, 'The challenge of proximity apps for Covid-19 contact tracing' (*Electronic Frontier Foundation* 10 April 2020).

replace, traditional contact tracing in a way that they automatically log every contact during the day.[69] This complements human less-than-perfect memory and may make it easier for health practitioners to work. However, an app treats all 'contacts' between two people the same. Spending the same amount of time in the same proximity with a grocery clerk in a shop who is protected by adequate equipment and with your partner in a private room carry, of course, different risks of transmission. False positives may also arise for two people who are in separate rooms, with thin walls, next to each other.[70]

EU guidance on the topic also made clear that national health authorities should play a primary role, possibly as data controllers, thus depriving private companies of the power to define the purpose and means of data processing.[71] The use of apps should remain voluntary, in order to avoid potential discrimination in public spaces and in the work place, and consent should not be asked for a 'bundle of different functionalities'.[72] The EDPB, however, recommends that consent should not be used as the legal basis for data processing, but rather the 'public interest' should be relied on.[73] This would be justified by the asymmetry between data controllers, which are often health authorities, and single individuals, who could feel the pressure to provide their consent vis-à-vis state authorities. Apps should be dismantled as soon as the health emergency is over in order to prevent the risk of mission creep after the end of the pandemic.[74] Collected data should not be reused for other purposes, especially other commercial or law enforcement purposes, unless provided for by law for scientific objectives.[75] Apps should reflect both the latest public health guidance and should rely on the most modern technologies in terms of privacy compliance, cybersecurity and accessibility.[76] The apps' source code should be made public and available for review.[77] Users' data should be processed for specific purposes, possibly defined by law, should be at least pseudonymised, stored securely and automatically deleted after a period of time proportionate to the incubation period.[78] A data protection impact assessment (DPIA) following article 35 GDPR is

69 EDPB (n 18 above).
70 '"App thought I'd catch Covid through neighbour's floor"' (*BBC News* 5 October 2020).
71 European Commission (n 24 above).
72 Ibid.
73 EDPB (n 18 above).
74 eHealth Network (n 63 above).
75 European Commission (n 24 above).
76 eHealth Network (n 63 above).
77 European Commission (n 24 above).
78 Ibid; eHealth Network (n 63 above); EDPB (n 18 above).

recommended given the processing of special categories of data on a large scale.[79] Furthermore, the EDPB recommends the publication of the DPIA in order to enhance the level of transparency of decision-making among the general population as well as public scrutiny.[80]

Last, but certainly not least, from an EU perspective, contact-tracing apps should be interoperable, and thus able to work properly in a context where cross-border movements are resumed. Given the improving situation and wider distribution of vaccines, when more people begin travelling from one country to another, the interoperability of these apps is getting more attention. The EU Commission is keeping track of the app interoperability: out of 27 member states, 21 have an app with only 11 being interoperable with others.[81] The situation in Ireland as regards contact tracing is particularly complicated by the presence of two jurisdictions, the Republic of Ireland and Northern Ireland, on the same island. Ireland is not part of the Schengen area, but is instead part of a Common Travel Area with the UK. More specifically, on the island of Ireland, at the moment, there is no physical border between the Republic and Northern Ireland. The UK did, however, leave the European Union in January 2020, and, owing to the Northern Ireland Protocol, Northern Ireland *de facto* remains part of the European internal market.[82] The conundrum that the introduction of contact-tracing apps has therefore created on the island of Ireland relates to the interoperability of multiple contact-tracing apps, respectively developed in an EU and a non-EU country. To make the situation even more complex, Northern Ireland has developed its own app, announcing its interoperability with both the Irish and British (including the apps of Scotland, Jersey and the NHS app used in England and Wales).[83] In a context where the Brexit negotiations reopened the question of the Irish border, with a pandemic which conversely knows no frontiers, the choice by individuals of which contact-tracing app to download becomes an issue of political allegiance, and the use by health authorities of data collected by those apps may trigger the complexities of a cross-border data transfer to a third country. An all-Ireland approach seems to be more than ever needed.[84] Only in this way can digital technology

79 EDPB (n 18 above).

80 Ibid.

81 European Commission, 'Mobile contact tracing apps in EU member states'.

82 Protocol on Ireland/Northern Ireland to the Agreement on the withdrawal of the United Kingdom of Great Britain and Northern Ireland from the European Union and the European Atomic Energy Community [2019] OJ C 384 I/92.

83 NI Direct Government Services, 'Coronavirus (Covid-19): StopCovid NI proximity app'; 'Ireland achieves world first in contact tracing app interoperability – Minister Donnelly' (*Gov.ie* 4 August 2020).

84 See further the articles by Mary Dobbs and Katharina Ó Cathaoir and Christie MacColl, in this issue.

simultaneously be at the service of public health, facilitate freedom of movement and be respectful for the rights to privacy and data protection.[85]

Lastly, the European Commission launched the EU Digital COVID Certificate (DCC) on 1 July 2021.[86] The data contained on the DCC includes the holder's name, date of birth, date of issuance, and information about type of vaccine, COVID-19 test or date of recovery from the virus, as well as a personal identifier, with this data being stored on the certificate without being retained by the app when checked by a third party.[87] The measure has received criticism owing to difficulties in its implementation and its impact on fundamental rights, beyond the rights to privacy and data protection. In particular, it was noted that a data protection impact assessment was not conducted due to the 'urgency' of the situation, thus potentially intensifying the risks of an already problematic system processing sensitive data related to the health of individuals.[88] Moreover, concerns over discrimination were strengthened in Ireland as the DCC could be used to access indoor hospitality in Ireland.[89] Implementation difficulties were indeed faced in Ireland as delays in implementing the system were criticised as denying those eligible their freedom of movement and right to travel.[90]

Lack of trust in Ireland: the importance of transparency and data protection literacy

Despite a series of criticalities related to the way the EU and the single member states are deploying digital technology to fight against the virus, it is possible to highlight that the attention to and respect of fundamental rights was a key character of the European approach. Yet, the results of the PRIVATT survey found that the Irish population perceives digital technology solutions employed to control the spread of COVID-19 as potentially infringing their fundamental rights, despite these solutions formally respecting the specific EU guidance and

85 See further the article by Maria Grazia Porcedda in this issue.

86 Regulation (EU) 2021/953 of the European Parliament and of the Council on a framework for the issuance, verification and acceptance of interoperable Covid-19 vaccination, test and recovery certificates (EU Digital Covid Certificate) to facilitate free movement during the Covid-19 pandemic 15.6.2021 OJ L211/1; European Commission (n 23 above).

87 Ibid.

88 See Oskar Josef Gstrein, 'The EU Digital COVID Certificate: a preliminary data protection impact assessment' (2021) 12 European Journal of Risk Regulation 370.

89 Department of Health and Department of An Taoiseach, 'EU Digital Covid Certificate' (*Gov.ie* 11 August 2021).

90 Barry O'Halloran, 'Delay over EU digital passes will deny travel rights to 1.5m Irish people – Ryanair' *Irish Times* (Dublin 1 July 2021).

national law. We argue that this data, from a socio-legal perspective, exposes a discrepancy between the formal legality and legal reality of the digital solutions adopted by the Government. In other words, we note that there is an apparent inconsistency between what is formally legal and what is perceived as fully safeguarding fundamental rights by Irish residents.

Firstly, from a socio-legal perspective, this observation exposes a potential lack of transparency and involvement of the general population in the decision-making processes that have coordinated the response to the virus. The necessity to resort to specialists, such as epidemiologists and virologists, has unavoidably positioned the political debates about the measures to implement in order to defeat the virus far from the general population. Also, the tight timeframe that governments and health authorities had in order to introduce restrictions to counteract the rapid spread of the virus did not favour a high level of inclusion in decision-making processes. This lack of involvement – combined with contradictory claims by experts and politicians and a general absence of transparency both at national and international level – was one of the factors that contributed to a general mistrust towards the actions of the Government in Ireland, in particular in relation to the deployment of digital technology solutions.

Secondly, this observation more generally begs two intertwined questions related to the level of awareness of legal safeguards offered by fundamental rights, and in particular in relation to the right to data protection, among the general population. One can indeed dispute to what extent the existence of concrete data protection guarantees, which aim to protect citizens against potential misuse of their data, is known by the general public. Privacy concerns related to the potential misuse of mobile apps introduced to fight COVID-19 are certainly not unfounded. As we have seen, in some countries, contact-tracing apps process location data and have been used by governments for purposes that went well beyond the mere fight against the virus. However, the response to this concern at EU level, albeit slow, was net and clear. The EU Commission, the e-Health Network and the EDPB issued detailed guidance on the use of digital technology in order to fight COVID-19 while at the same time safeguarding EU fundamental rights. And, beyond that, this bold approach was adopted thanks to the solid legal framework that has emerged over the past few decades in the case law of the CJEU, which has repeatedly affirmed that the essence of the right to data protection and privacy cannot be compressed to the benefit of other important interests, such as national security or public health. If, despite this commitment by EU institutions to make sure that technology employed to fight the pandemic respects the essence of fundamental rights, Irish residents still perceive a certain level of risk associated with

the technology solutions adopted, one could question to what extent EU legal guarantees are really understood by the general population.

The discrepancy between digital strategies which are formally compliant with EU data protection rules and people perceiving the risk of potential infringement of their fundamental rights might expose an issue in terms of knowledge of EU legal safeguards, in particular in relation to data protection law. Indeed, in some sectors, there was a widespread belief that data protection only emerged with the entry into force of the GDPR in 2018. While this is not the case, European data protection law is still a relatively recent body of law, emerging in the 1970s in response to technological developments surfacing in Europe.[91] Moreover, EU data protection and privacy norms are not codified in a single piece of legislation, but are stratified in different EU and national constitutional texts, EU regulations, directives and national statutes, as well as EU and national judicial decisions. We therefore hypothesise that Irish residents – although this observation can likely be extended to the entire EU population – may still have to familiarise themselves with the legal safeguards that this fragmented body of norms offers them.

Secondly, this point raises the interrelated question of to what extent the EU data protection and privacy framework is accessible to the general population. We already mentioned the issue of stratification of legal provisions related to privacy and data protection. An issue that is further exacerbated at national level given the 'unenumerated nature' of the right to privacy within the Irish Constitution.[92] In Ireland, indeed, the Constitution does not explicitly enshrine those rights, which have been progressively inferred from the text of the Constitution by Irish courts.[93] The GDPR, from this perspective, represents a turning point in EU data protection law because it introduces a uniform set of rules across Europe and stresses the importance of using clear and intelligible language.[94] However, further work is still probably required in order to achieve an adequate level of literacy among the general population in the field of data protection and privacy. We suggest that the current pandemic, among the many lessons that it offers us, will not only be an opportunity for state authorities and private companies to enhance their level of compliance with EU and national law and good practices in the field of data protection and privacy, but will also help the general

91 Gloria González Fuster, *The Emergence of Personal Data Protection as a Fundamental Right* of the EU (Springer 2014).

92 Eoin Carolan and Ailbhe O'Neill, *Privacy and the Irish Constitution* 2nd edn (Bloomsbury Professional 2019)

93 *Ryan v Attorney General* [1965] IR 294; *McGee v Attorney General* [1974] IR 284; *Norris v Attorney General* [1984] IR 36.

94 See article 12 GDPR.

population to familiarise themselves with those norms and understand the safeguards that they may offer. An enhanced knowledge of the legal protection offered by EU and national law in terms of privacy and data protection rights may ultimately lead to two positive effects. On the one hand, it could strengthen the critical attitude of the general population vis-à-vis technology solutions adopted by state authorities. This might be particularly useful if the Government were to implement effective participatory practices to allow the population to express their views on key measures potentially restricting the exercise of their freedoms. In this way, indeed, a population which is more aware of its legal entitlements could more easily contribute to decision-making processes by advancing critical comments and propose innovative ways to promote fundamental rights-compliant solutions. On the other hand, increasing the general population's knowledge of privacy and data protection guarantees will also help consolidate people's trust in innovative digital technology solutions proposed by state actors after accurate and transparent fundamental rights impact assessments. A virtuous-circle effect would emerge from this process: an enhanced commitment by state authorities to guarantee fundamental rights combined with an increased level of transparency would produce even better results if achieved in conjunction with a higher level of awareness among the general population of their legal entitlements, as well as an active involvement in decision-making processes. The dichotomy between states seen as absolute regulators and distrustful passive citizens would be overtaken by the prospect of a society where mutual trust between state and individuals is built on transparency and inclusion in decision-making processes, commitment to fundamental rights and a critical attitude from both sides towards new policies involving the adoption of digital technology tools.

CONCLUSION

In times of public emergencies, assessing people's potential perception of novel policy measures is quintessential to ensuring an elevated level of norm compliance and the ultimate success of a regulatory strategy. The ongoing COVID-19 pandemic has projected state actors and individuals into a state of uncertainty. Policymakers had to test different regulatory strategies in order to limit the spread of the virus. For many citizens this was the first global public emergency of their life. This feeling of uncertainty, which was shared across all societal actors, was at times combined with the fear of potential function creep of the instruments introduced by public authorities to counteract the diffusion of the disease, with particular apprehension about digital technology tools.

Indeed, in contrast to previous health emergencies, the current crisis is a technological one. Digital technology solutions are significantly contributing to help limit the spread of the virus. Their role is, however, Janus-faced. In this article, we have analysed the risks associated with the use of digital technology in the fight against the pandemic, highlighting in particular their potential compression of privacy and data protection rights as well as the broader danger of degeneration of these tools into mechanisms of state control. In several states across the world, the adoption of a war rhetoric has paved the way for a consolidation of government surveillance through digital technology solutions and, at first sight, an indefinite suspension of constitutional guarantees. A mistrust in the technological measures adopted by the Government to fight the pandemic as well as privacy and data protection concerns also characterised Irish residents' perception of the policy strategies adopted in the Republic, as highlighted by the results of the PRIVATT project. This article has proposed a socio-legal interpretation of these findings, highlighting a potential link between Irish privacy attitudes during the pandemic and a lack of legal literacy and an insufficient level of transparency and participation in decision-making.

The survey conducted in the context of the PRIVATT project has indeed revealed a shift in the propensity of Irish residents to consent to the use of their personal data to fight the spread of COVID-19. If at first sight this trend might be interpreted as evidence of trust in the Government's strategy to counteract the virus, the survey simultaneously shows that a still significant portion of the population has concerns related to potential privacy and data protection infringements through the use of digital technology tools introduced to fight the pandemic. This data exposes a discrepancy between the formal legality of the technological solutions adopted in Ireland and the legal reality where individuals perceive these solutions as potentially infringing their fundamental rights. In this paper, we have explained that, in the EU, the core principles of the rights to privacy and data protection cannot be relinquished in favour of public health, as their essence should remain preserved. This has led a multiplicity of EU actors to adopt detailed guidelines on how to unlock the potential of digital technology in the fight against the pandemic while preserving the essence of the fundamental rights to privacy and data protection. The fact that the measures adopted in Ireland explicitly follow these guidelines, but at the same time Irish residents still manifest privacy concerns, is argued to also expose a broader set of issues related to legal literacy of the population and transparency of decision-making practices. We posit that EU data protection law as well as Irish privacy law are not easily accessible to the general population due

to their relative novelty, complexity and stratification. Increasing the level of privacy rights literacy among the population may trigger a virtuous circle, enabling critical feedback from citizens as well as more participative decision-making processes. This result, combined with an enhanced level of transparency by the Government, may lead to a major awareness of the need to restrict fundamental freedoms, increase trust in the policy measures and, ultimately, ensure a higher level of compliance.

In light of our analysis, we conclude with a series of recommendations in relation to the adoption of digital technology tools to combat the spread of a pandemic. We encourage their use as general guidelines for enabling the measures necessary in emergency situations to become more trustworthy to people. From our analysis we understand that enhancing transparency and data protection literacy is of utmost importance. Adequate information should be provided to data subjects, even if legal bases other than consent for data processing are available. This information should be offered using clear and intelligible language in order to help improve the population's understanding of the norms and methods implemented by digital responses to COVID-19. This should be ensured with regards to the methods used and actors involved in digital responses to the COVID-19 crisis. Policymakers should be upfront about the challenges posed by the lack of knowledge and experience of events like the current pandemic. Indeed, while governments and policymakers may be doing their best with the information available to make responsible choices for the entire population, sometimes responses might fail despite these good intentions.

Moreover, in order to increase levels of trust of the general population in digital technology tools introduced to counteract a pandemic, more transparency and participation should be sought during decision-making processes. Involvement with and communication to the wider population in early phases of decision-making processes related to the employment of digital technology solutions to fight COVID-19 is crucial to enhance the level of legitimacy of the adopted solutions and as a trigger for greater transparency of the decision-making processes. To this end, a greater involvement of and reliance on public actors is recommended. The involvement of private actors just for the sake of efficiency should be avoided, and, in circumstances where they are used, how and why public and private actors are cooperating should be fully explained to minimise the discrepancy between formal legality of the measures adopted and a legal reality witnessing a general mistrust from the population.

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On the compatibility of pandemic data-driven measures with the right to data protection: a review of 'under-the-radar' measures adopted in Ireland to contain COVID-19

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ABSTRACT

This article reviews the compatibility of 'under-the-radar' data-driven measures adopted in Ireland to contain the COVID-19 pandemic with data protection law. Since data protection law implements and gives substance to the right to the protection of personal data enshrined in article 8 of the Charter of Fundamental Rights of the European Union, the article reviews the compatibility of data-driven measures with the applicable law in light of the Charter. The measures reviewed – thermal scanner guns, health self-check forms, Statutory Instruments for contact logging and the Vaccine Information System – appear well-meaning but partly incompatible with the right to data protection. The analysis points to the difficulty of reconciling public health and data protection without a systematic data-processing strategy and concludes with recommendations for right-proofing data-driven measures in the guise of a blueprint strategy for processing personal data for present and future pandemic purposes.

Keywords: fundamental right to protection of personal data; judicial review; legality; COVID-19 pandemic; data-driven measures; contact logging; vaccine information system; travel.

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INTRODUCTION

Since the beginning of the pandemic, policymakers in the European Union (EU) have adopted several data-driven measures to contain the spread of COVID-19. The 'comprehensive public health strategy to fight the pandemic'[1] was to include purpose-built technologies, off-the-shelf and even manual measures for locating infectious individuals in highly mobile societies, performing the necessary contact tracing to break the chain of infection and carrying out research to improve the response to the pandemic. Examples of purpose-built technologies include COVID-19 apps,[2] such as Ireland's COVID Tracker App,[3] Digital Green Certificates,[4] contact management systems and vaccine information systems (VISs). Off-the-shelf technologies are used, among others, in the context of return-to-work schemes, and manual measures include contact-logging by individuals and organisations.

Most data-driven measures rely on the processing of personal data and, therefore, trigger the question of how to reconcile the use of data for public health purposes with the right to the protection of personal data enshrined in article 8 of the Charter of Fundamental Rights (CFR) of the EU.[5] Yet, the question was publicly discussed primarily with respect to COVID-19 apps[6] on account of their potential for surveillance on a mass scale,[7] which creates the type of power imbalance that data protection legislation – and the multilevel system of human rights protection shared by EU member states – seeks to

1 European Data Protection Board (EDPB), 'Guidelines 04/2020 on the use of location data and contact tracing tools in the context of the COVID-19 outbreak' (EDPB 21 April 2020).

2 European Commission, 'Communication from the Commission: guidance on apps supporting the fight against COVID 19 pandemic in relation to data protection' C 124 I/1 (European Commission 17 April 2020).

3 Health Safety Executive (HSE), 'HSE launch the COVID Tracker App' (HSE 7 July 2020). On the Irish app, see Fennelly (n ✳ above) ch 2.

4 EDPB-EDPS, Joint Opinion on the Digital Green Certificate (31 March 2021).

5 Charter of Fundamental Rights of the European Union [2010] OJ C 83/389.

6 Early responses in Ireland: Rónán Kennedy, 'Data protection and COVID-19: short-term priorities, long-term consequences' (*Bloomsbury Professional Ireland* 8 May 2020); Trinity College Dublin Covid-19 Law and Human Rights Observatory. Early responses in Europe, among many: Valsamis Mitsilegas, 'Responding to Covid-19: surveillance, trust and the rule of law' (*QMUL School of Law Blog*, 26 May 2020); Vincenzo Zeno-Zencovich, 'I limiti delle discussioni sulle "app" di tracciamento anti-Covid e il futuro della medicina digitale' (*Media Laws* 26 May 2020); Oskar J Gstrein and Andrej Zwitter, 'Using location data to control the coronavirus pandemic' (*VerfBlog* 20 March 2020).

7 Lily Kuo, '"The new normal": China's excessive coronavirus public monitoring could be here to stay' *The Guardian* (London, 9 March 2020); Patrick Wintour, 'Coronavirus: who will be winners and losers in new world order?' *The Guardian* (London, 11 April 2020).

prevent.[8] Public discussion was certainly beneficial,[9] though apps were unlikely to become mandatory in light of regulatory constraints (see below). Other commonplace, and often mandatory, data-driven measures have instead gone under the radar and, consequently, eluded public scrutiny. Examples of under-the-radar measures include low as well as high-tech solutions ranging from contact-logging to the VIS.

This article discusses the legality of such under-the-radar measures from a data protection law perspective. Health policy and the delivery of health services is a primary responsibility of member states (article 168 Treaty on the Functioning of the European Union), who retain the privilege to introduce more specific provisions to adapt the application of EU data protection law in this area. Therefore, this article discusses the results of an appraisal of levels of compliance with data protection law of select data-driven measures that were adopted in Ireland to contain the spread of COVID-19 from summer 2020 through to summer 2021.[10] Data protection law, including the General Data Protection Regulation (GDPR)[11] and other relevant instruments, is understood here not only as a source of regulatory compliance, but also as the implementation of the right to the protection of personal data enshrined in article 8 of the CFR.[12] I refer to such a blend of regulation and rights as the dual nature of data protection law and appraise compliance with the applicable law in light of the CFR.

Given the dual nature of data protection law, the perspective adopted in this article is one of reconciliation between equally important objectives. Mass surveillance is an undesirable goal, as

8 Eg Christopher Docksey and Christopher Kuner, 'The coronavirus crisis and EU adequacy decisions for data transfers' (*European Law Blog* 3 April 2020); Elif Mendos Kuskonmaz and Elspeth Guild, 'Covid-19: a new struggle over privacy, data protection and human rights?' (*European Law Blog* 4 May 2020). Interestingly, the public and academic debate has overlooked apps deployed by employers to locate workers attending the workplace during the pandemic.

