



The Rights of Elders in Ireland during COVID-19

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1. Introduction

In response to the rapid spread of COVID-19 in early 2020, all European states adopted legislation to compel or encourage individuals to reduce social contact to slow the spread of the disease and avoid hospital surges. It quickly became clear that elders were medically vulnerable to serious side effects and death. Therefore, in some jurisdictions, legislation was adopted with the purpose of protecting elders, while in others, special restrictions were imposed on elders ‘for their own good’. In this paper, we examine aspects of the emergency legislation and recommendations introduced in Ireland to protect elders from COVID-19.

Elders’ rights during the pandemic are the focus of the article given that over 90% of COVID deaths in Ireland, as in other countries, were persons over 65 years.¹ Furthermore, although everyone has been impacted by the epidemic, COVID regulations and policies, such as prohibitions on gatherings, requirements on distancing and mandatory wearing of masks, can have a disparate impact on elders’ emotional, mental and physical health. However, elders are not a homogeneous group: they have varied levels of health and live in different settings, such as, alone, with a spouse, with family or in an institution. Finally, elders are not only vulnerable. They are autonomous human beings who hold rights in line with other citizens, such as, the right to family and private life, which we focus on in this paper.

We reflect on COVID restrictions imposed on elders through the lens of the right to private and family life (Article 8 ECHR), focusing on stay at home orders and recommendations advising elders to avoid social contact. Furthermore, we examine restrictions on visiting nursing homes given that in Ireland, more than half of all COVID deaths occurred in care homes.² In our analysis, we zero in on the principles of foreseeability and proportionality. To date to the best of our knowledge, there have not yet been any court cases on elder’s rights during the COVID pandemic under Article 8. Therefore, we highlight areas of concern and aspects that we submit should be considered in a proportionality assessment.

Ultimately, we argue that it is a mistake to view the COVID-19 pandemic solely as an external threat. Instead, COVID-19 exposes problems that pre-dated the ‘crisis’ and its effects should be understood in light of systemic breaches of elders’ dignity and institutional vulnerability. Consequently, the solutions suggested through the law - restrictions on movement and visitation bans - are too narrow and fail to address the underlying structures, such as, issues in the healthcare system, the limited home help for elderly and poor conditions in nursing homes.

At the time of writing, November 2020, we are approximately eight months into the pandemic, and we recognise that further interdisciplinary research must be conducted. In this

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¹ Central Statistics Office, 2020, COVID-19 Deaths and Cases, COVID-19 *Insight Bulletins: Deaths and Cases, Series 1*, 22 May 2020. Retrieved 17 November 2020, www.cso.ie/en/releasesandpublications/br/b-cdc/covid-19deathsandcases/.

² Health Information and Quality Authority, *The impact of COVID-19 on nursing homes in Ireland*, July 2020. Retrieved 17 November 2020, www.hiqa.ie/sites/default/files/2020-07/The-impact-of-COVID-19-on-nursing-homes-in-Ireland_0.pdf.

manner, this paper does not claim to be a comprehensive assessment but an initial analysis that highlights that the human rights issues facing elders go beyond the current restrictions and emergency and thereby require long-term solutions.

2. The Right to Family and Private Life as a Framework

The article focuses on restrictions on elders' rights under the framework of the right to private and family life (Article 8 ECHR). This right is not absolute and may be limited by a public authority if in accordance with the law and necessary in a democratic society. We recognise that stemming the spread of COVID-19 can form a legitimate aim and a pressing social need. However, the restrictions discussed in this paper can still amount to violations of Article 8.

Firstly, interferences with the right to private and family life must be in accordance with law, which the Court has held to mean that the law must be accessible and foreseeable.³ For example,

Domestic law must indicate with reasonable clarity the scope and manner of exercise of the relevant discretion conferred on the public authorities so as to ensure to individuals the minimum degree of protection to which they are entitled under the rule of law in a democratic society.⁴

We submit that the stressful and isolating circumstances of the pandemic heighten the state's obligation to ensure that individuals are in a position to act in compliance with the law. Given that individuals were encouraged to self-isolate, they were separated from their normal support networks and thereby rendered more vulnerable. Therefore, we underscore that COVID restrictions on Article 8 must be transparently communicated.

Secondly, lawful interferences must be proportionate to the aim pursued. The proportionality of the restriction will depend on the circumstances of the case, including which factors the Court focuses on in its assessment. In this article, we suggest that the structural circumstances, such as poor living conditions caused by lack of investments in elder care, should be taken into account when balancing the interference with the public health goal.

Finally, while we focus on the right to private and family life, this right interacts with full spectrum of human rights, which are also relevant to restrictions on elders' rights during the pandemic.⁵

3. COVID-19 Restrictions

Ireland, in line with other European states, amended its aged infectious disease legislation in response to the COVID-19 pandemic. On 20 March 2020, new powers were added to the 1947 Health Act which authorise the Minister for Health to adopt wide ranging regulations, including (but not limited to) travel restrictions within and to/ from the state; restrictions requiring people to remain at home, the prohibition of events, and 'any other measures that

³ See for example, *Sunday Times v. The United Kingdom* (No. 1) 6538/74, para. 49.

⁴ *Piechowicz v. Poland* 20071/07, para. 212.

⁵ For an analysis of the right to health see K. Ó Cathaoir, "Human rights in times of pandemics: necessity and proportionality", in: M. Kjærsum, M. Davis and A. Lyons (eds.), *Human rights and the Covid-19 crisis* (Routledge, forthcoming).

the Minister considers necessary in order to prevent, limit, minimise or slow the spread of COVID-19'.⁶ Using these powers, the Minister introduced a restrictive approach, whereby almost everyone was advised to remain at home.⁷ While the regulations did not target the elderly, side by side the restrictions, the Health Service Executive (HSE) promoted a policy of 'cocooning', i.e. recommending elders stay indoors at all times. This led to confusion for elders as to whether they were legally required to self-isolate.

In the coming sections, we analyse the stay at home order and the policy of 'cocooning', focusing on the legal requirement of foreseeability.⁸ Finally, structural weaknesses are discussed, which we argue contribute to elders' vulnerability during and beyond the pandemic.

3.1. Stay at home!