9 Apps' data protection shortcomings were quickly redressed thanks to the swift intervention of expert and policy communities. In Ireland, see on the Irish Council for Civil Liberties, Eoin O'Dell, 'Principles for legislators on the implementation of new technologies' (*Cearta* 29 April 2020); HSE Ireland/covid-tracker-app (GitHub); European Commission (n 2 above).

10 For a review of measures adopted between March and August 2020, see Maria Grazia Porcedda, 'Data protection implications of data driven measures adopted in Ireland at the outset of the Covid-19 pandemic' (2021) 7(2) *European Data Protection Law* 260–269.

11 Regulation 2016/679/EU of the European Parliament and of the Council of 27 April 2016 on the Protection of Natural Persons with Regard to the Processing of Personal Data and on the Free Movement of such data, and Repealing Directive 95/46/EC (General Data Protection Regulation) [2016] OJ L 119/1.

12 Eg Judgment of 15 June 2021, *Facebook Ireland and Others*, Case C-645/19, ECLI:EU:C:2021:483, para 45.

is a blanket prohibition against the processing of personal data to contain the pandemic. Ultimately, the challenge lies in designing a data-processing strategy that avoids the pitfalls of a zero-sum clash between public health and data protection.[13] As the Data Protection Commission (DPC) stated, data protection law 'does not stand in the way of the provision of healthcare and the management of public health issues'.[14] This is because the protection of personal data is a qualified right (alongside article 7 of the CFR protecting privacy),[15] whose enjoyment can be limited in line with article 52(1) of the CFR, provided the essence of the right is preserved. As the European Data Protection Board (EDPB) stated in a letter to Hungary in June 2020:

> Restrictions … to the extent that they void a fundamental right of its basic content cannot be justified. If the essence of the right is compromised, the restriction must be considered unlawful, without the need to further assess … the necessity and proportionality criteria.[16]

To begin with, I establish criteria to assess the compatibility of measures that collect personal data in light of the applicable data protection law by reading the rules enshrined in secondary law instruments in the context of the CFR, case law and authoritative guidance. I then discuss the extent to which sample data-driven measures, including measures that collect health data, comply with the applicable law and potentially interfere with article 8. In particular, I will demonstrate that thermal scanner guns may engender an overlooked interference with the right to data protection; self-check forms rest on weak legal bases; the quality of Statutory Instruments (SIs) for contact logging and locator

13 Department of Health, 'Ethical framework for decision-making in a pandemic' (17 April 2020); Andrea Mulligan, 'The ethics of lockdown: transparency, accountability and community involvement (COVID-19 Law and Human Rights Observatory 15 July 2020); European Union Agency for Fundamental Rights (EUFRA), 'Fundamental rights implications of Covid-19' (EUFRA 2020); Amedeo Santosuosso, 'La regola, l'eccezione e la tecnologia' (2020) 1 BioLaw Journal – Rivista di BioDiritto Special 609. The debate recalls in many ways the 'security v liberties' debate that dominated the post 9/11 legal order. My opinion on the need to avoid trade-offs understood as zero-sum games is illustrated in Maria Grazia Porcedda, 'Recrudescence of "security v privacy" after the 2015 terrorist attacks, and the value of "privacy rights" in the European Union' in Elisa Orrù, Maria Grazia Porcedda and Sebastian Weydner-Volkmann, *Rethinking Surveillance and Control: Beyond the 'Security versus Privacy' Debate* (Nomos 2017).

14 DPC, 'Data protection and COVID-19' (*DPC Blogs* 6 March 2020).

15 This piece does not explicitly review the impact of measures on the right to private life enshrined in art 7 CFR. Among others reviewing private life implications is Elspeth Guild, 'Covid-19: European rules for using personal data' (*QMUL School of Law Blog* 4 June 2020).

16 'Statement on restrictions on data subject rights in connection to the state of emergency in Member States' (EDPB 2 June 2020).

forms is unsatisfactory; the VIS potentially has unnecessary elements; and many measures could potentially interfere with the essence of data protection. These results show that the response to the pandemic was well meaning but potentially unsound, and they stress how difficult it can be to reconcile public health and data protection without a systematic data-processing strategy.[17] On this account, I conclude with recommendations for right-proofing data-driven measures for present and future pandemics.

COMPATIBILITY OF DATA-DRIVEN MEASURES WITH THE FUNDAMENTAL RIGHT TO DATA PROTECTION: CRITERIA FOR ANALYSIS

The compliance of data-driven pandemic measures with data protection law must be assessed in light of the CFR,[18] which enjoys the same legal status as the treaties and is applicable by virtue of articles 29.4–29.6 of the Constitution of Ireland.[19] The CFR's scope of application is as broad as the scope of EU law,[20] so it must be respected even when member states need to derogate from EU law: namely, at times of emergency,[21] such as the COVID-19 pandemic. As a result, the processing of personal data for pandemic purposes can benefit from lawful limitations to the exercise of the rights of data subjects, as set out in article 52(1) of the CFR and the applicable law, for example article 23(1)(e) of the GDPR and section 60 of the Irish Data Protection Act 2018[22] (DPA 2018). In the following, I conceptualise the criteria for the analysis of the compatibility of data-driven measures with Irish data protection law.

17 Department of Health (n 13 above); Mulligan (n 13 above); EUFRA (n 13 above); Santosuosso (n 13 above).

18 Judgment in *Österreichischer Rundfunk*, C-465/00, C-138/01 and C-139/01, EU:C:2003:294, para 68.

19 Mr Justice John L Murray, 'Review of the Law on the Retention of and Access to Communications Data' (April 2017) 55.

20 Opinion of 10 January 2019 of AG Szpunar in *Google LLC v CNIL*, Case C-507/17, EU:C:2019:15, para 55.

21 Judgment of 17 December 2015 in *Åkerberg Fransson*, C-617/10, EU:C:2013:105, para 29.

22 Data Protection Act 2018; Maria Helen Murphy, 'The Irish adaptation of the GDPR: the Irish Data Protection Act 2018' in K Mc Cullagh, P Tambou and S Bourton (eds), *National Adaptations of the GDPR* (Collection Open Access Book/Blog droit européen 2019); Rónán Kennedy and Maria Helen Murphy, *Information and Communications Technology Law in Ireland* (Clarus Press 2017) 97–130.

Permissibility of data-driven measures: criteria for analysis of data-driven measures

The Court of Justice of the European Union (CJEU) has consistently said that the processing of personal data that falls within the scope of EU data protection law constitutes an interference with the right to the protection of personal data.[23] To review the compatibility of data-driven measures with the applicable law in light of the CFR means considering the permissibility of such an interference in light of the boundaries drawn by a variety of sources that affect the interpretation of the applicable law. These include, first and foremost, article 52(1) of the CFR, the case law of the CJEU in landmark cases such as *Digital Rights Ireland*[24] and of the European Court of Human Rights (ECtHR), as well as guidance by the European Data Protection Supervisor (EDPS) and the European Data Protection Board (EDPB) in light of CJEU and ECtHR case law. The analysis follows the approach of the EDPS in its Toolkit on necessity[25] and Guidelines on proportionality.[26] There, the EDPS outlines a 'methodology' developing the 'macro-criteria'[27] contained in article 52(1) 'to better equip EU policymakers and legislators responsible for preparing or scrutinising measures that involve the processing of personal data and limit the rights to protection of personal data and to privacy' and thus 'help with the assessment of compliance of proposed measures with EU law on data protection'.[28]

The assessment of compliance, which must follow 'the required order of the lawfulness assessment'[29] of an interference, begins with establishing the existence of an interference with the right, followed by the presence of a legal basis. If such a legal basis exists, according to article 52(1) the essence, that is the very substance, must not be infringed.[30] The interference must then be justified in light of objectives of general interest recognised by the EU, following which

23 Eg Judgment of 3 October 2018 in *Ministerio Fiscal*, C-207/16, ECLI:EU:C:2018:788, para 51. A poignant criticism of this approach can be found in the work of Maria Tzanou, *The Fundamental Right to Data Protection: Normative Value in the Context of Counter-terrorism Surveillance* (Hart 2017).

24 Judgment of 8 April 2014 in *Digital Rights Ireland and Seitlinger and Others*, Joined Vases C-293/12 and C- 594/12, EU:C:2014:238, paras 35–46.

25 Assessing the Necessity of Measures that Limit the Fundamental Right to the Protection of Personal Data: A Toolkit (EDPS 2017).

26 EDPS, 'Guidelines on assessing the proportionality of measures that limit the fundamental rights to privacy and to the protection of personal data' (25 February 2019).

27 Ibid 5.

28 Ibid 4.

29 Ibid 7.

30 *Digital Rights Ireland* (n 24 above) paras 39–40.

come the necessity and proportionality tests. Thus, in my analysis, I use the 'macro-criteria' contained in article 52(1) of the CFR to outline the relevant components of the applicable law. This process is then followed by an appraisal of compliance of data-driven measures with data protection law.

Interference with the right to personal data protection

As stated above, processing that involves personal data falling within the scope of data protection law constitutes an interference. The following section clarifies when data-driven measures use personal data and thus fall within the scope of the applicable law.

Are data-driven measures based on personal data?

The starting point is to ascertain whether measures process personal data, as otherwise the right is not at stake. Not all pandemic measures process personal data, meaning information relating to a natural living person that either identifies them, or makes them identifiable when combined with other pieces of information (article 4(1) GDPR). Here lies a catch in data protection law; the growing pool of data available, alongside improved data science and statistical techniques, keeps broadening the scope of 'identifiable' data[31] and narrowing the scope of the antonym, 'anonymous' data.

Data that are anonymous on their own, such as those captured by motion sensors,[32] may allow for the identification of a natural person in combination with data from other sources, thereby becoming personal. The same applies to anonymised data, namely information that no longer enables the identification of an individual. Anonymised data are outside the scope of the applicable law, provided data subjects are not re-identified. When information enabling the re-identification of individuals is kept separate but is still available to the controller, data are considered to be pseudonymised (article 4(5) GDPR) and subject to the applicable law.

Recital 26 GDPR conveys an understanding of 'anonymity' as dependent on 'objective factors' that determine 'all the means reasonably likely to be used' by the controller or any other person to identify the data subject, and thus relative in nature. This provision

31 Nadezhda Purtova, 'The law of everything: broad concept of personal data and future of EU data protection law' (2018) 10 Law, Innovation and Technology 40.

32 Examples include devices to monitor the maximum number of people who can fit in a room or beepers that emit signals to help individuals maintain the desired physical distance.

is very close to recital 26 of repealed Directive 95/46,[33] which was interpreted in *Patrick Breyer*.[34] There, the court followed the systematic interpretation by AG Campos Sanchez-Bordona,[35] whereby 'reasonable' means are those within the framework of the law, provided they are lawful, and include the transfer of data from third parties in possession of additional information enabling identification. Although the law applicable to *Patrick Breyer* was Directive 95/46, the continuity between recital 26 of Directive 95/46 and the GDPR[36] suggests the court's interpretation is still relevant. For instance, in its COVID-19 Guidelines, the EDPB refers to a 'reasonability test' based on objective and contextual aspects and suggests that the robustness of anonymisation can be measured using three criteria: singling-out, linkability and inference.[37]

The legal and practical limits of anonymisation cannot be overstated. Data processed for research purposes (explicitly mentioned in recital 26 GDPR) to block COVID-19,[38] as foreseen by the VIS, are likely to fall into the category of anonymised data and are therefore susceptible to re-identification. Another example of seemingly anonymous data, those collected by non-contact thermometers, can soon take on the nature of personal data (see below).

Does the processing fall within the scope of data protection law?

Personal data-driven measures are amenable to data protection law when they fall within its material and territorial scope (articles 2 and 3 GDPR). A departure from these rules is the household exception (article 2(1)(c) GDPR), whereby information collected 'by a natural

33 Directive 95/46/EC of the European Parliament and of the Council of 24 October 1995 on the Protection of Individuals with regard to the Processing of Personal Data and on the Free Movement of such Data (Data Protection Directive) [1995] OJ L 281.

34 Judgment of 19 October 2016 in *Patrick Breyer*, Case C-582/14, ECLI:EU:C:2016:779.

35 Opinion of 12 May 2016 of AG Campos Sanchez-Bordona in *Patrick Breyer*, Case C-582/14, ECLI:EU:C:2016:339, paras 68–73.

36 But the GDPR may offer 'a more liberal conceptualisation of anonymised information'. See Triin Siil and Dan Bogdanov, 'Anonymisation 2.0: Sharemind as a tool for de-identifying personal data' (*Sharemind* 17 August 2018).

37 EDPB (n 1 above) 5.

38 Gianclaudio Malgieri, 'Data protection and research: a vital challenge in the era of COVID-19 pandemic' (2020) 37 Computer Law and Security Review 37; EDPB, 'Guidelines 03/2020 on the processing of data concerning health for the purpose of scientific research in the context of the COVID-19 outbreak' (EDPB 21 April 2020). In Ireland: SI 314/2018 – Data Protection Act 2018 (Section 36(2)) (Health Research) (Amendment) Regulations 2019.

person in the course of a purely personal or household activity' is not subject to data protection law. However, when individuals make such information available publicly (for example online), the household exception no longer applies, turning individuals into data controllers within the scope of the GDPR.[39]

The GDPR and the DPA 2018, which contains provisions pursuant to articles of the GDPR that require legislative intervention by member states' law, will apply in most cases.[40] The GDPR and DPA 2018 are particularised and complemented[41] by two *leges speciales* transposed into Irish law. The first is the Law Enforcement Directive for processing for law enforcement purposes.[42] The second is the ePrivacy Directive (EPD),[43] which applies to the processing of personal data in connection with the provision of publicly available electronic communications services in public communications networks in the EU and, insofar as article 5(3) is concerned, information society services (ISSs).[44]

EDP rules on the processing of traffic and location data[45] and of information stored in the terminal equipment of users[46] are the reason why COVID-19 apps could not be forced on people to automate contact

39 Judgment of 14 February 2019 in *Sergejs Buivids*, C-345/17, ECLI:EU:C:2019:122, para 43; Judgment of 11 December 2019 in *TK v Asociaţia de Proprietari bloc M5A-ScaraA*, C-708/18, ECLI:EU:C:2019:1064, para 55.

40 A&L Goodbody, 'Contact tracing apps – a privacy primer', Focus on Covid-19 (2020).

41 *Ministerio Fiscal* (n 23 above) para 31.

42 Directive (EU) 2016/680 of the European Parliament and of the Council of 27 April 2016 on the Protection of Natural Persons with Regard to the Processing of Personal Data by Competent Authorities for the Purposes of the Prevention, Investigation, Detection or Prosecution of Criminal Offences or the Execution of Criminal Penalties, and on the Free Movement of such Data, and Repealing Council Framework Decision 2008/977/JHA [2016] OJ L 119/89; transposed into Irish law by the DPA 2018.

43 Directive 2002/58/EC of the European Parliament and of the Council of 12 July 2002 Concerning the Processing of Personal Data and the Protection of Privacy in the Electronic Communications Sector [2002] OJ L 201 (E-privacy Directive), as updated in 2009; transposed into Irish law by SI 336/2011.

44 EDPB (n 1 above). Commented by S Guida, 'The European Data Protection Board's position on the processing of personal data in the context of Covid-19' (2020) 6(2) European Data Protection Law Review 262–264.

45 Arts 2(b) and 2(c) EDP, the latter: 'Any data processed in an electronic communications network or by an electronic communications service, indicating the geographic position of the terminal equipment of a user' of such a service.

46 To the extent that Covid-19 apps are amenable to ISSs, app providers could only place data in the terminal equipment and access data located therein with user consent. A thorough discussion as to whether Covid-19 apps fall in the definition of an ISS is beyond this paper. See Judgments of 20 December 2017, *Asociación Profesional Elite Taxi* C-434/15, EU:C:2017:981 and of 3 December 2020, *Star Taxi App*, C-62/19, EU:C:2020:980.

tracing. Providers of electronic communication services, including but not limited to Telcos, can only collect traffic and location data for the purposes specified in articles 6 and 9, with location data only to 'be processed when they are made anonymous, or with the consent of the users or subscribers to the extent and for the duration necessary for the provision of a value added service'.

Article 15 EPD enables the restriction of the scope of rights and obligations contained in articles 5, 6 and 9, but only for a strictly enumerated[47] list of objectives, a list which does not include public health. As a result, instruments adopted *qua* exception pursuant to article 15 EPD, including the now invalidated Directive 2006/24/EC, could not, on their own, help in the health response to COVID-19, but only its public security dimension.[48] Following *Ministerio Fiscal*, access to targeted and limited data is likely to be permissible for the fight against criminal offences that are not serious – an assessment that is for the referring court to make.[49] This could include the prosecution of violation of self-isolation measures by single individuals, insofar as they constitute an offence. It is unlikely, however, to include the monitoring of individuals for the sake of preventing the breaking of self-isolation measures.

In a development that deserves to be watched closely, the draft regulation set to repeal the EPD[50] makes provisions for processing traffic and location data to protect the vital interest of a natural person,[51] which 'may include for instance processing necessary for humanitarian purposes, including for monitoring epidemics'.[52] The GDPR and DPA 2018 are the relevant pieces of applicable law for data-driven measures reviewed in the second half of this article.

Whether the interference is in accordance with the law

The criterion to be 'in accordance with the law' refers to the need for (i) a legal basis (lawfulness) that (ii) meets parameters of quality (legality)

47 '... the list of objectives ... is exhaustive, as a result ... access must correspond, genuinely and strictly, to one of those objectives': *Ministerio Fiscal* (n 23 above) para 31.

48 Following judgment of 21 December 2016 in *Tele 2 Sverige*, Joined Cases C-203/15 and C-698/15, ECLI:EU:C:2016:970, para 102, only serious crime justifies the retention of traffic and location data.

49 *Ministerio Fiscal* (n 23 above) paras 53–57.

50 Council of the European Union, Proposal for a Regulation of the European Parliament and of the Council concerning the respect for private life and the protection of personal data in electronic communications and repealing Directive 2002/58/EC (Regulation on Privacy and Electronic Communications) – Mandate for negotiations with EP, Brussels, 10 February 2021 (2017/0003(COD)).

51 Ibid art 6b(1)(d).

52 Ibid recital 17a.

developed by the court and often borrowed from the ECtHR, in recognition of the Council of Europe's leading role on the rule of law.[53] Data protection legislation contains rules on lawfulness of processing and legality drawn from the rule of law, starting with the principles enshrined in article 5 GDPR – lawfulness, fairness and transparency, purpose limitation, data minimisation, accuracy, storage limitation, and integrity and confidentiality – which apply to the processing of any personal data.[54] For instance, the principles of lawfulness, fairness and transparency enshrined in article 5(1)(a) GDPR can be said to stem from the rule of law.[55] Many of these principles become actionable as rights of the data subjects and corresponding obligations of the data controller.

The GDPR also embodies a form of legality in that the data controller, the entity who decides the means and purposes of the processing, must have a lawful basis to act (articles 6 and 9 GDPR). The data controller has responsibility, *de facto* and *de jure*,[56] for fulfilling the data protection principles, in the form of technical and organisational measures commensurate with the risks entailed by the processing (article 24 GDPR). In other words, in order to benefit from the processing, the controller must safeguard the data so as to protect the data subjects concerned[57] – which turns the data controller into the *de facto* gatekeeper for data subjects' rights.

Legal basis for the processing of personal data within data-driven measures and determination of the controller

The Irish DPC notes that processing personal data for the sake of containing pandemics can take place under different legal bases.[58] For instance, 'where organisations are acting on the guidance or directions of public health authorities, or other relevant authorities' data concerning health can be processed based on article 9(2)(i) GDPR

53 Judgment of 6 October 2020 in *La Quadrature du Net and Others*, C-511/18, ECLI:EU:C:2020:791, para 103.

54 Combined reading of the Judgment of 29 June 2010 in *Bavarian Lager Ltd*, C-28/08 P, ECLI:EU:C:2010:378, para 61 and Judgment of 13 May 2014 in *Google Spain and Google*, C-131/12, EU:C:2014:317, para 96.

55 Lee A Bygrave, *Data Privacy Law: An International Perspective* (Oxford University Press 2014).

56 The responsibility of the controller is commensurate to their role in the processing, Judgment of 24 September 2019 in *GC, AF, BH, ED v Commission nationale de l'informatique et des libertés* (CNIL), Case C-136/18, ECLI:EU:C:2019:772, para 46.

57 Eg Judgment of 5 June 2018 in *Wirtschaftsakademie Schleswig-Holstein*, Case C-210/16, ECLI:EU:C:2018:388, para 28; *GC, AF, BH, ED* (n 56 above) para 43.

58 DPC (n 14 above).

and section 53 DPA 2018.[59] Employers must protect their employees under the Safety, Health and Welfare at Work Act 2005, which, together with article 9(2)(b) GDPR, provides a legal basis to process personal data concerning health.[60] Either way, suitable safeguards need to be implemented, for instance as laid down in section 36 DPA 2018. Furthermore, in case of emergency, protection of the vital interest of a data subject in line with articles 6(1)(d) and 9(2)(c) GDPR can act as a legal basis.

Consent (article 6(1)(a) GDPR) and the legitimate interests pursued by the controller (article 6(1)(f) GDPR) are unlikely to constitute valid bases for processing information other than data concerning health for pandemic purposes, a point shared by some, but not all, commentators.[61] Individuals are unlikely to agree to the required measures in a freely given, specific, informed and unambiguous manner; there is too much of a power imbalance between those requesting consent and data subjects. The legitimate interest basis is also unsuitable for its weakness vis-à-vis the interests or fundamental rights and freedoms of the data subject as per the interpretation of the court in *Rīgas satiksme*[62] and article 6(1)(f) GDPR.[63]

The most suitable bases for public authorities are article (6)(1)(e) GDPR and section 38 DPA 2018; these are necessary for either the exercise of official authority vested in the controller or the performance of a task carried out in the public interest. Private entities supporting the Health Service Executive (HSE) contact-tracing effort through contact logging could, in theory, be seen as performing a specific task carried out in the public interest, but the GDPR requires this legal basis to apply only when laid down in member state (or EU) law to which the controller is subject (articles 6(3) and 6(2), recitals 10 and 45). Although there is no need for 'a specific law for each individual processing' and 'a law as a basis for several processing operations … may be sufficient' (recital 45), such 'law' has to comply with the requirements of a legal measure (e.g. recital 41). This begs the question of what role private

59 See Costello in Costello et al (n ✳ above) ch 3.

60 For the UK, see Ruby Reed-Berendt and Edward Dove, 'Healthcare Workers' Data and Covid-19 Research' (UK-Reach Project 2020).

61 Kennedy (n 6 above).

62 According to the CJEU, there are 'three cumulative conditions so that the processing of personal data is lawful, namely, first, the pursuit of a legitimate interest by the data controller or by the third party or parties to whom the data are disclosed; second, the need to process personal data for the purposes of the legitimate interests pursued; and third, that the fundamental rights and freedoms of the person concerned by the data protection do not take precedence': Judgment of 4 May 2017 in *Rīgas satiksme*, C-13/16, ECLI:EU:C:2017:336.

63 'Such interests are overridden by the interests or fundamental rights and freedoms of the data subject which require protection of personal data.'

individuals or entities have when logging contacts for the benefit of the HSE COVID-19 contact-tracing programme. The adoption of an officially published instrument mandating contact logging would open up the path for the application of article 6(1)(c) GDPR (and possibly section 38 DPA 2018), which authorises processing operations pursuant to a legal obligation to which the controller is subject. Article 6(1)(c) GDPR is subject to the same conditions laid down for article (6)(1)(e) GDPR.

Quality of the legal basis

It is important to stress that references to 'law' do not necessarily mean an official Act adopted by a national or European legislative body in all circumstances, without prejudice to requirements pursuant to the constitutional order of the member state concerned. However, in all circumstances the 'law' must respect the parameters of quality proper of a 'law'.[64] However, such a legal basis or legislative measure should be *clear* and *precise* and its application should be *foreseeable* to persons subject to it, in accordance with the case law of the CJEU and ECtHR. In *Bara and Others*, the CJEU found that a legislative measure that was not the object of official publication was not in compliance with article 13 of Directive 95/46, now article 23 GDPR.[65] Furthermore, case law has stressed that for the most serious interference, the guarantees must be strongest.[66] It is therefore difficult to imagine how a serious interference could be permissible in the absence of legislation scrutinised by parliament, which raises questions as to the legality of early COVID-19 measures stemming from regulation and even soft law. I will discuss the matter in greater detail when I review select data-driven measures and in the conclusions.

Article 6(3) and recital 45 outline criteria for the quality of the law with respect to the lawful bases laid down in article 6(1)(c) and (e). The law must specify the purpose of the processing, a purpose that must be necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller when processing operations are based on article 6(1)(e). The law must

64 Recital 41 GDPR. European Data Protection Board, Guidelines 10/2020 on restrictions under article 23 GDPR (2020) 7, referring in particular to the ECtHR, 14 September 2010, *Sanoma Uitgevers BV v The Netherlands*, EC:ECHR:2010:0914JUD003822403, para 83. None of the measures reviewed in these pages explicitly aim at restricting the scope of the exercise of the right as in art 23 and recital 73 GDPR. Some processing operations need to be mandated by additional instruments (eg art 6(1)(c) and 6(1)(e), 9(2)(h) and (I) GDPR, ss 38, 51 and 53 DPA 2018).

65 Judgment of 1 October 2015 in *Bara and Others*, C-201/14, ECLI:EU:C:2015:638, para 40.

66 See, among others, *Tele 2 Sverige* (n 48 above).

also meet an objective of public interest and be proportionate to the legitimate aim pursued. Article 6 recommends the law contain specific provisions about:

- general conditions on lawfulness of personal data processing;
- types of personal data to be processed;
- the data subjects concerned;
- the purposes for, and entities to which, personal data may be disclosed;
- purpose limitation;
- storage period; and
- other measures for lawful and fair processing.

Given the language used ('should'), the inclusion of specific provisions in the law may appear to be desirable but optional from a regulatory perspective. However, when looking at data protection as a fundamental right, the provisions listed in article 6(3) appear necessary to respect, protect and fulfil the right, protect its essence[67] and comply with the substantive requirements of the rule of law: that is, the quality of the law and proportionality.

Unlike article 6(3), recital 45 recommends the law also contain the specifications for determining the controller. It is submitted that this addition is particularly important, not only because the identity of the data controller is not always self-evident,[68] but also because the controller is the gatekeeper for the exercise of the rights of data subjects. Uncertainty as to controllership can both generate confusion among those who process data following the guidance or directions of relevant authorities and curtail *de facto* the rights of data subjects who may not know whom to approach about enforcing their rights.[69] Clarifying matters of controllership is also relevant to understanding who should be the recipient of data collected according to guidance.[70]

In Irish law, section 36 DPA 2018 covers the introduction of suitable and specific measures for processing (and section 60 DPA 2018 covers restrictions). Importantly, the DPC is to be consulted before a minister makes regulations pursuant to sections 36, 38 and 51 (as well as section 60). The adoption of delegated legislation is not mandatory, though provisions such as section 53 DPA 2018 require that suitable

67 The essence includes limiting the purposes for which data can be processed and adopting rules to ensure the integrity and confidentiality of the data: Opinion 1/15 of the Court (Grand Chamber), ECLI:EU:C:2017:592, para 150.

68 To this effect, see EDPS, Concepts of controller, processor and joint controllership under Regulation (EU) 2018/1725, 7 November 2019.

69 Judgment of 1 October 2015 in *Weltimmo*, C-230/14, EU:C:2015:639; *Wirtschaftsakademie Schleswig-Holstein* (n 57 above).

70 Müge Fazlioglu, 'Confusion as to how to share data with public authorities' (*International Association of Privacy Professionals* 21 April 2020).

and specific measures be taken to process data concerning health for purposes of public interest in the area of public health (following section 36 DPA 2018).

A systematic reading of the applicable law suggests that guidance requiring the processing of data without the necessary safeguards could amount to undue restrictions and could be challenged on rule of law grounds. Limitations to the rights of data subjects should stem from legislation derogating from the GDPR in line with article 23(1). Yet, the requirements for derogating legislation listed in article 23(2) are similar to those contained in article 6(3) and recital 45, as the list is formulated in an open-ended manner.

Whether the interference is compatible with the essence

The CJEU identified two elements that are the essence of article 8 of the CFR: the presence of a provision that 'limits ... the purposes for which ... data may be processed' and 'rules intended to ensure, inter alia, the security, confidentiality and integrity of that data, as well as to protect it against unlawful access and processing'.[71] These find correspondence in the principles of purpose limitation and integrity and confidentiality of data protection law. Therefore, any measure restricting the right without making provisions for purpose limitation, as well as integrity and confidentiality of data, is capable of crushing the essence and becomes automatically impermissible. It should be noted that the requirement of compatibility with the essence is a source of academic debate[72] as is the assessment of a breach of the essence.

Whether the interference is justified, necessary and proportionate

This article presumes that data-driven measures satisfy the condition that the interference is justified, as 'safeguarding public health' is 'an important objective of general public interest' justifying restrictions to data protection law pursuant to section 60(o) DPA 2018. However, a measure that intends to meet an important objective of public interest may still be discarded on grounds of necessity and proportionality.

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71 Opinion 1/15 of the Court (Grand Chamber), ECLI:EU:C:2017:592, para 150.

72 See generally, Maja Brkan, 'The concept of essence of fundamental rights in the EU legal order: peeling the onion to its core' (2018) 2 European Constitutional Law *Review* 332–368; Maria Grazia Porcedda, 'On boundaries: finding the essence of the right to the protection of personal data in privacy and data protection' in Ronald Leenes et al (eds), *Data Protection and Privacy: The Internet of Bodies* (Hart 2018); Lorenzo Della Corte, 'A right to a rule: on the substance and essence of the fundamental right to personal data protection' in Dara Hallinan et al (eds), *Data Protection and Privacy: Data Protection and Democracy* (Hart 2020); Dara Hallinan, 'The essence of the right to the protection of personal data: essence as a normative pivot' (2021).

Whether the interference is necessary and proportionate

Earlier, I introduced the EDPS Toolkit on necessity[73] and the Guidelines on proportionality,[74] which primarily address decision-makers preparing legislation capable of interfering with article 8 CFR but are also useful for appraising the permissibility of interferences in light of existing legislation. The Toolkit and Guidelines are premised on the idea that the double requirements of necessity and proportionality[75] must be assessed on a case-by-case basis, and to this effect the EDPS develops a four-stepped methodology. The necessity test, which must be strictly met, requires first of all to factually describe the measure and secondly to identify whether the measure limits data protection (and other rights). Thirdly, one must define the measure's objectives against which to assess necessity and, lastly, choose the option that is effective and least intrusive.

Proportionality in a narrow sense must only be appraised for a measure that is strictly necessary, as evidenced by *Digital Rights Ireland* and *Schrems*.[76] The first step is to assess the legitimacy, or importance, of the objective and its effectiveness and efficacy, namely to what extent the proposed measure would meet this objective. The second step is to evaluate the scope, extent and intensity of the interference based on the effective impact of the measure on the rights. Third, comes the fair balance evaluation of the measure. The fourth and final step is to draw conclusions on the proportionality of the proposed measure, including the identification and safeguards which could make the measure proportionate. It is argued that none of the data-driven measures reviewed in this article reaches the proportionality stage of the test, as they all fail at previous stages, as I demonstrate next.

REVIEW OF SELECT 'UNDER-THE-RADAR' DATA-DRIVEN MEASURES

This section reviews several 'under the radar' pandemic data-driven measures, although not all measures deserving analysis are included. For instance, the Contact Management Programme (CMP), arguably a crucial component of the public health response to COVID-19 and any pandemic, is not reviewed here for want of technical documentation

73 EDPS (n 25 above).

74 EDPS (n 26 above).

75 On the necessity–proportionality nexus, see EDPS (n 25 above) 5.

76 Ibid 7; EDPS (n 26 above) 10, referencing *Digital Rights Ireland* (n 24 above) paras 46, 65 and 69, and Judgment of 16 July 2020 in *Facebook Ireland and Schrems*, C-311/18, ECLI:EU:C:2020:559, paras 92–93.

enabling ascertainment of its permissibility.[77] I review under-the-radar measures in light of the criteria just outlined: presence of an interference with the right to data protection; respect for the essence of the right; satisfaction of quality of the law requirements; meeting an objective of public interest, which is presumed here; necessity; and proportionality. To begin with, I show how thermal scanner guns can interfere with the right to data protection, meaning that they are not automatically permissible. I then show that self-check forms may not have an adequate legal basis and that instruments mandating contact logging do not fully satisfy 'quality of the law' requirements. I subsequently examine whether the VIS stands the test of necessity. I finally raise questions as to the compatibility of data-driven measures with the essence of article 8 of the CFR.

Thermal scanner guns may interfere with the right to data protection

Thermal scanner guns taking individuals' temperature have been widely used in a variety of settings. Models of thermal scanners capable of storing the temperature taken – and only the temperature taken with no logs of time and day – collect information which is not capable of identifying individuals; the ability of such data to become 'identifiers' is highly unlikely, as noted by DPAs across Europe.[78] However, the more information is stored, the higher the information's ability to identify an individual in conjunction with other data, based on the 'reasonably likely' test of *Patrick Breyer* and the EDPB, as discussed earlier. The finding changes dramatically for models of thermal screeners[79] connected to the internet that contain cameras and can support custom integrations such as third-party system software. These are akin to CCTV systems that collect data concerning health.

In its Guidance accompanying the 'return to Work Protocol', the DPC stressed the lack of HSE guidance concerning the use of thermo-scanners and advised against their use until such guidance is issued. Even if this mooted the need for further assessment, it would nonetheless be important to stress that the Health Information and Quality Authority found mass thermal screening (eg infrared thermal

77 Health Protection Surveillance Centre, 'Contact tracing guidance'. The CMP is analysed in Porcedda in Costello et al (n ✳ above) ch 1.

78 Christina Etteldorf, 'EU member state data protection authorities deal with COVID-19: an overview' (2020) 6(2) European Data Protection Law Review 265.

79 For purely illustrative purposes, see AXSIS Thermal Scanner Enabled Digital Hub.

scanners) at airports to be ineffective 'in identifying infectious individuals and limiting spread of disease'.[80]

The continued use of 'guns' that do not collect personal data could be no more than 'hygiene theatre'.[81] Other forms of thermal scanning capable of collecting personal data could constitute an interference requiring a legal basis, but in light of their manifest inadequacy such measures are unlikely to be deemed necessary and proportionate.

Self-check forms and measures for contact logging are unlikely to be 'in accordance with the law'

Self-check forms lack the requisite legal basis

In general, few data-driven measures are adopted pursuant to a clear and unambiguous legal basis.[82] At the beginning of the pandemic, many data-driven measures such as contact logging by individuals, businesses and entities of all kinds were based on guidance (hereafter the Government Roadmap) rather than statutory law, which raised rule of law challenges.[83] The 2021 Government Roadmap no longer encourages individuals and recreational facilities to undertake contact logging.[84] Non-essential businesses are instead encouraged to take 'protective measures' which, for the hotel sector specifically, include 'customer details recorded for contact tracing process'.[85] Eventually, the recording of customer details for contact-tracing purposes was given statutory footing (see further below). 'Protective measures' not specifically linked to statutory requirements include thermal scanner guns (reviewed earlier) and self-check forms for visitors to business premises, for example retailers,[86] universities and customers of hairstylists and beauticians[87] – forms that process data concerning health (article 4(15) GDPR).

80 Health Information and Quality Authority, 'Thermal screening' (6 August 2020).

81 Derek Thompson, 'Hygiene theater is a huge waste of time' (*The Atlantic* 27 July 2020).

82 See Porcedda in Costello et al (n ✳ above) ch 1.

83 Porcedda (n 10 above).

84 Department of the Taoiseach, 'COVID-19 resilience and recovery 2021 – the path ahead' (15 September 2020) 8 and 11.

85 Ibid 50.

86 NSAI, 'COVID-19 retail protection and improvement guide' version 21 (2020) 19.

87 'Re-opening guidelines for Irish hair salons and barber shops' (HABIC June 2020) 17. Paul Moore, 'Rules you have to follow in Ireland's hairdressers and barbers upon reopening' *Irish Mirror* (Dublin, 9 May 2021).

To ensure the Safety & Health of all people interacting with (insert Salon Name), clients and visitors must complete this declaration form prior to entering or on arrival our salon. If you indicate to us you have symptoms of COVID-19 OR you have been abroad in the last 14 days with exception to Northern Ireland you will be required to either restrict your movements or self-isolate.

Where this is the case, you are prohibited from entering the salon/barber shop and advised to seek professional medical help/ assistance in line with HSE Guidelines.

			Yes	No
1.	Have you visited any of the countries outside Ireland excluding Northern Ireland?		☐	☐
2.	Are you suffering any flu like symptoms?		☐	☐
3.	Are you experiencing any difficulty in breathing, shortness of breath?		☐	☐
4.	Are you experiencing any fever/temperature symptoms?		☐	☐
5.	Did you consult a Doctor or other medical practitioner?		☐	☐
6.	How are you feeling Health wise?	**Well**	☐	**Unwell** ☐
7.	Have you been in contact with someone who is confirmed to have COVID-19 has visited an affected region in the past 14 days?		☐	☐

Figure 1: Hair and Beauty Industry Confederation (HABIC) of Ireland visitor questionnaire.

The processing of data concerning health, as many COVID-19-related measures do, can be seen as a serious interference and deserves higher protection (recital 51 GDPR).[88] For such a reason, national DPAs disagree as to the permissibility of self-health screening questionnaires for employees,[89] let alone visitors. Data collected through self-check forms can be lawfully processed under the combined legal bases of articles 6(1)(c) and 9(2)(b), but only if, as the DPC notes, 'the processing is necessary[90] for the purpose of carrying out its obligations in the field of employment (such as the obligations arising under the 2005 Act)'.[91] If self-check forms emanated from the Safety, Health and Welfare at Work Act 2005, then they would have a legal basis. The compatibility of self-check forms with data protection law would then need to be assessed in light of their necessity, which remains to be demonstrated; self-check forms in their current form seem disproportionate and are

88 Judgment of 24 September 2019 in *GC, AF, BH, ED* (n 56 above) paras 44 and 67.

89 Etteldorf (n 78 above).

90 This links to the principles of fairness and purpose limitation.

91 DPC, 'Data protection implications of the return to work safely protocol' (June 2020) 3.

likely to amount to an impermissible interference with the right to data protection.[92]

If self-check forms did not emanate from the Safety, Health and Welfare at Work Act 2005, then a legal basis would need to be found. A facsimile of self-check forms for visitors was drawn up by the National Standards Authority of Ireland (NSAI)[93] and has remained unchanged throughout the pandemic. From a rule of law perspective, guidance can qualify as a legal basis if it fulfils the quality of law requirements illustrated earlier, including clarity and foreseeability,[94] which enable citizens to adjust their conduct. In spite of its publicity,[95] the Government Roadmap is unlikely to meet quality of law parameters: not only does it not meet the parameters required by articles 6(2) and (3) and *a fortiori* article 9 GDPR, but also, it never required visitors to produce self-check forms as one of the protective measures. Self-health check forms emanate from guidance, rather than standards,[96] which was not produced pursuant to a mandate issued by the legislature and is unlikely to constitute a legal basis. In sum, self-check forms suffer from many shortcomings that make them incompatible with data protection law.

Instruments for contact logging and locator forms display 'quality of the law' shortcomings

Three Statutory Instruments (SIs) were adopted to support contact-tracing efforts. One such SI gives statutory basis to the recording of customer details by hotels, eateries and bars for contact-logging purposes.[97] Two SIs specifically required international passengers entering Ireland to 'retain', 'give or otherwise make available' to

92 Elsewhere I show that the lack of a 'generic data protection notice', which data controllers could easily affix in their premises to inform people of their rights, deprives data subjects of effective protection and is akin to restrictions to their rights, in defiance of art 23 GDPR and s 60 DPA 2018. See Porcedda in Costello et al (n ✳ above) ch 1. See also Maria Grazia Porcedda, 'Businesses need to be careful with personal data during pandemic' *Irish Times* (Dublin, 20 July 2020).

93 NSAI, 'COVID-19 workplace protection and improvement guide' version 7 (2020) 16.

94 Judgment of 25 May 2021, *Big Brother Watch and Others v UK*, App nos 58170/13, 62322/14 and 24960/15, CE:ECHR:2018:0913JUD005817013.

95 EDPS (n 25 above) 4.

96 The legal standing of standards adopted in the context of EU delegated legislation has changed since Judgment of 27 October 2016 in *James Elliot*, Case C-613/14, ECLI:EU:C:2016:821, para 40. However, the ability of standards, especially those adopted by national bodies, to act as a legal basis remains to be assessed.

97 Health Act 1947 (Section 31A – Temporary Restrictions) (Covid-19) (No 2) Regulations 2021. An informal consolidation of the regulations and related amendments is available at 'Informal consolidation of COVID-19 regulations'.

a relevant person or a member of the Garda Síochána a negative COVID-19 test result,[98] and to fill in and hand in to the 'relevant person' a locator form.[99]

The adoption of multiple instruments with similar aims creates a jigsaw puzzle of data collection requirements. One difference concerns controllership, which is determined by the identification of the means and purposes of the processing. Different SIs identify different controllers, and in one case (locator forms) controllership has changed from one version to the other. In particular, legislation affecting hotels, eateries and bars identifies three different controllers for three different purposes. For instance, hotels, restaurants and pubs are controllers when collecting data, thereby opening up the path for the application of article 6(1)(c) GDPR. Hotels, eateries and bars certainly decide the means of processing but not its purpose. The fact that data are ultimately collected for the benefit of contact tracing puts hotels, eateries and bars in a position closer to that of a processor than a controller. In all cases, the SIs presuppose a transfer of personal data currently lacking the requisite interinstitutional arrangements.[100]

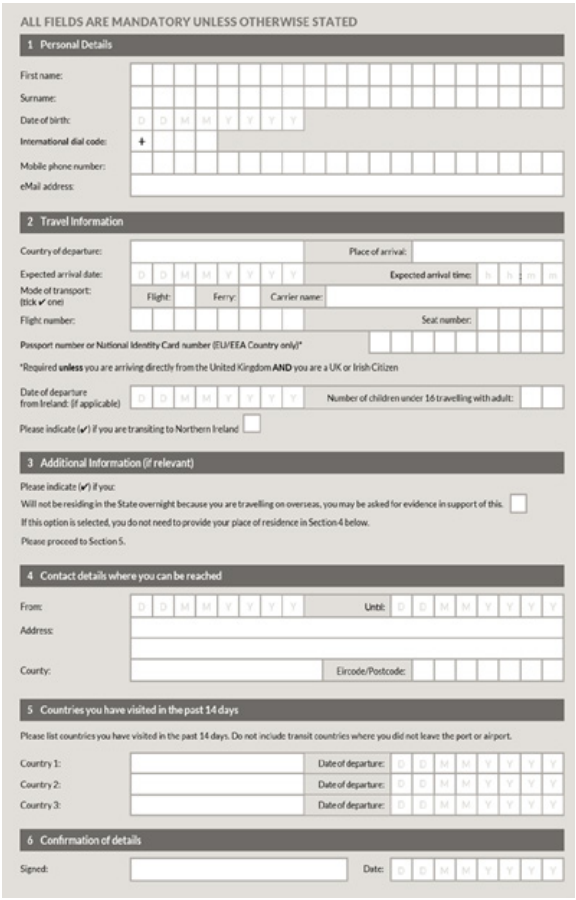
The jigsaw puzzle effect is worsened by the fact that all SIs have been amended multiple times in the space of a year, partly because measures were adopted on a trial-and-error basis and needed to be adjusted, partly to reflect initiatives coordinated at EU level, such as the adoption of Digital Green passes, and partly to lift restrictions. Frequent amendments of such fragmentary legislation undermine legal certainty, thereby impacting foreseeability, not to mention the operational costs to the addressees of legislation.

These instruments also show substantive similarities, begging the question of why the legislator privileged multiple instruments as opposed to an overarching law disciplining data processing for contact logging and tracing for pandemic purposes. First, all SIs lay down penal provisions and endow the Garda Síochána with enforcement powers with respect to preventing, detecting, investigating or prosecuting a criminal offence arising from a contravention of a provision stated to be a penal provision. Secondly, all SIs present exceptions to the term for data retention identified in legislation. Thirdly, none of the SIs

98 Reg 5(1) of SI 135/2021 Health Act 1947 (Section 31A – Temporary Restrictions) (COVID-19) (Restrictions upon travel to the State from Certain States) (No 5) Regulations 2021, revised to 14 June 2021. See also 'Statutory instruments relating to the COVID-19 pandemic'.

99 SI 45/2021: Health Act 1947 (Section 31A – Temporary Requirements) (Covid-19 Passenger Locator Form) Regulations 2021 revokes SI 181/2020: Health Act 1947 (Section 31A – Temporary Restrictions) (COVID-19 Passenger Locator Form) Regulations 2020. There, the HSE was also a data controller.

100 See Costello in Costello et al (n ✳ above) ch 3.



ALL FIELDS ARE MANDATORY UNLESS OTHERWISE STATED

1 Personal Details

First name:
Surname:
Date of birth: D D M M Y Y Y Y
International dial code: +
Mobile phone number:
eMail address:

2 Travel Information

Country of departure: Place of arrival:
Expected arrival date: D D M M Y Y Y Y Expected arrival time: h h : m m
Mode of transport: (tick ✔ one) Flight: Ferry: Carrier name:
Flight number: Seat number:
Passport number or National Identity Card number (EU/EEA Country only)*
*Required **unless** you are arriving directly from the United Kingdom **AND** you are a UK or Irish Citizen
Date of departure from Ireland: (if applicable) D D M M Y Y Y Y Number of children under 16 travelling with adult:
Please indicate (✔) if you are transiting to Northern Ireland

3 Additional Information (if relevant)

Please indicate (✔) if you:
Will not be residing in the State overnight because you are travelling on overseas, you may be asked for evidence in support of this.
If this option is selected, you do not need to provide your place of residence in Section 4 below.
Please proceed to Section 5.

4 Contact details where you can be reached

From: D D M M Y Y Y Y Until: D D M M Y Y Y Y
Address:
County: Eircode/Postcode:

5 Countries you have visited in the past 14 days

Please list countries you have visited in the past 14 days. Do not include transit countries where you did not leave the port or airport.

Country 1: Date of departure: D D M M Y Y Y Y
Country 2: Date of departure: D D M M Y Y Y Y
Country 3: Date of departure: D D M M Y Y Y Y

6 Confirmation of details

Signed: Date: D D M M Y Y Y Y

Figure 2: Example of passenger locator form.

satisfies in full the requirements of article 6(2) and (3). To exemplify the issue I focus on locator forms.

The degree of intrusiveness of locator forms[101] is arguably greater than simple contact logging because such forms collect more categories of personal data and are imposed on all international passengers. Moreover, the use of digital locator forms is riskier than the use of paper ones as per the revoked SI 181/2020 because the use of automated means of processing can facilitate further, unauthorised processing compared to manual processing. Legislation mandating the collection of travel forms constitutes a legal basis in line with article 6(1)(e) GDPR, but in its current form it arguably lacks the elements to ensure lawful and fair processing identified above.

101 Ibid, defined in reg 3. The previous version can be found at on the Irish Statute Book website. The regulations also cover passenger location form receipts, which are not reviewed here.

The revised locator form collects more categories of personal data than the revoked SI 181/2020. The updated section on 'travel information' gathers more information than the 2020 version and also features a new section titled 'countries you have visited in the past 14 days'. The form collects identity card data for EU citizens and passport data for all other citizens, with the exception of UK or Irish citizens, who are exempted; it also collects information such as flight and seat numbers. The principles of purpose specification and data minimisation require the text to adequately reflect the necessity of the data for the purposes of the processing. However, such categories are not adequately reflected in the regulations, which only explicitly refer to – and thus justify the need for – collecting passengers' 'contact details', namely a telephone number and email address, as well as the 'place of residence', meaning 'the place, or places, in the State or in Northern Ireland[102] at which he or she intends to reside' (regulation 2).

Furthermore, in common with all SIs, processed data must be erased 28 days after the date of arrival, with the exception of 'when they are required for the purposes of the prevention, investigation, detection or prosecution of *a criminal offence*' (regulation 8(4), emphasis added), an exception that was first laid down in the 2020 Regulations. This exception is common to all SIs seen in this section and is highly problematic. Firstly, it *de facto* broadens the purposes for which data can be used, which sits uncomfortably with the 'quality of the law' tenet.[103] Secondly, the purpose '*a criminal offence*' is unspecified and is broader than the penal provisions identified in the SI thus providing insufficient clarity and foreseeability (on purpose limitation, see below). Finally, by stating that the data will be deleted when no longer required, the regulation fulfils the storage limitation principle only formally: without clearly specifying which 'criminal offence' the data could be processed for, the regulation opens up the possibility of endless retention, which would undermine the substance of the principle. As a result of these shortcomings, the SIs could excessively interfere with data protection law and therefore be partly invalid.

Are guidance and SIs in accordance with data protection law?

On balance, all data-driven measures drawing from guidance or SIs state the main purpose of the processing. Yet, measures do not consistently include the safeguards for data processing to ensure the lawful and fair processing listed in article 6(3) GDPR. SIs generally include provisions stating:

102 This was added in SI 45/2021 (n 99 above).

103 See also Oran Doyle, 'Quarantine after international travel: legal obligations, public health advice, pervasive confusion' (*COVID-19 Law and Human Rights Observatory Blog* 27 July 2020).

- the types of personal data to be processed;
- the data subjects concerned;
- the purposes for and entities to which personal data may be disclosed; and
- the identification of the data controller, though not always with clarity for all categories.

Some SIs fail to indicate clear storage periods and are silent on the conditions on lawfulness of personal data processing. Guidance rarely goes beyond the identification of the types of data to be processed and data subjects concerned. The mandatory language used by guidance sits uncomfortably with the requirements of article 6(3) GDPR and the criteria of 'clarity', 'precision' and 'foreseeability' found in recital 41 GDPR, constitutional law and international human rights instruments. Furthermore, the more intrusive the processing, the less likely it is to pass the legality test in case of judicial review.[104] All documents specify purposes, but none of those reviewed thus far clearly limit them. Thus, most measures would hardly be 'in accordance with the law'.

Necessity: the Vaccine Information System

The VIS is 'an end-to-end comprehensive digital solution to support the delivery and rollout of the nationwide COVID-19 vaccination programme'.[105] It is based on several frameworks, such as the Health Identifiers Act 2014, section 31 of the Health Act 1947, the Infectious Diseases Regulations 1981 (SI 390/1981)[106] and policies (ie the European Commission eHealth Network).[107] The VIS is justified by an objective of public interest and therefore the present analysis focuses on necessity.

In accordance with the methodology developed by the EDPS, to ascertain necessity one must first describe the measure. This can be easily accomplished thanks to the data protection impact assessment (DPIA) first published in December 2020. Although the publication of the DPIA was a very welcome move for transparency and public scrutiny, it should be noted that, first, the DPIA was edited 23 times between its publication and September 2021, and, second, the 'table of versions' does not enable the reader to track and identify changes to

104 See Ibid; Oran Doyle, 'Leaving home: reasonable excuses, vagueness, and the rule of law' (*COVID-19 Law and Human Rights Observatory Blog* 5 June 2020); Oran Doyle, 'On legal obligations and golf-gate' (*COVID-19 Law and Human Rights Observatory Blog* 28 August 2020).

105 HSE, Vaccine Information System for COVID-19 Vaccination Programme Data Protection Impact Assessment, version 1.8 (22 April 2021) 6.

106 Ibid 32–33.

107 Ibid 20.

the text.[108] It is even questionable whether a DPIA should be edited at all, as it is not a data management plan. Version 0.6 incorporates comments from the DPC, possibly in relation to prior consultation.[109] The present analysis is based on version 18.

The development, testing, security, operation and maintenance of the system is the joint responsibility of the HSE and IBM. The latter oversees the configuration of the VIS, which is hosted on Salesforce's HealthCloud platform[110] 'within Salesforce data centres within the European Economic Area (EEA)'.[111] The overall data controllers are the HSE and general practitioners (GPs) (with respect to their patients' data), as well as the Central Statistics Office (CSO), whereas IBM is identified as a processor, alongside pharmacists, healthcare facilities (acting under section 38 of the Health Acts 2004), private hospitals and Department of Public Expenditure and Reform. Salesforce is a subprocessor.

All these entities receive patient data, which include several categories of personal information: first name, middle name (optional), surname, mother's maiden name, date of birth, personal public service number (PPSN), sex, nationality, ethnicity, the individual health identifier (IHI),[112] home address, county, country, area code/Eircode, GP name, occupation, prioritisation category, vaccination status, contraindication to vaccination, health state, pregnancy, COVID history and vaccination history.[113] The Health Products Regulatory Authority and Department of Health are the recipients of anonymised data. Patient data are to be retained in perpetuity, though it is not clear on what system and therefore whether processors will also retain data in perpetuity.[114] The DPIA discusses risks and mitigation strategies, including generic technical and organisational measures and a description of data security measures.

Analysis of the Vaccine Information System

A reading of version 18 of the DPIA shows that the VIS limits the right to data protection. The VIS pursues a number of objectives, including vaccination, archival purposes for the HSE and GPs and statistical purposes for the CSO. Such objectives appear *prima facie* necessary, but based solely on the DPIA it appears difficult to carry out the last

108 Ibid.

109 Ailbhe Daly, 'Private information of thousands who received Covid vaccine exposed in HSE blunder' *Irish Mirror* (Dublin, 25 February 2021).

110 HSE (n 105 above) 13.

111 Ibid 35.

112 'Generated for each person registered for a vaccination': ibid 27.

113 Ibid 26–28

114 Ibid 23.

step of the necessity test, namely to choose the measure that combines effectiveness and minimal intrusion. First, the DPIA identifies three lawful bases, articles 6(1)(e), 9(2)(h) and (i) GDPR,[115] for the 'purposes of processing personal data for the vaccination programme', rather than for each specific purpose pursued by the different data controllers (eg vaccination and archival purposes for the HSE and GPs, statistical purposes for the CSO etc). This prevents an analysis of effectiveness.

Secondly, although the importance of the principle of data minimisation is stressed several times across the document, justification as to the need to collect data is only given for data enabling to uniquely identify a patient (IHI).[116] As for the remaining, long and broad, list of personal data to be collected, the DPIA only describes when the data are collected, not why they are adequate, relevant and limited to what is necessary in relation to the purposes for which they are processed.[117] This hinders an analysis of effectiveness and minimal intrusion.

A third cause for concern is that both IBM and Salesforce 'are providing support of the Vaccine Information System from outside the EEA';[118] it is unclear why these companies, who have European and particularly Irish offices,[119] are operating from outside the EEA and where from exactly. The DPIA mentions 'appropriate arrangements as set out in Chapter 5 of the GDPR in order to facilitate the transfer and/or processing of vaccine data outside the EEA' but does not provide any further details as to such arrangements, for example whether they rely on binding corporate rules or standard contractual clauses. The transfer of VIS data to the United States (US), following the CJEU's decision in *Facebook Ireland and Schrems*,[120] which invalidated Commission Implementing Decision (EU) 2016/1250 of 12 July 2016 on the adequacy of the protection provided by the EU–US Privacy Shield, would be highly problematic. Equally problematic would be the use of standard contractual clauses, as they do not automatically afford a level of protection essentially equivalent to that guaranteed within the EU, read in the light of the CFR.[121] Once more, an analysis of effectiveness and minimal intrusion is not possible.

Fourthly, all data collected are to be retained in perpetuity; this decision appears to be a serious breach to the principle of storage limitation, as it is unrelated to specific purposes and specific

115 Ibid 31.
116 Ibid 18.
117 Ibid 26.
118 Ibid 34.
119 Ibid. See also Salesforce, 'Europe, Middle East and Africa'; IBM Research Europe.
120 *Schrems* (n 76 above).
121 Ibid para 105.

controllers/processors. It is also unclear whether the processors and sub-processors would retain such data in perpetuity as well.[122] This point effects maximal intrusion and therefore challenges necessity.

Fifthly and relatedly, such an endless retention period necessarily invalidates the risk assessment: if data are to be held in perpetuity, by all parties involved, the risks of breaches of data protection legislation (which apply so long as the data subject is alive) are vastly multiplied, which the risk assessment does not adequately take into account.[123] Such a state of affairs has a knock-on effect on security. In February 2021, an individual who was erroneously given access to the IT system used by the HSE contacted the *Irish Mirror* to blow the whistle. The human error enabled the whistleblower to access confidential data such as PPSNs, addresses, names and contact details about thousands of vaccine recipients 'despite earlier warnings by data chiefs'.[124] Moreover, the list of technical and organisational security measures provided, which on paper appear adequate,[125] will need to be updated in years to come, for instance with the development of quantum computing. In sum, the VIS is implemented in such a manner that challenges the requirement to choose the most effective and least intrusive measures, thereby appearing unnecessary and therefore limiting the right to data protection by a greater extent than required.

Respect for the essence: a transversal shortcoming?

Following article 52(1) CFR, the assessment of whether the essence is infringed (ie whether the right is emptied of its core elements)[126] must be done immediately after the analysis of lawfulness. However, as mentioned earlier, a methodology to ascertain respect of the essence is hitherto missing and the operationalisation of the concept is debated by scholarship. The following analysis is, therefore, exploratory.

A purposive interpretation of the law in light of the essence would invalidate most measures. First, derogations from strict data retention periods for as vague a purpose as 'a criminal offence' would fail to constitute a provision that 'limits ... the purposes for which ... data may be processed,'[127] thereby crushing the essence and invalidating the relevant measure (or part thereof). The same could potentially apply to data stored by the VIS 'in perpetuity'. Secondly, all SIs and most data-

122 HSE (n 105 above) 23.
123 Ibid 26, risk #10 and mitigation #10.
124 Daly (n 109 above).
125 An assessment is impossible without reference to detailed technical measures and specific standards.
126 EDPS (n 26 above).
127 Opinion 1/15 of the Court (Grand Chamber), EU:C:2017:592, para 150.

driven measures, except the VIS DPIA, lack provisions addressing the integrity and confidentiality of the data collected. Whether or not the essence is compromised, the importance of securing personal data cannot be overstated due to the increased risk of data breaches tied to an unaware, overwhelmed or home-bound workforce.[128] Unsafely discarded logged contacts, even manual ones from hotels, eateries and bars could be a treasure trove for fraudsters, adding to the tally of phishing (email), vishing (voicemail) and smishing (text messaging) frauds, which were up by 45 per cent in 2020[129] and by 50 per cent in 2021.[130] The use of cloud-computing solutions, which the VIS relies on, can increase the costs of a data breach by exfiltrated/lost unit.[131]

The ransomware attack suffered by the HSE in May 2021 demonstrates how data security requirements need to become a regulatory priority and cannot be left to contractual arrangements between the controller and the processor.[132] Importantly, the security incident did not seem to affect the VIS.[133] The incident provides a cautionary tale for any data collection system put into place. A report published in May 2021 on the National Incident Management System within the HSE found 'lack of clear governance, leadership and management … The HSE owns this data and should be taking responsibility for leading a long-term strategic approach to ensure the effective collection and use of this data.'[134]

128 DPC, 'Protecting personal data when working remotely' (12 March 2020).

129 'Garda stats: domestic violence, drug possession and fraud on the rise during lockdown' (*The Journal.ie* 12 June 2020).

130 Conor Lally, 'Online crime jumps by half last year as cyber fraud increases' *Irish Times* (Dublin, 12 March 2021).

131 Larry Ponemon, '2017 cost of data breach study'. The CMP also relies on cloud computing.

132 See Maria Grazia Porcedda, 'Patching the patchwork: appraising the regulatory framework on cyber security breaches' (2018) 35(5) Computer Law and Security Review 1077–1098.

133 Eoin Butler, 'Life as a Covid vaccine volunteer' *Irish Times* (Dublin, 13 June 2021).

134 Health Information and Quality Authority, 'Review of information management practices for the National Incident Management System (NIMS) within the HSE' (May 2021).

CONCLUSIONS: LEGISLATORS OUGHT TO DEVELOP A BLUEPRINT FOR PROCESSING PERSONAL DATA FOR PANDEMIC PURPOSES

This article has reviewed the compliance of data-driven measures adopted in Ireland some months into the COVID-19 pandemic with regard to the right to data protection. The analysis was conducted on the basis of criteria drawn from the applicable law read in light of the CFR. The analysis shows that thermal scanner guns can potentially interfere with the right to data protection; self-check forms rest on shaky legal bases; the quality of SIs for contact logging is insufficient; elements of the VIS seem unnecessary; and a rigorous interpretation of the essence of the right to data protection could invalidate many data-driven measures. Crucially, while the rationale of such interventions can be justifiable, the delivery does not fully comply with data protection law.

A systematic review of the applicable law in light of the right to data protection suggests that digital and manual data-driven measures that process data without the necessary safeguards could amount to undue restrictions and could be challenged on rule of law grounds. Such an outcome is in keeping with the findings of other commentators who stressed the potential inadequacy of national rules overseeing the state of emergency[135] and the consequences this carries for legality.[136] The outcome points to the difficulty of reconciling public health and data protection without a systematic data-processing strategy.

The lack of coordination was fully understandable at the beginning of the COVID-19 epidemic, as EU member states were relatively inexperienced in pandemics and consequently have been learning as they went along.[137] However, EU member states could have made better use of lessons learnt from other situations of emergency, such as terrorism and the related data retention debate. Indeed, the relevance of data retention debates has not escaped commentators:[138] the related judicial saga has traced the boundaries of pandemic

135 Alan Greene, 'Ireland's response to the COVID-19 pandemic' (*VerfBlog*, 11 April 2020); Conor White, 'The Oireachtas and mandatory face coverings' (*COVID-19 Law and Human Rights Observatory Blog* 13 July 2020); Gianluca Sardi, 'L'emergenza sanitaria da Covid-19 nella Repubblica d'Irlanda. Strumenti giuridici per contrastare la pandemia e conseguenze problematiche sulla protezione dei diritti fondamentali' (2020) DPCE Online 2.

136 Conor Casey, Oran Doyle, David Kenny and Donna Lyons, 'Ireland's emergency powers during the Covid-19 pandemic' (Irish Human Rights and Equality Commission 2020).

137 Martina Cardone and Marco Cecili, 'Osservazioni sulla disciplina in materia di tutela dei dati personali in tempi di Covid-19. L'Italia e i modelli sudcoreano, israeliano e cinese: opzioni a confronto' (2020) Nomos 1.

138 Kennedy (n 6 above).

interventions. Furthermore, successive waves of lockdown have offered the opportunity to review and, where necessary, correct the responses given in the heat of the moment. To an extent, this has happened with the adoption of SIs for contact logging and the publication of the VIS DPIA, but, as seen, such measures could benefit from additional correction.[139]

The applicable law provides the necessary elements for an intervention that reconciles the objectives of protecting personal data and public health. A half-hearted application can come at great cost – as evidenced for instance by the ransomware attack and data breach suffered by the HSE – and undermine trust in the provision of public services. On this account, I formulate three recommendations towards a blueprint for data processing for pandemic purposes.

First, I recommend *the adoption of an overarching instrument that contains the blueprint for data processing for pandemic purposes*. The criteria for compliance with the applicable law discussed above can be repurposed as a blueprint for such processing, in combination with the EDPS Toolkit on necessity and the Guidelines on proportionality. In the Irish transposition of data protection law, the blueprint would ideally be a measure of the rank of an SI or higher, laying down the legal basis for contact logging and transfers of data to the HSE for contact-tracing purposes, in a clear, precise and foreseeable manner, following the criteria stemming from article 6(2) and (3) GDPR and the DPA 2018 outlined above. The obligation to consult the DPC would help to ensure adherence to the law.

Accordingly, the law should at a minimum identify the department retaining overall controllership (eg Department of Health), list co-controllers and refer to inter-institutional data-sharing arrangements. The law should outline the data subjects concerned within different contexts, such as travel, entertainment, employment, healthcare and so on and clarify the categories of data to be collected in abidance with the principles of purpose limitation and data minimisation. The law should clarify when the processing of data concerning health is necessary and proportionate. The blueprint should identify thresholds to protect the integrity and confidentiality of data and deadlines for the erasure of data commensurate with the risks engendered by the settings of data-processing operations.

Secondly, to fulfil transparency requirements the blueprint should include *a facsimile data protection notice for all entities asked to process personal data for pandemic purposes*, to step up the effectiveness of data subject's rights. Such notice could be in the guise of COVID-19-related posters affixed to the walls (or shown on websites) of businesses and public institutions.

139 Porcedda (n 10 above).

Thirdly, the blueprint should be complemented by a commitment to *aggregate and publish documentation concerning the digital components of the response to COVID-19 as well as future CMPs*, to match the level of transparency achieved for measures such as the COVID-19 app and enable public scrutiny, including from a cybersecurity perspective. This includes *opening up the DPIA carried out for the VIS and future similar systems to public consultation* and clarifying where patient data are being transferred to and under what arrangements, as set out in chapter 5 of the GDPR.

The adoption of a blueprint for data processing would remove the need for constantly updating guidance and legislation, with the extant impact on legal certainty for all members of society. It would also represent a concrete step towards the reconciliation between the rights to data protection and to public health worthy of democracies committed to the rule of law.

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Domestic abuse: the 'shadow pandemic'

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ABSTRACT

Since the onset of the COVID-19 pandemic, incidents of domestic abuse have increased substantially around the world. The lockdown measures which were adopted by many jurisdictions, although necessary to limit the spread of the virus, nevertheless resulted in those living in abusive relationships finding themselves to be even more isolated. Indeed, UN Women has termed violence against women during the COVID-19 pandemic as the 'shadow pandemic'. This article discusses the increased levels of domestic abuse globally, proceeds to examine the rise in instances of domestic abuse on the island of Ireland, and then analyses the measures adopted in both Northern Ireland and the Republic of Ireland in response. It is argued that, although meritorious steps were taken in both jurisdictions, essentially the pandemic has exacerbated pre-existing difficulties with the responses of both Northern Ireland and the Republic of Ireland to this issue.

Keywords: domestic abuse; COVID-19 pandemic; responses on the island of Ireland; response of United Nations Special Rapporteur on violence against women.

INTRODUCTION

The COVID-19 pandemic has undoubtedly constituted a public health emergency that is unprecedented in living memory. Since the first cases of the virus emerged in December 2019, by the end of December 2021 around 282 million confirmed cases of COVID-19 worldwide had been reported to the World Health Organization (WHO), with over 5,411,000 deaths as a result of the virus.[1] In Northern Ireland, since the first case of COVID-19 in this jurisdiction was diagnosed on 27 February 2020, by the end of 2021 there had been 394,854

1 World Health Organization, 'WHO coronavirus (COVID-19) dashboard'.

confirmed cases and 2979 deaths due to the virus.[2] In the Republic of Ireland, since the first case of COVID-19 was confirmed on 29 February 2020, by the end of 2021 there had been 731,467 confirmed cases, with 5890 deaths.[3] However, it is also important to remember that the COVID-19 pandemic has caused serious health concerns beyond actual cases of the virus itself. Gender-based violence, including domestic abuse, is now well-recognised as constituting a health issue,[4] and, since the onset of the pandemic, incidents of domestic abuse have increased dramatically around the world,[5] including on the island of Ireland.[6] Essentially, the lockdown measures which have been adopted by many states, although necessary to limit the spread of the virus, have nevertheless had the impact of exacerbating the suffering of many victims of domestic abuse. Those already living in abusive relationships have found themselves to be even more isolated and trapped in such situations, given the lockdown and social-distancing measures which have been imposed. In addition, the widespread anxiety caused by the COVID-19 pandemic in terms of health concerns and financial worries has increased tensions within many relationships, all too often resulting in abuse. The increase in rates of domestic abuse has been so marked that UN Women, the United Nations (UN) entity dedicated to gender equality, has termed violence against women during the COVID-19 pandemic as being the 'shadow pandemic'.[7]

This article will examine the increase in instances of domestic abuse at a global level since the onset of the COVID-19 pandemic. It will then proceed to focus on the increased levels of domestic abuse in Northern Ireland and the Republic of Ireland, and will analyse the steps taken in both jurisdictions to respond to domestic abuse since the onset of the pandemic. It will be argued that, although in both Northern Ireland and the Republic of Ireland meritorious steps were taken to respond to the increased rates of domestic abuse, essentially the pandemic has exposed and exacerbated pre-existing problems with the responses of both jurisdictions to this issue.

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2 Department of Health, 'COVID-19 statistics Northern Ireland'.

3 WHO, 'Ireland situation'.

4 See, for example, Keerty Nakray (ed), *Gender-based Violence and Public Health* (Routledge 2013).

5 UN Women, 'COVID-19 and ending violence against women and girls'.

6 Please note that, although the term 'domestic abuse' is used throughout this article, it is recognised that there is debate surrounding the use of the terms 'domestic abuse', 'domestic violence' and 'domestic violence and abuse'. For further discussion of the issues surrounding terminology, see Jo Aldridge, '"Not an either/or situation": The minimization of violence against women in United Kingdom "domestic abuse" policy' (2021) 27 Violence Against Women 1823.

7 UN Women (n 5 above).

DOMESTIC ABUSE GLOBALLY DURING THE COVID-19 PANDEMIC

As the WHO has stated, 'Violence against women tends to increase during every type of emergency, including epidemics.'[8] Studies show that, since the beginning of the pandemic, rates of domestic abuse have increased around the world.[9] For example, in England and Wales, the police recorded 259,324 offences flagged as domestic abuse-related in the period from March until June 2020. This represented a 7 per cent increase from the same period in 2019.[10] Of course, domestic abuse is caused by the actions of individual perpetrators, and the existence of the COVID-19 pandemic must in no way whatsoever be seen to negate the responsibility of such perpetrators for their actions. However, the measures which have been adopted by governments around the world in order to limit the spread of COVID-19, although necessary, have nevertheless had the impact of exacerbating the suffering of those experiencing domestic abuse. The nature of such abuse is that it occurs behind closed doors, and by the end of March 2020 more than 100 countries had instituted either a full or partial lockdown, with many others recommending restricted movement.[11] Measures mandating that people should only leave their homes for essential purposes and severely limiting social contact[12] meant that many victims of domestic abuse were essentially trapped with their abusers with very little means of escape. The situation was further exacerbated for victims who, due to pre-existing health conditions, were shielding from the virus and who could not therefore leave their homes at all. Indeed, such victims may have been in the position of being heavily reliant on their abusers in terms of purchasing food and collecting medication.[13] Parallels can be drawn with the research carried out by Hague, Thiara, Magowan and Mullender regarding the experiences of disabled women subjected to domestic abuse, in which it was found that, 'The women's narratives illustrate the intense vulnerability to, and dependence

8 WHO,'COVID-19 and violence against women. What the health sector/system can do' (7 April 2020).

9 UN Women (n 5 above).

10 Office for National Statistics, 'Domestic abuse during the coronavirus (COVID-19) pandemic, England and Wales' (November 2020).

11 'The world in lockdown in maps and charts' (*BBC News* 7 April 2020).

12 See, for example, the Health Protection (Coronavirus, Restrictions) (England) Regulations 2020; the Health Protection (Coronavirus, Restrictions) (Wales) Regulations 2020; the Health Protection (Coronavirus) (Restrictions) (Scotland) Regulations 2020; and the Health Protection (Coronavirus, Restrictions) (Northern Ireland) Regulations 2020.

13 Women's Aid, 'A perfect storm: the impact of the COVID-19 pandemic on domestic abuse survivors and the services supporting them' (August 2020) 12.

they often had on, their abusive partners/others for everyday tasks, the resulting isolation, and not being able to leave.'[14] It is common for perpetrators of domestic abuse to attempt to isolate victims by cutting them off from family and friends – with lockdown and social-distancing measures, this was automatically effected without any effort on the part of perpetrators.

According to a survey carried out by Women's Aid in April 2020, 67.4 per cent of those currently experiencing abuse said that it had got worse since the onset of the COVID-19 pandemic,[15] and 76.1 per cent said that they were having to spend more time with their abuser.[16] In addition, 71.7 per cent said that their abuser had a greater level of control over their life since COVID-19,[17] and 78.3 per cent said that the pandemic had made it more difficult for them to leave their abuser.[18] In another survey carried out by Women's Aid in June 2020, 91.3 per cent of those suffering abuse said that the pandemic had affected their experiences of abuse in one or more ways.[19] For example, 52.2 per cent said that they felt more afraid[20] and 58 per cent said that they felt that they had no one to turn to for help during lockdown.[21] Some were reluctant to go to family or friends due to fears of spreading the virus, and 31.9 per cent said that their friends or family could not help them because of lockdown restrictions.[22] In addition, the stresses associated with both the pandemic itself in relation to health concerns, and also the impact of lockdown and social-distancing measures in terms of financial worries, placed additional strains on relationships which all too frequently resulted in the occurrence of domestic abuse. For example, in the survey carried out by Women's Aid in April 2020, 30.4 per cent of those experiencing domestic abuse said that their abuser blamed them for the economic impact of COVID-19 on the household.[23]

The situation was exacerbated by the fact that, at the very time of rising rates of domestic abuse, services available to victims were reduced, again due to lockdown and social-distancing measures. This

14 Gill Hague, Ravi Thiara, Pauline Magowan and Audrey Mullender, 'Making the links: disabled women and domestic violence' (Women's Aid Federation England 2008) 45.

15 Women's Aid 'The impact of Covid-19 on domestic abuse support services: findings from an initial Women's Aid survey' (April 2020) 3.

16 Ibid [3].

17 Ibid [5].

18 Ibid [4].

19 Women's Aid (n 13 above) 9.

20 Ibid.

21 Ibid.

22 Ibid 8.

23 Ibid 4.

meant that, in effect, services were reduced at the time they were most needed. According to a survey carried out by Women's Aid of service providers, 84.4 per cent said that they had had to reduce or cancel one or more services,[24] with 36.4 per cent of refuge providers having to do so.[25] Also, 48.9 per cent had been impacted by staff off work due to illness,[26] and 64.4 per cent by staff unable to come into work as they were self-isolating.[27] In addition, fundraising activities have been heavily curtailed due to the pandemic and 68.9 per cent of service providers who responded to the survey said that they were concerned about future loss of income from fundraising.[28]

In research published in February 2021, it was also found that the COVID-19 pandemic seemed to be 'compounding or exacerbating' the experiences of many male victims of domestic abuse.[29] Again it was found that, in some instances, perpetrators were using the pandemic as an opportunity to exert greater control, such as by using lockdown restrictions to keep victims trapped at home, or by deliberately breaking the rules to put the health of their partners at risk. Many victims felt 'more isolated than ever',[30] and in some cases being at home all the time increased tension and anxiety, thus leading to more abusive behaviours. In addition, for some victims the fact that they had lost their jobs, were furloughed or were on reduced incomes meant it was more difficult for them to leave due to reduced economic independence. For example, some victims felt they were unable to afford to move into a new property.[31]

In July 2020, the UN Special Rapporteur on violence against women, its causes and consequences, presented a report to the UN General Assembly in which she stated that:

> The intersection between the COVID-19 pandemic, and its lockdown measures, and the pandemic of violence against women, has exposed pre-existing gaps and shortcomings in the prevention of violence against women as a human rights violation that had not been sufficiently

24 Women's Aid (n 15 above) 3.
25 Ibid [3].
26 Ibid [6].
27 Ibid.
28 Ibid [12].
29 Nicole Westmarland, Stephen Burrell, Alishya Dhir, Kirsten Hall, Ecem Hasan and Kelly Henderson, '"Living a life by permission" : the experiences of male victims of domestic abuse during COVID-19' (*Respect* 5 February 2021) 32.
30 Ibid [32].
31 Ibid [32]–[33].

> addressed by many States even before the onset of the COVID-19 pandemic.[32]

For example, prior to the pandemic, the Special Rapporteur had asserted that around-the-clock national toll-free helplines should be available for victims of domestic abuse.[33] However, in many states, such helplines were still not available around the clock and were not free of charge. During the COVID-19 pandemic, many helplines reported an increase in the number of calls, thus highlighting the necessity for such services.[34] Also, prior to the pandemic, many shelters were under-resourced and had limited capacity. The increase in cases of domestic abuse during the pandemic had therefore meant that almost all shelters had become overstretched or full, with the problems being further exacerbated by a lack of capacity in many shelters for social distancing or self-isolation.[35] The Special Rapporteur concluded that:

> The COVID-19 pandemic represents an opportunity to bring about meaningful and lasting change at the national, regional and international levels, as it has placed the issue of gender-based violence against women, and domestic violence against women, in particular, in the spotlight.[36]

DOMESTIC ABUSE ON THE ISLAND OF IRELAND DURING THE COVID-19 PANDEMIC

On 23 March 2020, lockdown restrictions were announced for Northern Ireland, along with the rest of the UK. Under these measures, it was only permissible to leave home for four reasons – shopping for basic necessities such as food and medicine; one form of exercise per day; medical need, or to provide care or help to a vulnerable person; and travelling to and from work, but only when work could not be done from home. Even when the activity in question fell within one of these four categories, the amount of time spent away from home was to be minimised as far as possible.[37] Essentially, the key and often-repeated

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32 UN Special Rapporteur, 'Report of the Special Rapporteur on violence against women, its causes and consequences, Dubravka Šimonović: intersection between the coronavirus disease (COVID-19) pandemic and the pandemic of gender-based violence against women, with a focus on domestic violence and the "peace in the home" initiative' (24 July 2020, A/75/144) para 3.

33 UN Special Rapporteur, 'Report of the Special Rapporteur on violence against women, its causes and consequences' (13 June 2017, A/HRC/35/30) para 107.

34 UN Special Rapporteur (n 32 above) paras 47–48.

35 Ibid para 53.

36 Ibid para 89.

37 'Coronavirus: strict new curbs on life in UK announced by PM' (*BBC News* 24 March 2020).

message was, 'Stay at home; protect the National Health Service; save lives'. Similar measures were implemented in the Republic of Ireland on 27 March 2020.[38]

It is certainly not disputed that such lockdown measures were necessary. At the time when these restrictions were implemented, 335 people in the UK had died as a result of contracting COVID-19,[39] as had 22 people in the Republic of Ireland.[40] This was a deadly new virus about which little was known at the time, for which there was no vaccine, and for which no effective treatments had yet been developed. In such circumstances, lockdown measures were the only option open to governments to adopt. In order to reduce the spread of the virus, the best course of action was to attempt to keep people apart as much as possible. Essentially, in the absence of interaction, a virus cannot spread.

However, it was immediately apparent to those working in the area of combating domestic abuse that such measures could potentially be catastrophic for victims. On 20 March 2020, even before lockdown measures were imposed and 'stay at home' messages were still in the form of government advice only, Women's Aid NI issued a statement which asserted that:

> We know that the government's advice on self or household-isolation will have a direct impact on women and children experiencing domestic violence and abuse in Northern Ireland. Home is often not a safe place for survivors of domestic violence and abuse. We are concerned that social distancing and self-isolation will be used as a tool of coercive and controlling behaviour by perpetrators and will shut down routes to safety and support.[41]

The statement proceeded to comment that:

> The impact of self-isolation will also have a direct impact on specialist services, who are already operating in an extremely challenging funding climate and will be rightly concerned about how to continue delivering life-saving support during the pandemic.

Women's Aid NI therefore called for safety advice and planning for those experiencing domestic abuse to be included in national government advice on COVID-19, and for workers within frontline domestic violence services to be recognised as 'key workers'. Women's Aid NI also welcomed an announcement from the Department of

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38 '"Stay home": Varadkar announces sweeping two week lockdown' *The Guardian* (London, 27 March 2020).

39 'Coronavirus: strict new curbs' (n 37 above).

40 'Stay home' (n 38 above).

41 Women's Aid NI, 'Women's Aid NI statement on Covid-19 and the domestic abuse sector' (20 March 2020).

Communities, which funds refuges and outreach services, that there would be no impact to the voluntary and community sector, and called upon the Northern Ireland Assembly to consider the safety and needs of survivors of domestic abuse in Northern Ireland and relevant services as a fundamental priority within their guidance and contingency planning for the COVID-19 pandemic.

It rapidly became apparent that the predictions made by Women's Aid NI were entirely accurate. According to statistics released by the Police Service of Northern Ireland (PSNI), there were 31,848 domestic abuse incidents in Northern Ireland during 2020, one of the highest rates since such records began in 2004/2005.[42] Since the first lockdown in this jurisdiction began on 23 March 2020, the PSNI had by May of that year received at least 3755 calls relating to domestic abuse.[43] From 1 April until 21 April 2020, the PSNI received 1919 calls regarding domestic abuse, which represented an increase of 10 per cent on the approximate number of 570 calls which were usually received each week prior to the onset of the COVID-19 pandemic. By the end of April 2020, three people had been killed as a result of domestic abuse since the beginning of the lockdown.[44] On 23 March 2021, a year since the beginning of the first lockdown, Women's Aid Federation Northern Ireland joined with a number of other bodies working in the area of combating domestic violence, to issue a statement asserting that,

> It was clear from the outset that lockdown measures would exacerbate women and girls' experiences of violence and abuse, and shut down routes to safety and support. Over the past year this has been borne out in the huge increases in demand our sector has witnessed, the increasing complexity of need from those we support, the strains that frontline workers have faced in responding to survivors in trauma, the new ways that perpetrators are using Covid-19 as tools for abuse and control, and of course the tragic murders of women and children that we remember today.[45]

In the Republic of Ireland, An Garda Síochána reported a 25 per cent increase in domestic abuse calls in April and May of 2020 as compared to April and May of 2019.[46] In November 2020, Safe Ireland published

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42 Northern Ireland Statistics and Research Agency, 'Domestic abuse incidents and crimes recorded by the police in Northern Ireland: update to 31 December 2020' (25 February 2021).

43 Amnesty International UK, 'Northern Ireland: with domestic violence at all-time high, funding urgently needed for frontline groups' (18 May 2020).

44 'Coronavirus: three domestic killings since lockdown began' (*BBC News* 28 April 2020).

45 Women's Aid, 'COVID-19: one year on' (23 March 2021).

46 'Increase in domestic abuse incidents linked to Covid-19 lockdown' *Irish Examiner* (Cork, 1 June 2020).

a report on women and children who sought support from domestic abuse services in the Republic of Ireland during the first six months of the COVID-19 pandemic.[47] According to this report, from March until August 2020, an average of 1970 women and 411 children had received support from a domestic abuse service each month. Of those women and children, an average of 575 women and 98 children each month had accessed the service for the first time. In July, at least 2210 women received support, which was the highest number of any month during this period.[48] In February 2021, Safe Ireland issued a similar report, this time covering the period from September until December 2020.[49] According to this report, an average of 2018 women and 550 children accessed domestic abuse services each month. Of these, an average of 611 women and 122 children accessed such services for the first time each month.[50]

From March until August 2020, 33,941 helpline calls were received. Services also received 2260 helpline emails, 3452 texts and 1047 online chat messages during this period of time. Whilst the number of in-person support sessions decreased sharply, domestic abuse services provided 33,624 phone support sessions and 575 video support sessions from March until August.[51] Between September and December 2020, domestic abuse services received 23,336 helpline calls. In addition, 871 helpline emails were received, as were 1631 texts and 404 online chat messages. Domestic abuse services also provided 18,892 phone support sessions, 166 video support sessions and 8783 in-person support sessions.[52]

On average there were 191 women and 288 children staying in domestic abuse accommodation each month between March and August 2020. These figures encompassed averages of 121 women and 176 children in refuge accommodation each month; 28 women and 37 children in safe homes each month; and 42 women and 75 children in supported housing each month.[53] From March until August there had been 1351 requests for refuge, which equates to an average of 225 requests per month or eight requests per day, which could not be

47 Safe Ireland, 'Tracking the shadow pandemic – a report on women and children seeking support from Domestic Violence Services during the first 6 months of COVID-19' (November 2020).

48 Ibid [1]–[3].

49 Safe Ireland, 'Tracking the shadow pandemic – lockdown 2. A report on women and children seeking support from Domestic Violence Services September 2020–December 2020' (February 2021).

50 Ibid [2]–[3].

51 Safe Ireland (n 47 above) 4–5.

52 Safe Ireland (n 49 above) 5–6.

53 Safe Ireland (n 47 above) 6.

met due to a lack of capacity.[54] For the period from September until December 2020, there were on average 167 women and 265 children in domestic violence accommodation each month. These figures encompassed averages of 108 women and 168 children in refuge each month; 22 women and 35 children in safe homes each month; and 37 women and 62 children in supported housing each month.[55] From September until December 2020, 808 requests for refuge – an average of 202 requests per month or seven requests per day – could not be met due to lack of capacity.[56]

While such statistics make for grim reading, they cannot, however, be said to be surprising. Measures mandating that people should only leave their homes for essential purposes and for the minimum length of time possible resulted in a situation whereby many victims of domestic abuse were essentially trapped at home with their abusers. Whilst previously one or both parties may have gone out to work, thereby affording the victim some respite, the move to working from home where possible had the effect of closing off even this limited measure of escape. Likewise, a victim of domestic abuse may have escaped for short periods of time whilst leaving children at school or collecting them after school, however, again such forms of relief were shut off as schools were closed. In addition, even the act of contacting support services was made more difficult for many victims, due to fears of being overheard by their abusers.[57] In April 2020, a number of victims in the Republic of Ireland reported that they felt unable to leave abusive households in case they got into trouble for breaching the restriction mandating that people should not travel beyond two kilometres of their homes.[58]

In addition, victims reported difficulties with accessing courts to obtain safety orders. Courts were being adjourned or were closing early, and some victims experienced problems in getting to court and also with obtaining child care when going to court or legal appointments, particularly due to the closure of Child and Youth Services in the Republic of Ireland. In addition, some victims reported that requirements to wait outside courthouses due to COVID-19 restrictions could be difficult and intimidating.[59]

For victims who had to shield from the virus due to pre-existing health conditions and who could not therefore leave their homes at all, the situation was made even worse as such victims may have been in the

54 Ibid 9.
55 Safe Ireland (n 49 above) 7.
56 Ibid 9.
57 Safe Ireland (n 47 above) 12.
58 Ibid 12.
59 Ibid 11–13.

position of being reliant on those abusing them to collect medication and carry out essential shopping.[60] In addition, the fact that people could not mix with those from another household cut off potentially vital sources of support for victims of abuse.[61] Indeed, a common tactic of perpetrators of domestic abuse is to isolate victims from their friends and family members. The lockdown measures served to do this without the need for any action on the part of perpetrators. In addition, even as regards relationships which were not previously violent, the anxieties associated with the pandemic and resulting lockdown measures in terms of, for example, health concerns and financial worries, placed additional stresses on some relationships which may have resulted in abuse.

In addition, at the very time of rising need, domestic abuse support services found themselves working in particularly challenging circumstances, due to the necessity to adapt working practices in light of the difficulties posed by the COVID-19 pandemic. To allow for social distancing, domestic abuse services had to restrict the numbers of families they could accommodate, with some communal refuges closing units. Safe Ireland reported that many services were operating in old premises which were unsuitable for implementing social distancing. It was also reported that a lack of in-person contact made it more difficult for domestic abuse services to build a rapport with service users.[62]

Additionally, domestic abuse support services experienced staff shortages due, for example, to self-isolation requirements or to staff testing positive for COVID-19. In order to ensure the continuation of services, some staff had to be redeployed to areas of the service where they were most needed. This left other areas with a skeleton staff managing many services. Also, vital sources of fundraising ended, due to the need to close charity shops and cancel church-gate collections and other fundraising events.[63]

RESPONSES TO DOMESTIC ABUSE IN NORTHERN IRELAND DURING THE COVID-19 PANDEMIC

Measures have been adopted by the governments in both Northern Ireland and the Republic of Ireland to address the issue of domestic abuse since the onset of the COVID-19 pandemic. It is, however, important to remember that the existence of domestic abuse is not a problem which suddenly came into being because of the pandemic. For example, in June 2019, Criminal Justice Inspection Northern Ireland

60 Women's Aid (n 13 above)12.
61 Safe Ireland (n 47 above) 12.
62 Ibid 11–12.
63 Ibid 11.

(CJINI) published a report on the handling of domestic abuse cases by the criminal justice system in Northern Ireland.[64] In this report seven recommendations were made as regards improvements which were deemed by the CJINI to be necessary. According to the CJINI, the PSNI should develop an action plan within six months, to develop further the approach to dealing with cases of domestic abuse and address issues which were highlighted as regards the training and development of new recruits and first responders in relation to coercive and controlling behaviour, harassment and stalking behaviour; and in relation to risk assessment practices in cases of domestic abuse. In addition, CJINI recommended that the PSNI and the Multi-Agency Risk Assessment Conference (MARAC) Operational Board should develop an action plan within six months, to develop further the multi-agency safeguarding arrangements for cases of domestic abuse in Northern Ireland. It was recommended that the PSNI and the Public Prosecution Service (PPS) should, within three months, develop an implementation plan to develop further the prosecution team approach for cases involving domestic abuse or with a domestic motivation. In addition, the Criminal Justice Board, in conjunction with its partners, should, in the nine months following the report, ensure the delivery and roll-out of Northern Ireland-wide schemes to enable the clustering of domestic abuse cases to a designated court in each Administrative Court Division; and a properly costed contract for an independent domestic violence advisory (IDVA) service to address the safety of victims at high risk of harm. Also, the Department of Justice should review how potential inadequacies in current legislation regarding the act of choking or strangulation could be addressed; and develop plans for legislation to introduce protection orders for stalking and harassment. In addition, the PPS should review the use of special measures in cases of domestic abuse and take action to address any issues arising.[65] It can be seen therefore that problems surrounding responses to domestic abuse pre-existed the COVID-19 pandemic, although it is certainly the case that the pandemic and the associated lockdown measures served to exacerbate these difficulties.

Since the beginning of the COVID-19 pandemic, steps have been taken by both the Northern Ireland Department of Justice and the PSNI to raise awareness among victims of domestic abuse that help and support were still available.[66] For example, the Department of Justice

64 CJINI, No Excuse: Public Protection Inspection II: A Thematic Inspection of the Handling of Domestic Violence and Abuse Cases by the Criminal Justice System in Northern Ireland (June 2019).

65 Ibid [12]–[13].

66 Department of Justice and Department of Health 'Coronavirus (COVID-19) – support for victims of domestic abuse'.

implemented a media campaign entitled 'See the Signs', while the PSNI initiated another media campaign termed 'Behind Closed Doors'. Also, although the work of the courts had been severely affected by the pandemic, emergency applications for non-molestation orders and restraining orders could still be made through the Family Proceedings Courts. The Departments of Justice and Health issued guidance stating that household isolation instructions introduced as a result of the COVID-19 pandemic did not apply if a person needed to leave their home to escape from domestic abuse.[67] This guidance also provided advice on what domestic abuse is; what signs to look for; and where help and support could be obtained.

In addition, the PSNI led a multi-agency proactive operational response, in collaboration with the Departments of Justice, Health and Communities as well as voluntary sector partners, with the aim of ensuring a joined-up approach to the prevention of harm and the provision of support.[68] The PSNI, in collaboration with Women's Aid and in conjunction with the Northern Ireland Housing Executive, established 'crash pads' in Belfast, Ballymena and Lisburn to enable a safe environment of self-isolation for victims of domestic abuse suffering with COVID-19.[69] In terms of support for victims, prior to the COVID-19 pandemic, the PSNI under its 'victim call back' system would 'call back' victims within approximately 10 days. However, the PSNI revised this during the lockdown period and reduced the average time taken to call victims to within 24 hours.[70]

Also, the 'Ask for ANI' scheme, a UK-wide initiative which was launched on 14 January 2021, enables victims of domestic abuse to use the codeword 'ANI' ('Action Needed Immediately') in participating pharmacies to let staff know that they need to access support. When the codeword is used, a trained member of staff offers a private space for the victim to phone either the police or support services such as a domestic abuse helpline. The staff member also offers to assist the victim in doing so. It certainly seems that the introduction of this scheme was a very positive development as regards responding to domestic abuse in Northern Ireland, as in other parts of the UK, particularly in the context of the COVID-19 pandemic. For example, the Chief Executive of SafeLives, Suzanne Jacob, commented that:

> Victims of domestic abuse are experts in their own situation and it's survivors of abuse who first asked for this scheme. We need to give victims as many options as possible, including during the very tight

67 Ibid [2]–[3].
68 Ibid [4].
69 Northern Ireland Policing Board, Report on the Thematic Review of the Policing Response to COVID-19 (2020) [93]–[94].
70 Ibid [95].

> restrictions of lockdown. The Ask for ANI scheme will provide a further vital lifeline for domestic abuse victims trapped by their perpetrators because of Covid. A trip to a participating shop or pharmacy might be a critical opportunity for someone to get the help they desperately need. We commend the government for listening to survivors and launching this scheme, and hope that more retailers take up the scheme so that victims across the country have a route to safety.[71]

One of the most significant developments as regards responses to domestic abuse in Northern Ireland during the COVID-19 pandemic was the passing of the Domestic Abuse and Civil Proceedings Act (Northern Ireland) 2021.[72] This legislation was introduced in the Northern Ireland Assembly on 31 March 2020, just eight days after the beginning of the first lockdown, and received royal assent on 1 March 2021. Under this Act, a specific offence of domestic abuse was created. According to section 1 of the legislation, it is a criminal offence to engage in a course of behaviour that is abusive of another person where the parties are personally connected to each other; a reasonable person would consider the course of behaviour to be likely to cause physical or psychological harm; and the perpetrator intends the course of behaviour to cause physical or psychological harm, or is reckless as to whether the course of behaviour causes such harm. Under section 5(2), the parties are 'personally connected' if they are, or have been, married to each other or civil partners of each other; they are living together, or have lived together, as if spouses of each other; they are, or have been, otherwise in an intimate personal relationship with each other; or they are members of the same family. In addition, important steps were taken in the 2021 Act to assist complainants in giving evidence in cases involving the domestic abuse offence. Section 23 of the legislation amends article 5 of the Criminal Evidence (Northern Ireland) Order 1999 to make such complainants eligible for special measures when giving evidence. These special measures may include: screening the complainant from the accused;[73] giving evidence by means of a live link;[74] giving evidence in private;[75] or video-recording the complainant's evidence in chief,[76] cross-examination or re-examination.[77] Also, section 24 of the 2021 Act inserts a new

71 UK Government 'Pharmacies launch codeword scheme to offer "lifeline" to domestic abuse victims' (14 January 2021).

72 For further discussion of this legislation, see Ronagh J A McQuigg, 'Northern Ireland's new offence of domestic abuse' (2021) Statute Law Review (early online access 17 May 2021).

73 Criminal Evidence (Northern Ireland) Order 1999, art 11.

74 Ibid art 12.

75 Ibid art 13.

76 Ibid art 15.

77 Ibid art 16.

article 22A into the 1999 Order, stating that no person charged with an offence involving domestic abuse may cross-examine the complainant in person.

The 2021 Act was certainly a crucial development, not least because it brought Northern Ireland into line with the other jurisdictions within the UK and Ireland in terms of criminalising coercive control.[78] Prior to the Act the legislative position in relation to domestic abuse in Northern Ireland was problematic, as there was no specific offence of domestic abuse in this jurisdiction. Instead, incidents of domestic abuse had to be prosecuted under general criminal law statutes such as the Offences Against the Person Act 1861. This was relatively unproblematic in relation to incidents of physical violence, as these could be prosecuted under the 1861 Act as, for instance, common assault under section 42, aggravated assault under section 43, assault occasioning actual bodily harm under section 47, assault occasioning grievous bodily harm under section 18, or unlawful wounding under section 20. In *R v Ireland and R v Burstow*,[79] it was established that a recognisable psychiatric illness could constitute 'bodily harm' for the purposes of sections 18, 20 and 47 of the Offences Against the Person Act. However, states of mind which are not supported by medical evidence of psychiatric injury are not encompassed by the 1861 legislation. Prosecuting cases of psychological abuse using the 1861 Act was therefore problematic, and this remained the position in Northern Ireland until the enactment of the 2021 legislation.

It has now been recognised that physical violence is only one aspect of domestic abuse, and that psychological abuse can be just as harmful.[80] With this recognition came the realisation by many that a specific offence was necessary to capture the particular harms involved. For example, Bettinson and Bishop state that, 'the creation of an offence of controlling or coercive behaviour in an intimate or family relationship is necessary in order for the criminal law to better

78 Coercive control was criminalised in the Republic of Ireland under s 39 of the Domestic Violence Act 2018; coercive and controlling behaviour was criminalised in England and Wales under s 76 of the Serious Crime Act 2015; and abusive behaviour (including psychological abuse) towards a partner or ex-partner was criminalised in Scotland under s 1 of the Domestic Abuse (Scotland) Act 2018.

79 [1997] 4 All ER 225.

80 See Evan Stark, *Coercive Control: How Men Trap Women in Personal Life* (Oxford University Press 2007); Evan Stark, 'Rethinking coercive control' (2009) 15 Violence Against Women 1509; Evan Stark, 'Looking beyond domestic violence: policing coercive control' (2012) 12 Journal of Police Crisis Negotiations 199; Tamara L Kuennen, 'Analysing the impact of coercion on domestic violence victims: how much is too much?' (2007) 22 Berkeley Journal of Gender, Law and Justice 2; and Emma Williamson, 'Living in the World of the domestic violence perpetrator: negotiating the unreality of coercive control' (2010) 16 Violence Against Women 1412.

reflect the reality of the central harm of domestic violence'.[81] The need for the criminalisation of psychological abuse has also been recognised in regional and international human rights standards. For instance, in *Volodina v Russia*,[82] the European Court of Human Rights stated that the feelings of fear, anxiety and powerlessness which are caused by coercive and controlling behaviour can amount to inhuman treatment under article 3 of the European Convention on Human Rights (the right to be free from torture and inhuman or degrading treatment or punishment). In addition, in its General Recommendation 19 the UN Committee on the Elimination of Discrimination Against Women (the CEDAW Committee) recognised that 'coercion' can amount to gender-based violence.[83] Indeed, in its 2019 Concluding Observations on the UK's eighth periodic report, the CEDAW Committee voiced concern regarding the legislative position in relation to gender-based violence in Northern Ireland and recommended that the UK, 'Adopt legislative and comprehensive policy measures to protect women from all forms of gender-based violence throughout the State party's jurisdiction, including Northern Ireland.'[84] The creation of the new domestic abuse offence in this jurisdiction goes some way towards addressing such concerns.

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81 Vanessa Bettinson and Charlotte Bishop, 'Is the creation of a discrete offence of coercive control necessary to combat domestic violence?' (2015) 66 Northern Ireland Legal Quarterly 179, 196. For further discussion of the need for a discrete offence, see Marilyn McMahon and Paul McGorrery (eds), *Criminalising Coercive Control: Family Violence and the Criminal Law* (Springer 2020); Michele Burman and Oona Brooks-Hay, 'Aligning policy and law? The creation of a domestic abuse offence incorporating coercive control' (2018) 18 Criminology and Criminal Justice 67; Vanessa Bettinson, 'Criminalising coercive control in domestic violence cases: should Scotland follow the path of England and Wales?' (2016) Criminal Law Review 165; Heather Douglas, 'Do we need a specific domestic violence offence?' (2015) 39 Melbourne University Law Review 434; Cheryl Hanna, 'The paradox of progress: translating Evan Stark's coercive control into legal doctrine for abused women' (2009) 15 Violence Against Women 1458; Jennifer Youngs, 'Domestic violence and criminal law: reconceptualising reform' (2015) 79 Journal of Criminal Law 55; Victor Tadros, 'The distinctiveness of domestic abuse: a freedom based account' (2005) 65 Louisiana Law Review 989; and Deborah Tuerkheimer, 'Recognising and remedying the harm of battering: a call to criminalise domestic violence' (2004) 94 Journal of Criminal Law and Criminology 959.

82 [2019] ECHR 539, para 75. For further discussion of *Volodina v Russia*, see Ronagh McQuigg, 'The European Court of Human Rights and domestic violence: *Volodina v Russia*' (2021) 10 International Human Rights Law Review 155.

83 Committee on the Elimination of Discrimination Against Women, General Recommendation No 19: Violence Against Women (1992) para 6.

84 Committee on the Elimination of Discrimination Against Women, 'Concluding observations on the eighth periodic report of the United Kingdom of Great Britain and Northern Ireland' CEDAW/C/GBR/CO/8 (14 March 2019) para 30(b).

However, although the passage of the domestic abuse legislation through the Assembly coincided with the COVID-19 pandemic, the legislation itself cannot be said to constitute a response to the pandemic. Legislation criminalising coercive and controlling behaviour in Northern Ireland had in fact been drafted prior to the three-year suspension of the Northern Ireland Assembly from January 2017 until January 2020,[85] and securing the enactment of such legislation was a key priority of the Department of Justice.[86] However, as the Justice Minister, Naomi Long MLA, stated during Assembly debates on the Bill, the urgent need to address the issue of domestic abuse became 'even more apparent during the current COVID-19 crisis'. This may therefore have contributed towards easing the passage of the Bill through the Assembly, and certainly the impact of the COVID-19 pandemic on rates of domestic abuse arose on a number of occasions during Assembly debates on the legislation. For example, the Justice Minister commented that:

> As we advise people to stay home, stay safe, save lives, we are also mindful that, for many in our community, home is not a safe place or a haven from harm. Instead, it is the very place where they are most vulnerable to abuse and to their abuser. Combined with physical distancing, which so often ends in social isolation, those already at risk have found themselves frequently without their most basic support networks or the temporary respite from abuse that being able to leave their home, even for a short time, might bring, compounding their vulnerability and the risk of harm. Whilst the current crisis has raised awareness of the plight of those who are victims of domestic abuse, it is imperative that our response is not temporary or fleeting, because domestic abuse is neither.[87]

Nevertheless, even if legislation criminalising coercive and controlling behaviour had been in place prior to the onset of the pandemic, it is unlikely that this would have contributed to any substantial extent towards limiting the rise in rates of domestic abuse in Northern Ireland, or to improving responses to this increase. Coercive control had been criminalised in the Republic of Ireland prior to the pandemic under section 39 of the Domestic Violence Act 2018, however, as will be discussed later in this article, the same increase in rates of domestic abuse can be seen in this jurisdiction, and similar responses were put in place.

Whilst there have certainly been a number of very meritorious responses to the issue of domestic abuse in Northern Ireland during the

85 See 'New abuse law "held up by lack of NI Assembly"' (*BBC News* 19 January 2018).

86 Northern Ireland Assembly, 'Official Report: Tuesday 28 April 2020', Naomi Long MLA, Justice Minister.

87 Ibid Naomi Long MLA, Justice Minister.

period spanned by the COVID-19 pandemic, it is clear that problems remain. In a joint statement issued in March 2021 by a number of bodies working in the area of combating domestic abuse, including Women's Aid NI,[88] it was asserted that there was still serious concern regarding 'the lack of meaningful partnership working between the UK government, devolved administrations in Wales, Scotland and Northern Ireland, and our specialist sector. This has limited the ability of all nations and regions to meet the needs of women and girls and the life-saving specialist services that support them.' Essentially, 'urgent action' was needed on 'funding, equal protection and support, prevention and practical measures to protect women and girls experiencing violence and abuse during COVID 19.' It was asserted that: 'Whilst the UK government has delivered emergency funding for the VAWG sector over the past year, it has been piecemeal, fragmented and unequal.' In particular, 'Specialist services in Northern Ireland did not receive comparable levels of funding to other nations.' The statement noted that, although the 'Ask for ANI' scheme 'was born from the urgent need to improve gateways to help for women trapped at home with their abuser', it was not launched until nearly a year after the onset of the pandemic, and there had been 'continued concerns with how this is working across all four nations in the UK, the level of training for pharmacy staff responding to disclosures, as well as how effectively such schemes link up to local specialist support services'. The statement concluded that:

> violence against women is still not factored in at the highest levels of the pandemic response, not seen as a fundamental priority in the public health response we need. As the first year of COVID 19 comes to end, we cannot return to 'business as usual'. We need a new approach, which equally protects all women and girls, and ends the societal inequalities that drive violence and abuse against them.

Northern Ireland is currently the only jurisdiction within the UK which does not have a strategy specifically dedicated to addressing gender-based violence, although it is notable that in March 2021 Women's Aid NI launched a petition calling on the Assembly to develop and implement a strategy on violence against women and girls,[89] following which the Assembly passed a motion calling for such a strategy. On 10 January 2022, the Northern Ireland Executive Office, the Department of Justice and the Department of Health together published a 'Call for Views' to inform the development of a 'Domestic

88 'Covid-19: one year on – a joint statement from Women's Aid, Imkaan, Women's Aid Federation Northern Ireland, End Violence Against Women, Welsh Women's Aid and Scottish Women's Aid' (23 March 2021).

89 Women's Aid NI, 'Sign our petition to the Northern Ireland Assembly and help make a difference to the lives of women & girls' (9 March 2021).

and Sexual Abuse Strategy' to be led by the Department of Justice and the Department of Health, and a 'Strategy to tackle Violence Against Women and Girls' to be led by the Executive Office. In addition, in April 2021 a follow-up review[90] was published in respect of the 2019 report by CJINI on the handling of domestic abuse cases by the criminal justice system.[91] Although seven recommendations had been made in the 2019 report, the follow-up review found that only one of these had been implemented, whilst four had been only partially achieved and one not implemented. The CJINI Chief Inspector, Jacqui Durkin, welcomed the new domestic abuse legislation and also evidence that the PSNI and the PPS had improved how they shared information and worked together in relation to cases of domestic abuse. In addition, she commended the collaborative work which had been carried out by the PSNI-led Domestic Abuse Independent Advisory Group in relation to responding speedily to the need for greater numbers of victims to access services as a result of the COVID-19 pandemic. However, Ms Durkin also stated that she was 'disappointed with the pace of progress and that key recommendations to implement an advocacy service to support victims of domestic violence and abuse and establish regional domestic violence and abuse courts remained outstanding'.[92] Initial discussions had taken place with the Presiding District Judge as regards piloting a domestic violence and abuse court in Belfast. It was envisaged that this model would work in a similar manner to the arrangements in the District Judge's domestic violence court in the Magistrates' Court in Derry/Londonderry, however, details had not been discussed, and this work had been paused due to the pandemic.[93] In addition, Ms Durkin remarked that:

> Domestic violence and abuse is a long standing problem throughout our community that has been exacerbated by the COVID-19 pandemic with many new and repeat victims finding their homes are not a safe place, but a place of fear and anxiety during the lockdown restrictions.[94]

90 CJINI (n 64 above).

91 CJINI, *No Excuse: A Thematic Inspection of the Handling of Domestic Violence and Abuse Cases by the Criminal Justice System in Northern Ireland. A Follow-Up Review of the Inspection Recommendations* (April 2021).

92 CJINI, 'Inspectorate "disappointed" at pace of progress on domestic violence and abuse recommendations' (21 April 2021).

93 CJINI (n 91 above) 25.

94 CJINI (n 92 above).

RESPONSES TO DOMESTIC ABUSE IN THE REPUBLIC OF IRELAND DURING THE COVID-19 PANDEMIC

Various measures were also adopted in the Republic of Ireland as regards addressing the issue of increased rates of domestic abuse in the context of the COVID-19 pandemic. Similar to the public awareness campaigns carried out in Northern Ireland, in the Republic of Ireland the Department of Justice, in conjunction with a range of bodies working in the area of combating domestic abuse, instigated a national public awareness campaign entitled 'Still Here', which communicated the essential message that, 'If your home isn't safe, support is still here.' This campaign was carried out across television, radio and social media platforms and emphasised that restrictions on movement in the context of COVID-19 lockdowns did not apply to someone escaping from a risk of harm or seeking to access essential services.[95] Also, both the Courts Service and the Legal Aid Board prioritised domestic abuse and child care cases, and the Legal Aid Board established a helpline to assist victims of domestic abuse.[96]

Similar to the PSNI, An Garda Síochána also took a proactive response and established 'Operation Faoiseamh' to support victims of domestic abuse. This operation was launched on 1 April 2020 as part of An Garda Síochána's community engagement response to COVID-19. The aim of this operation was to prevent loss of life and to ensure that victims of domestic abuse were supported and protected during the COVID-19 pandemic. Phase one of the operation involved the utilisation of Garda Victim Liaison Offices, Divisional Protective Service Units and other appropriate resources to reach out to victims of domestic abuse with a view to ascertaining issues of concern, offering support and ensuring that issues were dealt with quickly and effectively. The feedback from victims was reported to be 'overwhelmingly positive'.[97] Phase two of the operation began on 13 May 2020 and focused on the execution of arrests and the commencement of prosecutions for offences regarding breaches of court orders obtained pursuant to relevant provisions of the Domestic Violence Act 2018.[98] On 28 October 2020, phase three of the operation began, during which continued efforts were made to make contact with victims to provide support and to offer the assistance of local and specialised resources. A further drive

95 Department of Justice, 'If your home isn't safe support is still here'.
96 Oireachtas Library and Research Service, 'L&RS note: domestic violence and COVID-19 in Ireland' 5.
97 An Garda Síochána, 'Operation Faoiseamh – domestic abuse' (9 June 2020).
98 Ibid.

to arrest and bring before the courts offenders who had breached court orders also commenced on 28 October 2020.[99]

Nevertheless, as with Northern Ireland, difficulties still remained, particularly in relation to the provision of sufficient funding for domestic abuse services. Safe Ireland commented that:

> Domestic abuse specialist support services are a critical part of the infrastructure in Ireland to respond to tens of thousands of women and children annually. However, Covid-19 exposed decades of limited investment in these services. These organisations struggled with the challenges of relying on a small pool of staff with limited availability of relief staff, physical premises that aren't all suitable to facilitate public health requirements and a significant breakdown in linkage to the national public health decision-making infrastructure resulting in limited access to testing, PPE and clinical care.[100]

As Safe Ireland proceeded to remark: 'Covid-19 has exposed very clearly the serious weaknesses in Ireland's support infrastructure.'[101]

In March 2021, Safe Ireland published a discussion paper entitled *No Going Back* which asserted that the COVID-19 pandemic offers society 'the greatest impetus' in decades to change responses to domestic, sexual and gender-based violence.[102] The paper stated that:

> We are very clear that Covid-19 does not cause domestic and sexual violence, it has exposed it. This epidemic and the arising communal empathy towards it, have, in turn, fully revealed the inadequate, siloed and poorly resourced way in which we are responding to coercive control generally, and domestic violence specifically.[103]

Safe Ireland proceeded to make four key recommendations in terms of changing responses to domestic, sexual and gender-based abuse. Firstly, it was stated that a dedicated Minister and Ministry to address such abuse was needed, with 'reach across all of the departments and agencies with which a survivor may interact, with a cross-sectoral inter-departmental budget and a Cabinet Standing Committee'. Secondly, the paper called for 'a cross-sectoral framework for policy and services which provides for integrated delivery of public and independent services and supports'. It was asserted that this framework should be held within the same government department 'to avoid current fragmentation and incoherent policy, planning and provision'.

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99 An Garda Síochána 'Operation Faoiseamh (phase 3) – An Garda Síochána continues to support victims of domestic abuse' (28 October 2020).

100 Safe Ireland, 'Creating safe homes and safe communities: supports for domestic violence and coercive control in budget 2021' (2020).

101 Ibid.

102 Safe Ireland, No Going Back: A Sustainable Strategy and Infrastructure to Transform our Response to DSGBV in Ireland (March 2021) [3].

103 Ibid [3].

Safe Ireland's third recommendation was for a National Services Development Plan to ensure that a network of specialist, skilled and local services is established 'so that survivors everywhere can expect the same professional response'. Services should be 'adequately and sustainably resourced'. Safe Ireland's fourth recommendation was for a prevention strategy as regards domestic, sexual and gender-based abuse. The discussion paper stated in this regard that:

> The Covid-19 pandemic has elicited a significant community response and awareness of (such abuse), in particular, the vulnerability of women and girls. It makes sense to utilize this public awakening to develop a strategy that addresses the root causes of sex and gender-based violence.[104]

LOOKING TO THE FUTURE

Vaccines are currently being rolled out relatively quickly in a number of states, therefore resulting in the easing of lockdown restrictions in these countries. For example, at the time of writing, the vaccination programmes in both jurisdictions on the island of Ireland are being rolled out successfully.[105] However, the avoidance of further lockdowns is by no means certain. COVID-19 is still a very new virus and a number of variants have been identified to date. It is possible that the virus could mutate into a strain which is unresponsive to the vaccines currently available, thus necessitating further lockdown measures until such times as the vaccines can be adapted to be effective against such a variant. The risks which 'stay at home' messages pose for victims of domestic abuse could therefore materialise again even in such states which seem to be currently coping relatively well with the COVID-19 threat.

However, there are also longer-term lessons which can be learnt. Essentially, it is inaccurate to view the issues surrounding domestic abuse during the COVID-19 pandemic as simply being created by the pandemic itself and thus to expect that there will be no such problems in a post-pandemic society. As was commented by the UN in April 2020: 'The pandemic is deepening pre-existing inequalities, exposing vulnerabilities in social, political and economic systems which are in turn amplifying the impacts of the pandemic.'[106] This statement is very pertinent to the issue of domestic abuse. As was noted by the UN Special Rapporteur on violence against women, the pandemic

104 Ibid [9].

105 See Department of Health, 'NI COVID-19 vaccinations'; and Government of Ireland, 'Vaccinations'.

106 United Nations, 'Policy brief: the impact of COVID-19 on women' (9 April 2020) 2.

has 'exposed pre-existing gaps and shortcomings in the prevention of violence against women as a human rights violation that had not been sufficiently addressed by many States even before the onset of the COVID-19 pandemic'.[107] There is a danger of viewing the current problems regarding responses to domestic abuse as simply being caused by the measures adopted by states in relation to COVID-19. In reality, the COVID-19 pandemic has served to expose and exacerbate pre-existing difficulties with the responses of states to domestic abuse. For example, as mentioned above, in many states the helplines for victims of domestic abuse were not available around-the-clock. This problem was then brought into sharp relief during the pandemic as many helplines experienced an increased volume of calls, thus placing greater pressure on services which may have been insufficient in the first place and highlighting the need for improved provision of such services.[108] Likewise, prior to the pandemic, many shelters had limited capacity and were under-resourced. Again the surge in cases of domestic abuse during the pandemic served to place even greater pressure on already inadequate service provision. The fact that the COVID-19 pandemic has raised awareness of the shortcomings of state responses to domestic abuse may contribute towards an improvement in such responses in the future. The increase in rates of domestic abuse during the COVID-19 pandemic has been widely covered by the media, thus raising public awareness of the issues involved.

It is certainly the case that the pandemic has exposed and exacerbated pre-existing problems with the responses of both Northern Ireland and the Republic of Ireland to this issue. For example, in Northern Ireland, in June 2019 CJINI had identified a number of difficulties with the response of the criminal justice system to domestic abuse and made seven recommendations for improvement. These were problems which pre-dated the pandemic, and in April 2021 it was found that only one of these recommendations had been implemented, whilst four had been only partially achieved and one not implemented. It is certainly not sufficient to view a potential end to the pandemic as constituting a resolution to the issue of domestic abuse. Essentially, as was asserted in the joint statement issued by Women's Aid NI, along with a range of other bodies, in March 2021, 'we cannot return to "business as usual". We need a new approach, which equally protects all women and girls, and ends the societal inequalities that drive violence and abuse against them.' Likewise, in the Republic of Ireland, Safe Ireland commented, also in March 2021, that the pandemic and the associated impact on rates of domestic abuse have 'fully revealed the inadequate, siloed and

107 UN Special Rapporteur (n 32 above) para 3.
108 UN Special Rapporteur (n 33 above) paras [47]–[48].

poorly resourced way in which we are responding to coercive control generally, and domestic violence specifically.'[109]

CONCLUSION

The COVID-19 pandemic is undoubtedly an unprecedented situation which caused intractable problems for governments worldwide, including in both jurisdictions on the island of Ireland. Until the COVID-19 vaccines were widely rolled out, the most effective way of preventing the spread of the virus was to keep people apart to as great an extent as was possible. A virus does not spread itself – it can only spread through the interaction of individuals and if such interaction is kept to a minimum, the transmission of the virus will also be minimised. This was of course the premise behind the lockdown measures which were implemented around the world, including in both jurisdictions on the island of Ireland. Until the vaccines were available, the most effective way to protect oneself from COVID-19 was to remain at home to the greatest extent possible. For the majority, home was thus the safest place to be for the duration of the pandemic. However, the paradox for those experiencing domestic abuse was that, while home may have been the safest place in relation to the COVID-19 pandemic, it was nevertheless the most dangerous place to be as regards the 'shadow pandemic' of domestic abuse, as was demonstrated by the increase in rates in domestic violence in both Northern Ireland and the Republic of Ireland. In both jurisdictions meritorious steps were taken during the pandemic to respond to the increased rates of domestic abuse. Similarities can be seen as between the two jurisdictions in relation to the responses adopted. For example, public awareness campaigns were implemented, and both the PSNI and An Garda Síochána responded in a pro-active and effective manner. Nevertheless, similarities can also be identified as regards the difficulties that remained, particularly in relation to levels of funding for support services.

There are certainly lessons to be learnt from the COVID-19 pandemic as regards the issue of domestic abuse. The fact that the pandemic has served to highlight the shortcomings of responses to this issue may contribute towards an amelioration in such responses in the future. As Safe Ireland stated, the pandemic offers society 'the greatest impetus' in decades to change responses to domestic, sexual and gender-based violence.[110] The challenge for all states, including both jurisdictions on the island of Ireland, must now be to act on the lessons of the 'shadow pandemic' and work towards a common goal of combating domestic abuse.

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109 Safe Ireland (n 102 above) 3.
110 Ibid.

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Does Ireland need a constitutional right to health after the COVID-19 pandemic?

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ABSTRACT

There will be many legal legacies of the COVID-19 pandemic. This commentary argues that one of them should be the constitutionalisation of the right to health in Ireland. The overriding objective of saving lives has not always been explicitly linked with fundamental rights protection in government communications or the mainstream media. When the state police power permits the adoption of extraordinary measures to protect the public's health, why would there be a need for a constitutional right to health? This commentary argues that the existence of a constitutional right to health in Ireland would make the process of designing, implementing and explaining the necessity of restrictions in times of public health crisis a more transparent exercise. Moreover, a constitutional right to health would provide a normative and procedural framework for reviewing government decisions that restrict one aspect of the right to health (for example maternity care) to protect another (protection from infectious disease). This commentary links these considerations to the recent proposal to amend the Irish Constitution to include a right to health and addresses the concerns raised about such a process in light of the benefits of a constitutional right to health as well as the social changes wrought by the COVID-19 pandemic. The commentary also evaluates the constitutional text that was proposed and highlights some of the considerations that must be taken into account when drafting a constitutional right to health.

Keywords: right to health; constitution; Ireland; COVID-19; pandemic.

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INTRODUCTION

It is clear in the aftermath of the COVID-19 pandemic that the world's legal preparedness to respond to public health emergencies is inadequate. At the international level, governments have agreed to craft a new global instrument to govern pandemic prevention, preparedness and response.[1] The European Union is strengthening its legislation on serious cross-border health threats.[2] However, state governments must now also consider how they will improve national public health law frameworks, with particular focus on the role that the right to health should play in the governance of future public health emergencies. Very few countries recognise a legal obligation for the government to protect citizens' health – only 14 per cent of national constitutions guarantee the protection of public health, while only 38 per cent guarantee the protection of healthcare.[3] Ireland is one of the majority of countries that do not recognise any right to health in their constitutions. However, in November 2019, just before the start of the COVID-19 pandemic, the Dáil debated the Thirty-ninth Amendment of the Constitution (Right to Health) Bill 2019 (henceforth 'the Bill'),[4] which proposed to insert a right to health into the Irish Constitution. A change of government and the emergence of COVID-19 in quick succession subsequently buried the important national debate that was initiated by the Bill. This commentary returns to that debate and argues that Ireland should seriously consider the constitutionalisation of the right to health, given the key role that right to health analysis could and should have played in the Irish Government's response to COVID-19, particularly in relation to the controversial restrictions placed on healthcare and public health services.

Restrictions adopted to combat COVID-19 were not often publicly accompanied by fundamental rights analysis, both in Ireland and globally, despite the fact that these restrictions had a profound impact upon the enjoyment of a broad range of fundamental rights.[5] While it is possible for governments to derogate from fundamental rights treaties

1 WHO Second Special Session, *The World Together: Establishment of an Intergovernmental Negotiating Body to Strengthen Pandemic Prevention, Preparedness And Response*, SSA2/CONF./1, 27 November 2021.

2 Proposal for a regulation on serious cross-border threats to health, COM (2020) 727.

3 J Heymann et al, 'Constitutional rights to health, public health and medical care: the status of health protections in 191 countries' (2013) 8(6) Global Public Health 639.

4 Dáil Deb 26 November 2019, vol 990, no 1.

5 S Sekalala et al, 'Health and human rights are inextricably linked in the COVID-19 response' (2020) 5 British Medical Journal Global Health e003359.

during a public health emergency,[6] many national constitutions do not provide a similar possibility to derogate from the fundamental rights established within them.[7] The Irish Constitution permits derogation from fundamental rights only in times of war or armed rebellion.[8] Public health measures may limit the enjoyment of a fundamental right only when they are proportionate – when available evidence demonstrates that they are the least restrictive yet still effective means for achieving the public health objective. Upon such analysis some restrictions adopted during the COVID-19 pandemic appear to legitimately restrict the enjoyment of fundamental rights, and some perhaps do not.[9]

Some public health measures involved restricting access to healthcare and public health services such as maternity care, cancer screening and mental health and disability services. Although the available science showed that preventing the social contact that occurs through these services would slow transmission of COVID-19, it was also clear that people's health would suffer in other equally serious ways as a direct consequence of the restrictions.[10] In such situations, a proportionality analysis within a fundamental rights framework should be conducted

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6 For example, art 15 of the European Convention on Human Rights provides that: 'In time of war or other public emergency threatening the life of the nation any High Contracting Party may take measures derogating from its obligations under this Convention to the extent strictly required by the exigencies of the situation.' For a discussion of derogation from fundamental rights during the COVID-19 pandemic, see: A Lebret, 'COVID-19 pandemic and derogation to human rights' (2020) 7(1) Journal of Law and the Biosciences lsaa015.

7 See Venice Commission, 'Observatory on emergency situations'.

8 Art 28.3.3: 'Nothing in this Constitution other than Article 15.5.2 shall be invoked to invalidate any law enacted by the Oireachtas which is expressed to be for the purpose of securing the public safety and the preservation of the State in time of war or armed rebellion, or to nullify any act done or purporting to be done in time of war or armed rebellion in pursuance of any such law.'

9 See, for example, W van Aardt, 'COVID-19 school closures and the principles of proportionality and balancing' (2021) S3 Journal of Infectious Diseases and Therapy 2; H Gunnarsdóttir et al, 'Applying the proportionality principle to COVID-19 antibody testing' (2020) 7(1) Journal of Law and the Biosciences lsaa058; E Paris, 'Applying the proportionality principle to COVID-19 certificates' (2021) 12(2) European Journal of Risk Regulation 287; G Androutsopoulos, 'The right of religious freedom in light of the coronavirus pandemic: the Greek case' (2021) 10 Laws 14.

10 For example, see the assessment of the Irish Medical Organisation of the impact of COVID-19 restrictions on cancer services in Ireland: 'Oireachtas Health Committee on the impact of the Covid-19 pandemic on cancer services' (2 June 2021). On the impact of restrictions on mental health in Ireland, see Policy Brief: Mental Health and COVID-19 – The Opportunity to Resource, Rebuild and Reform Ireland's Mental Health System (Mental Health Reform June 2021). On the impact of restrictions on partner visiting in maternity hospitals, see 'The experiences of women in the perinatal period during the Covid-19 pandemic' (Psychological Society of Ireland 5 May 2021).

to ensure that these restrictions are imposed in a justifiable manner. The impacted right in these situations is the right to health,[11] which places an obligation upon states to ensure the availability, accessibility, acceptability and quality of all health facilities, goods and services.[12]

However, the Irish Government did not attempt to publicly explain whether restrictions to health services constituted a legitimate limitation on the right to health. This is likely attributable to the absence of a fundamental right to health in Ireland. Although health protection and promotion is a public good to which all humans are entitled,[13] Ireland has not recognised this human right in its Constitution as a fundamental right. This situation is unfortunate first of all because the existence of a fundamental right to health in Ireland would have provided normative legitimation for most aspects of the Government's pandemic response.[14] Moreover, it meant that there was no constitutional pressure placed upon the Government to conduct and publicly share an analysis of whether restrictions to health services specifically placed justifiable limitations on the right to health. Most significantly, it meant that when restrictions to health services were no longer the least restrictive intervention necessary to protect public health, it was impossible to hold the Government accountable for a violation of the right to health.[15] Consequently, decisions concerning the restriction of health services during the emergency phase of the COVID-19 pandemic may have caused illegitimate health harm to citizens, who had no legal possibility of asking a court to provide them with redress.

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11 Art 12 of the International Covenant on Economic, Social and Cultural Rights, which Ireland has ratified, proclaims the right to the 'highest attainable standard of physical and mental health'.

12 UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment 14: The Right to the Highest Attainable Standard of Health (art 12 of the Covenant), 11 August 2000, E/C.12/2000/4, para 12.

13 For an analysis of why ideas of justice demand the existence of a right to health, see: J P Ruger, *Global Health Justice and Governance* (Oxford University Press 2018). In addition to the ICESCR cited above, the preamble of the Constitution of the World Health Organization (WHO) also proclaims a right to health: 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'. Art 25 of the Universal Declaration of Human Rights also notes health as essential to an adequate standard of living.

14 For a more detailed analysis of the relationship between the right to health and COVID-19 responses, see L Forman and J Kohler, 'Global health and human rights in the time of COVID-19: response, restrictions, and legitimacy' (2020) 19(5) Journal of Human Rights 547.

15 There is no mechanism in international law to enforce the right to health contained in international treaties, meaning that states must constitutionalise the right to health for it to be justiciable.

The constitutional amendment proposed by the Bill would rectify this inadequacy in Irish law, and the resurrection of a national debate on this topic should be one of the legal legacies of the COVID-19 pandemic. Ireland's fundamental rights framework should, following our pandemic experience, facilitate the justification of restrictions to healthcare and public health services in terms of the right to health, and should permit citizens to claim redress where their right to health has clearly been violated by such restrictions. This commentary will make this argument in three stages. First, an example of how a right to health analysis could clarify whether pandemic restrictions on health services are legally legitimate will be outlined. Second, the objections raised against the Bill will be examined. Finally, the particular conception of the right to health proposed in the Bill will be evaluated.

THE ANALYSIS OF PANDEMIC RESTRICTIONS ON HEALTH SERVICES UNDER THE RIGHT TO HEALTH

Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) establishes a right to the 'highest attainable level of physical and mental health'. This was interpreted in General Comment 14 of the United Nations (UN) Economic and Social Council,[16] which provides guidance on how healthcare and public health services can be restricted in order to achieve other public health objectives. For example, maternity hospitals in Ireland severely restricted the visiting privileges of partners of pregnant women, thus curtailing their ability to provide physical and emotional support during the perinatal period. This was sensible at the height of the pandemic. However, hospitals have continued to maintain these visitor restrictions long after the Government insisted that they should be relaxed.[17] Extensive research conducted in several countries on women's experience of pregnancy and childbirth during the pandemic has shown that visitor restrictions generated significant risk to their mental and physical health.[18] These harms raise the question of whether it would have been possible to

16 General Comment 14 (n 12 above).

17 E O'Regan, 'Maternity hospitals continue restrictions despite pressure' (*Independent.ie* 26 January 2022); L Boland, 'Campaigners to raise gaps in partners' access at maternity hospitals in meeting with HSE' (*The Journal* 27 February 2022).

18 J Sanders and R Blaylock, '"Anxious and traumatised": users' experiences of maternity care in the UK during the COVID-19 pandemic' (2021) 102 Midwifery 103069; A Wilson et al, 'Australian women's experiences of receiving maternity care during the COVID-19 pandemic: a cross-sectional national survey' (2021) 49(1) Birth 30–39; S Panda et al, 'Women's views and experiences of maternity care during COVID-19 in Ireland: a qualitative descriptive study' (2021) 103 Midwifery 103092.

strike a more proportionate balance between the protection of public health from infectious disease and the promotion of good maternal health when incidence of COVID-19 was low.[19]

It is clear from General Comment 14 that controlling epidemic disease and ensuring perinatal health are both obligations of comparable priority to the core obligations arising from the right to health,[20] meaning that governments should give equal priority to each. When those obligations conflict though, a proportionality analysis must be conducted to determine whether one can be prioritised above the other.[21] General Comment 14 provides further guidance in this regard. One of the core obligations of the right to health is to 'ensure equitable distribution of all health facilities, goods and services',[22] and a specific legal obligation noted in relation to the right to health of women is 'the removal of all barriers interfering with access to health services'.[23] When this is combined with the suggestions that the right to health is violated by states in the event of a 'failure to take measures to reduce the inequitable distribution of health facilities, goods, and services'[24] and a 'failure to adopt a gender-sensitive approach to health',[25] it is plausible to suggest that limitations to perinatal women's health will be disproportionate where they are unfair or insensitive to the particular needs of perinatal women. The maintenance of highly restrictive visitor policies by maternity hospitals long after recommendations had been made to relax such policies in the wake of decreasing COVID-19 incidence and increasing vaccination levels does not seem to meet these conditions. Such policies appear insensitive to the particular needs of perinatal women given the consistent calls of maternal health groups and even the Government for visitor restrictions to be relaxed, and they appear inequitable given the lifting of most other COVID-19 restrictions throughout society.

Despite this analysis, Irish women cannot rely upon fundamental rights law to seek redress for any harm they suffered as a result of

19 K Shah Arora et al, 'Labor and delivery visitor policies during the COVID-19 pandemic: balancing risks and benefits' (2020) 323(24) Journal of the American Medical Association 2468; J Ecker and H Minkoff, 'Laboring alone? Brief thoughts on ethics and practical answers during the coronavirus disease 2019 pandemic' (2020) 2(3) American Journal of Obstetrics and Gynecology 100141; J Lalor, 'Balancing restrictions and access to maternity care for women and birthing partners during the COVID-19 pandemic: the psychosocial impact of suboptimal care' (2021) 128 BJOG 1720.

20 General Comment 14 (n 12 above), para 44(a) and (c).

21 Ibid para 29.

22 Ibid para 43(e).

23 Ibid para 21.

24 Ibid para 52.

25 Ibid.

potentially illegitimate restrictions. It seems wrong that during a public health emergency Irish citizens can challenge limitations to their right to access a court,[26] but cannot then use that access to ask the court to review a situation such as that analysed above. Moreover, it seems wrong that during a public health emergency Irish courts are able to censor individuals for unlawful actions which place the health of others at risk,[27] yet are unable to declare that the Government should provide redress where decisions for which they are ultimately accountable cause illegitimate health harms.[28]

The existence of a constitutional right to health as proposed by the Bill would rectify this situation in two important ways. Firstly, the inclusion of a right to health in the Constitution would encourage the mainstreaming of right to health analysis into government decision-making,[29] which if practised diligently during a pandemic could increase the likelihood that more nuanced and sensitive decisions will be reached.[30] There is no shortage of support for policymakers in this regard – for example, the Irish Human Rights and Equality Commission published a report containing recommendations for how rights-based analysis could be better integrated into legislative and executive decision-making on pandemic restrictions. These included, for example, involving human rights experts more closely in the decision-making process and publishing more detailed and timely analyses of the human rights implications of pandemic legislation.[31]

Secondly, the inclusion of a right to health in the Constitution would, if suitable enforcement mechanisms are also made available

26 *Heyns v Tifco Ltd & Others* [2021] IEHC 329.

27 *Medical Council v Waters* [2021] IEHC 252.

28 Mr Justice Meenan clarified the non-justiciability of the Constitution's directive principles of social policy in the context of challenges to coronavirus restrictions in *O'Doherty & Another v The Minister for Health & Others* [2020] IEHC 209, para 52: 'I am also satisfied that the applicants are not entitled to rely upon Article 45, which sets out principles of social policy. These principles are not "cognisable by any court under any of the provisions of this Constitution", as stated in the Article.'

29 M Amos, 'Lessons from the COVID-19 pandemic for the UK human rights law framework' (31 July 2020).

30 The norms flowing from the right to health have been relied upon to unify and organise political debate in response to the HIV/AIDS pandemic, such that practical decisions on actions to improve health were taken: D Fidler, 'Fighting the axis of illness: HIV.AIDS, human rights, and US Foreign Policy' (2004) 17 Harvard Human Rights Journal 99.

31 C Casey et al, *Ireland's Emergency Powers during the Covid-19 Pandemic* (Irish Human Rights and Equality Commission 2021) 102.

to facilitate timely access to the courts,[32] make it possible for courts to review government decisions on restrictions to health services and order redress for affected individuals if the restrictions are found to disproportionately breach their right to health.[33] It is clear from experiences in other jurisdictions that a justiciable right to health is a powerful tool for improving access to healthcare and the protection of public health, in particular where governments have failed to respond adequately to ongoing health crises such as the HIV/AIDS pandemic.[34] However, the possibility of courts ordering governments to take certain health policy actions is politically controversial for a number of reasons, which include the potential for resource diversion and the blurring of the separation of powers.[35] In the Irish context, several objections to introducing a constitutional right to health were raised in the Dáil during the debate on the Bill in November 2019 and will be evaluated in the next section of this commentary.

OBJECTIONS TO CONSTITUTIONALISING A RIGHT TO HEALTH

The Bill prompted a number of objections from the Government and did not progress past the second stage, with the Dáil voting to delay further debate until the Department of Health and the Constitutional Convention on Economic and Social Rights had considered it in more detail within the context of the ongoing Sláintecare reforms. A report

32 The importance of court access for improving the utility of the right to health is clear from Colombia's experience with *tutela* actions: A Arrieta-Gómez, 'Realizing the fundamental right to health through litigation' (2018) 20(1) Health and Human Rights 133.

33 The issues raised by right to health litigation are mapped in O Cabrera and A Ayala, 'Advancing the right to health through litigation' in J Zuniga et al (eds), *Advancing the Human Right to Health* (Oxford University Press 2013). An example of the health protections that can be secured through right to health litigation is provided by J Sellin, 'Justiciability of the right to health – access to medicines – the South African and Indian experience' (2009) 2 Erasmus Law Review 445.

34 L Forman, 'Justice and justiciability: advancing solidarity and justice through South African's right to health jurisprudence' (2008) 27 Medicine and Law 661; M Tveiten, 'The right to health secured HIV/AIDS medicine – socio-economic rights in South Africa' (2003) 72 Nordic Journal of International Law 41.

35 Concerns raised by right to health litigation are outlined in Cabrera and Ayala (n 33 above), as well as in C Flood and B Thomas, 'Justiciability of human rights for health' in L Gostin and B Meier (eds), *Foundations of Global Health and Human Rights* (Oxford University Press 2020).

to the Oireachtas Joint Committee on Health was promised, but this never materialised.[36]

Three objections raised by the Government in the debate stand out. The first is that the content of the right to health is unclear, and that the experience of other jurisdictions with a justiciable right to health would not necessarily translate to the Irish context. The second is that inserting only a right to health into the Constitution could weaken the work done to support other socio-economic rights. The third is that constitutionalising a right to health would place the judiciary in control of health policy.

The first objection is astute. The creation of a constitutional right to health has resulted in both positive and negative developments in other jurisdictions, depending upon exactly how the right to health is conceived and interpreted.[37] The experience of a justiciable right to health is unique to each jurisdiction, and experience from other jurisdictions cannot be the sole evidence relied upon to inform the creation of a constitutional right to health in Ireland. More evidence is indeed required on the possible consequences of creating a fundamental right to health in Ireland, before a decision is taken to put a constitutional amendment of this nature forward to the required referendum.

The second and third objections do not reflect the nuanced nature of the right to health and are now outdated in light of our experience of the COVID-19 pandemic. Regarding the second objection, it is true that constitutionalising the right to health may lead to resources being used on health that could have been used to further the protection of other socio-economic rights.[38] The claim that this is unacceptable finds some support in the interpretation given to states' obligations to work towards the progressive realisation of economic and social rights within their maximum available resources.[39] States may choose how to organise their budgets to provide what they believe to be the best possible resource allocation to socio-economic rights protection, but

36 It is noteworthy that the Thirty-seventh Amendment of the Constitution (Economic, Social and Cultural Rights) Bill 2018 attracted similar concerns from the Government and, after a vote, was also delayed to allow for further consideration.

37 K Young and J Lemaitre, 'The comparative fortunes of the right to health: two tales of justiciability in Colombia and South Africa' (2013) 26 Harvard Human Rights Journal 179; O L M Ferraz, 'The right to health in the courts of Brazil: worsening health inequities?' (2009) 11(2) Health and Human Rights 33.

38 A Yamin and O Parra-Vera, 'Judicial protection of the right to health in Colombia: from social demands to individual claims to public debates' (2010) 33 Hastings International and Comparative Law Review 431.

39 Art 2 ICESCR; UN CESCR, General Comment 3: The Nature of States Parties' Obligations (art 2, para 1, of the Covenant), 14 December 1990, E/1991/23.

moving funding from one socio-economic right to another (for example from education to health) would be problematic for the progressive realisation of the defunded right.[40]

However, these concerns may be less relevant following the COVID-19 pandemic. Rhetoric on the importance of protecting human health dominated public discourse in Ireland, and the Irish Government committed itself to the position that protecting public health and saving lives was the most important priority for society.[41] If this is true in a public health emergency, it should also be true for existing chronic health crises such as rising rates of childhood obesity. Indeed, the position that health ranks foremost among social priorities finds consistent support in the case law of the European Court of Justice.[42] In light of this, prioritising the funding of actions that will improve healthcare and public health services and thus better safeguard the right to health can no longer be seen as unacceptable – indeed the pandemic has shown us in graphic detail why the opposite might be true.

In relation to the third objection, the experience of other jurisdictions does indicate that the availability of a justiciable right to health leads to significant judicial influence on health policy.[43] However, as the Government itself argued, this experience would not necessarily transfer to Ireland, especially since Irish courts are largely

40 A Blyberg and H Hofbauer, 'The use of maximum available resources' (International Budget Partnership 2014).

41 'As the Roman Statesman Cicero said "the safety of the people shall be our highest law". This is the approach we have taken since the pandemic was declared in March", speech by An Taoiseach Leo Varadkar (Dublin, 5 June 2020); 'But the most important responsibility that we all share is to protect the lives of those we love', speech by An Taoiseach Micheál Martin (Dublin, 30 December 2020); 'All of this, and much more, was necessary because our number one priority had to be the protection of people's lives and public health', speech by An Taoiseach Micheál Martin (Dublin, 31 August 2021).

42 This has been confirmed in relation to, for example, prescription medicine sales (Case C-148/15 *Deutsche Parkinson Vereinigung* ECLI:EU:C:2016:776), dental care (C-339/15 *Vanderborght* ECLI:EU:C:2017:335), optical care (C-108/09 *Ker-Optika* ECLI:EU:C:2010:725), alcohol control (C-170/04 *Rosengren* ECLI:EU:C:2007:313) and chemicals regulation (C-473/98 *Toolex* ECLI:EU:C:2000:379).

43 D Wang, 'Right to health litigation in Brazil: the problem and the institutional responses' (2015) 15 Human Rights Law Review 617;

supportive of government decision-making in health.[44] Moreover, it is misleading to assert, as the Government did, that a constitutional right to health would mean that any executive or legislative decision on health 'could easily be challenged in court'. Despite advances in socio-economic rights jurisprudence, it is still difficult to establish a breach of the right to health unless the claimant can show that the government owes them a clearly defined duty, such as the duty to ensure access to certain medicines or medical care.[45] The vast majority of right to health case law in which judges have ordered governments to provide services has occurred in lower and middle-income countries that have acute problems with basic healthcare priorities such as medicines availability. These problems are not widespread in a rich country with a good healthcare system such as Ireland, and so there is far less need for Irish judges to step in and make orders for basic healthcare provision. Moreover, Irish courts are conservative in their interpretation of socio-economic rights and have sought to respect the separation of powers,[46] contrary to the suggestion made by the Government in the Dáil debate. Even if Irish judges were to become more willing to give liberal interpretations to socio-economic rights, it is still more likely than not that they would adopt a measured approach to adjudicating the right to health.[47] Moreover, it is far more likely that the right to health would be relied upon to challenge more isolated instances of serious failings in the healthcare system, or by specific segments of the population that experience difficulty accessing satisfactory healthcare, rather than to instigate a wholesale diversion of resources or to weaken the authority of the executive and legislature to make health policy.

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44 For example, one of the most significant cases in Irish constitutional law – *Ryan v Attorney General* [1965] IR 294 – in which the courts created the doctrine of unenumerated constitutional rights, concerned the mass fluoridation of drinking water for the protection of dental health. The courts upheld the Government's ability to pursue such a policy. In several other cases concerning health care provision or public health policy, the courts have refused to grant relief to applicants (for example *Teehan v HSE and Another* [2013] IEHC 383) or upheld the legitimacy of the Government's public health powers and actions (for example *Bederev v Ireland* [2016] IESC 34). Moreover, the Irish courts have upheld many of the Government's coronavirus regulations, thereby confirming the broad scope of the public health police power: *Ryanair DAC v An Taoiseach, Ireland, and the Attorney General* [2020] IEHC 461; *The Irish Coursing Club v Minister for Health and Minister for Housing* [2021] IEHC 47).

45 Z Nampewo et al, 'Respecting, protecting and fulfilling the human right to health' (2022) 21 International Journal for Equity in Health 36.

46 T Murray, 'Economic and social rights in Ireland' in D Farrell and N Hardiman (eds), *The Oxford Handbook of Irish Politics* (Oxford University Press 2021).

47 M Lau et al, 'Creating universal health care in Ireland: a legal context' (2021) 125 Health Policy 777.

Once again though, the COVID-19 pandemic has weakened the validity of these concerns. The use of the state police power to protect public health has never been so extensively held in the public spotlight, and the level of public awareness of the ways in which public health law can restrict individual freedoms and entitlements is now arguably at the highest level it has ever been. It was always true that difficult decisions could be taken to promote health. However, now the public are acutely aware that even social priorities once thought to be sacred, such as the ability to access quality healthcare when needed, can be subjugated for the protection of wider population health. This has led to heightened public concern that these essential priorities should be valued and protected even more strongly than they have been to date. The ability for judges to adjudicate disputes over how healthcare and public health services can be restricted should therefore no longer be considered objectionable, given the very visible levels of damage to health that society has had to watch pandemic restrictions inflict.

In summary, there are legitimate questions to be answered in relation to the adoption of a constitutional right to health. However, these must take account of the true nature of the right to health, as well as the 'new normal' created by the coronavirus pandemic. The final section of this commentary will therefore examine in greater detail the conceptualisation of the right to health put forward by the Bill.

THE RIGHT TO HEALTH PROPOSED BY THE BILL

The Bill attempts a compromise between breadth and specificity in the conceptualisation of the right to health. The three substantive provisions would recognise 'the equal right of every citizen to the highest attainable standard of health protection', guarantee 'affordable access to medical products, services, and facilities appropriate to defend the health of the individual', and require the Government to 'give due regard to any health interests which serve the needs of the common good'. There are many ways of drafting a constitutional right to health, and it is possible to frame the right in narrower or broader terms than this formulation proposed by the Bill.

Drafting a constitutional right to health in even broader language[48] better aligns with article 12 ICESCR. General Comment 14 makes clear that the right to the 'highest attainable standard of physical and mental health' includes a right to both individual medical care and a right to wider societal conditions in which it is possible to live a healthy life. However, this breadth can be difficult to translate into concrete

48 For example, the 2009 Constitution of Bolivia states in art 18 that 'All persons have the right to health', without further qualifications.

terms. This – and presumably also the fear of resource diversion – is why many countries which have constitutionalised the right to health have conceptualised it in narrower terms, as a right to healthcare.[49] This would enable individuals to contest the deprivation of medical care, but not the socio-economic decisions made by their government that influence health outcomes. Clearly, this makes the right easier to interpret, but also reduces its potential as a tool to promote greater action on the social determinants of health.

The Bill attempts to balance these considerations, but seems to have done so in a contradictory manner. Although the use of the term 'health protection' was praised in the Dáil debate for its inclusiveness, health protection in fact refers quite specifically to the branch of public health practice that focuses on controlling communicable disease and environmental health threats.[50] Health protection does not cover actions that address the influence of socio-economic factors upon health outcomes – this is the domain of health promotion and health prevention.[51]

Other aspects of the Bill's drafting are also problematic. Firstly, the right to health as set out in the ICESCR is to be realised both progressively and within the state's available resources. However, the Bill splits this requirement over two separate provisions. The drafting implies that health protection is to be achieved progressively but not within the state's available resources, that access to healthcare is to be achieved within available resources but not progressively, and that other public health activities are not subject to either requirement. This might seem a pedantic observation, but the existence of legal obligations can depend upon interpretative questions as specific as this. Second, the term 'medical products' is used in the Bill but does not appear anywhere in General Comment 14, which instead identifies 'essential drugs' and 'health facilities' as core aspects of the right to health.[52] If the intention is to refer to these core aspects of the right to health, then they should be used in place of the term 'medical products', which instead implies a reference to medical devices or technology. If the intention was indeed to refer to the core aspects of the right to health, then the Bill should also have stipulated (in line with General

49 For example, South Africa's 1996 Constitution states in art 27(1) that 'Everyone has the right to have access to: a. health care services, including reproductive health care.'

50 See, for example, A Nicoll and V Murray, 'Health protection – a strategy and a national agency' (2002) 116(3) Public Health 129.

51 H Madi and S Hussain, 'Health protection and promotion' (2002) 14 Eastern Mediterranean Health Journal S15.

52 General Comment 14 (n 12 above) para 43.

Comment 14) that the Government must guarantee access without delay and as a resource priority, rather than simply required that the Government 'endeavour, within its available resources, to guarantee affordable access', which suggests a weaker obligation. Thirdly, the drafting of 'give due regard to any health interests which serve the needs of the common good' is too vague to produce firm legal effects, and raises the extremely difficult question of what the 'common good' is in any particular situation, let alone what level of obligation 'due regard' generates. Since this provision relates to public health issues, it should instead refer to concrete public health concepts such as the social determinants of health.[53] This would allow a court to clearly identify the specific public health duties that are placed on the Government by the provision.

The wording that brings a right to health into the Irish Constitution must be carefully crafted to maximise the impact that the right to health can make to the lives of citizens. A vague or contradictory conceptualisation of the right to health may have the opposite effect of trapping litigants in lengthy legal battles that are resolved too late for any redress to improve their health situation – such an eventuality would be particularly undesirable during a pandemic. To give due credit to the Government, this was another concern that it raised in the Dáil debate.

CONCLUDING REMARKS

One of the lessons that states must learn from the coronavirus pandemic is that legal systems, as well as health systems, must be reformed so that stronger and clearer rules are in place to govern the next public health emergency. Part of this legal reform should involve bringing the right to health into the national legal order, if it is not already recognised. This would generate greater transparency and accountability if restrictions must again be placed on health services in order to protect public health. Having to make policy decisions that damage the health of many in order to protect the health of many more is a difficult and unpopular thing for any government to do, and putting in place an appropriate fundamental rights framework within which to make such decisions seems eminently desirable. Now is an ideal time for Irish lawmakers to return to the important debate initiated by the Bill. The Irish public have never been so engaged with and attuned to health policy issues, so the quality of public debate on the issue of a

53 R Wilkinson and M Marmot (eds), *Social Determinants of Health: The Solid Facts* (WHO 2005); *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health* (WHO 2008).

constitutional right to health will never be better. If political leaders are serious about building a better society in the wake of the COVID-19 pandemic, then a serious national conversation about a constitutional right to health is an excellent place to start.

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Book review: *Pandemic Legalities: Legal Responses to COVID-19 – Justice and Social Responsibility* edited by Dave Cowan and Ann Mumford*

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This is an important book that was written at a time of a great unknown – the early stages of the COVID-19 pandemic. COVID-19 has undoubtedly shaped the world in which we live; the application of lockdown powers, the closure of many businesses, the use of personal protective equipment (PPE), and restrictions on visitation in care homes (to name but a few) have all had an incalculable impact on human life and human thriving. This book considers the influence of austerity measures in the context of the COVID-19 pandemic. Each of the contributing authors discusses and analyses the impact of austerity in their specific legal and social specialisms. The book questions what good can come from the pandemic and what a fair and just response would look like. The editors, Dave Cowan and Ann Mumford, note that severe underfunding has had a profound impact on vulnerable people in society, and they are of the view that austerity represented a 'wrong turn'.[1] Many of the problems that already existed have now become 'entrenched and exacerbated' due to COVID-19. They claim that austerity has the most disproportionate impact on the poorest in society. The book itself is linked to the fear of what might come in the future and to how changes in law and legal structures could have a positive societal impact. It provides a legal and socio-legal backdrop to insights into the manner in which both justice and social responsibility were the headlines, footnotes and *raison d'être* of the early days of COVID-19.

The book is divided into two distinct parts. Part 1 ('Justice') sets out the rule of law in the context of the pandemic. This rule of law is actualised and vivified in a number of thought-provoking contexts, including asylum seekers, criminal trials and children. Cowan

* Dave Cowan and Ann Mumford (eds), *Pandemic Legalities: Legal Responses to COVID-19 – Justice and Social Responsibility* (Bristol University Press 2021)

1 Ibid 2.

discusses 'residential security' and how the basic right to stay in one's home became very significant during the pandemic. He refers to the murky use of 'administrative quasi-legislation', letters and 'self-congratulatory and inaccurate tweets' by the Government.[2] He argues that '[t]he real test . . . will be how these new techniques of government are used and developed as we move out of lockdown and back to some sort of normality in everyday life'.[3] In relation to vulnerable litigants, Nick Gill claims that the use of 'remote justice' has the potential to have an impact on how justice is achieved by people who are vulnerable.[4] He states that there has been increased confusion, anxiety and mistrust since the onset of the pandemic. Gill, however, also argues that some possible advantages of remote hearings include 'reducing confusion over court and tribunal etiquette, reducing the association some appellants have with face-to-face hearings and disrespect, and improving the convenience of the proceedings'.[5] Linda Mulcahy is of the view that justice in an online arena must strive to put the poor and most vulnerable centre-stage in terms of implementation and application. She states that 'the poor remain at the top of our priorities' and how important it is that 'romanticized visions of what happens in physical courthouses is not allowed to cloud evaluations'.[6] Kathryn Hollingsworth argues that a 'general-relational' approach to children in the justice system is required. She praises some of the recent policy shifts in youth justice but argues that more 'robust accountability' is required.[7] The dual lenses of racism and rights are used to portray inequalities and injustices in the operation of justice in this era. It is argued that legal scholars must teach 'perspectives and theories that expose the realities that people of colour are subjected to through law' and that we should 'teach the world we want to see'.[8] Simon Halliday, Jed Meers and Joe Tomlinson consider the concept of social solidarity and the manner in which it acted as a 'double-edged sword': 'while much lauded as an extraordinary feature of UK society's response to the pandemic, it likely operated to suppress a sense of grievance over the government's pandemic response policy'.[9] Finally in Part 1, a most interesting chapter on PPE by Albert Sánchez-Graells provides 'a cautionary tale' for governmental rule in the context of the arguably understandable, but flawed, panic response.[10]

2 Ibid 26.
3 Ibid 26.
4 Ibid 27.
5 Ibid 38.
6 Ibid 51.
7 Ibid 54.
8 Ibid 77.
9 Ibid 81.
10 Ibid 93.

Part 2 of the book ('The Social') deals with what could be further defined as the social response to the pandemic and social responsibility in the era of the pandemic. This section contains a labyrinth of informative and occasionally eye-opening chapters that deal with accountability, adult social care, housing, taxation and education. A critical overview is given of the corporate sector, social security, labour law, and tax and spending in the aftermath of the pandemic. Tamara Hervey, Ivanka Antova, Mark Flear and Matthew Wood refer to the context of healthcare in a post-Brexit COVID-19 era. Their research focuses on communities who feel 'left behind' and who show consequential distrust of politicians. Many respondents speak about the need for laws that protect 'ordinary people'. The chapter also refers to the devolved nature of healthcare and discusses how the current law in this regard can fail to 'secure legitimacy of health governance'.[11] Rosie Harding deliberates upon the impact of COVID-19 on residents in care homes and those who were 'shielding'. She also scrutinises the relationship between law and social care and argues that a new model is needed 'which focuses on fairness rather than profit [as] the only way to create a stable, safe and sustainable social care sector for the future'.[12] Instead of thinking about care as a low-skilled job that rests on the shoulders of women, she argues that its importance must be recognised as a 'fundamental building block of society'.[13] Rowan Alcock, Helen Carr and Ed Kirton-Darling call for a new approach to housing and homelessness. They argue that '[a]s with much other needed reform, none of this can be done without careful reflection on the relationship between the market and society, significant investment and a renewal in understanding of the vital role of investment by the state in our collective physical and social infrastructures'.[14] Alison Struthers examines the lasting impact of austerity measures on education. She also considers how COVID-19 has brought to light many educational inequalities that already existed. Struthers calls for change and states that '[i]t is time for the government to prove that they are willing to prioritize those most adversely affected by the ills of this pandemic by providing schools with the funding, resources, staffing and time necessary to allow the COVID-19 generation a genuine chance to reach their fullest potential'.[15] Sally Wheeler queries what has been learned about the corporate sector during the COVID-19 pandemic and considers retail trading during this period. She draws attention to the concepts of fast fashion, responsible investing and responsible

11 Ibid 117.
12 Ibid 119.
13 Ibid 130.
14 Ibid 140.
15 Ibid 151–152.

consumption and stresses the interconnectedness of these competing variables. Jed Meers analyses the role of social security during and after the pandemic and argues that social security systems are 'facing huge economic shock' as a consequence of COVID-19.[16] It is claimed here that governments should learn from the inequality-related problems associated with austerity measures. In relation to labour law, Katie Bales interrogates the Government's Coronavirus Job Retention Scheme and the position of undocumented people who were let down by the state during the pandemic. Finally, Ann Mumford and Kathleen Lahey cast a discerning eye on the tax regime, analysing the historical changes in tax policies and the issue of inequality in this regard.[17]

Both sections of this book are, in many ways, highly politically charged. They do not – and there is no apology for this – embrace any form of legal or political neutrality and overt objectivity. There is a sense that all the authors are almost stunned by the various inequalities that have come to light both before the pandemic and during it. In fact, the overriding motif of the book is a certain palpable sadness that all of the systems and all of the governance and all of the well-meaning approaches used to cull the spread of the pandemic have made the lot of the poor even poorer. These have halted the slow progress of those who were at some stage inching out of poverty and disadvantage but now, by virtue of the killing-off of educational opportunities, have been hurled back into unfairness, housing crises, disadvantage and the consequences of austerity. The authors draw our attention, in increasingly vociferous ways, to the divides that exist in the justice system, in labour laws and in the ways in which money is spent, and has been spent, in injurious ways throughout the onset of the pandemic. The authors leave the reader with a sense of anguish for those who are 'left behind' and for those who are in social care. They seem to suggest that the justice system has not dealt all that well with vulnerable litigants and with children: rights and solidarity may not have been to the fore in the manner in which they might have been and should have been.

Is this a book that will gather dust on the bookshelf, full of earnest thought and passionate reasoning or is it one that has the potential to bring about action and change? The answer to that question might be found in the mind and heart of the reader. He or she or they may be compelled to think and reflect upon how the vulnerable people in society, and the poorest of the poor, have been hardest hit by the austerity measures evoked by the response to the pandemic. If this is accomplished, then the contributors and the editors will have achieved their purpose.

16 Ibid 184.
17 Ibid 199–208.

Is it a good book? It is certainly a worthy book and, thematically, it is all-embracing, all inclusive. There is little left out in the coverage of the pandemic and austerity responses. The theme of the book is fleshed out rigorously and with fervour, and the reader is left both informed and knowledgeable. Equally, however, the book covers so vast an area that, at times, the coverage of the assigned topic merely scratches the surface and fails to dig into some of the deeper legal, political and ethical issues that underpin both governmental action and public response to that action. I was left with the pervading feeling of 'Why, why did the Government act as it did and why was the response as it was?' To some degree, the 'Why?' question was insufficiently addressed in the book. At the level of ethical preparedness, ethical reasoning and ethical accountability, there were some discernible gaps. But that may only serve to whet the appetite for more because, in essence, this is a hugely informative book. It lifts the lid off the cosiness of flawed governmental action, and it highlights the suffering that was endured by those whose suffering pre-dated and was aggravated by the pandemic. The very cohesive 'Introduction' sets out the pathway of the book. It is a pity that no concluding chapter was included, which could have brought all the interlinking themes of the book together and – in doing so – provided the reader with a summative sense of the core messages of the book.

There will be many books written about the pandemic, but there will be few that embrace so many areas with so discerning and challenging an analysis. It behoves us to read this book acutely and to think about and act upon the inequalities it has unearthed.

Introduction

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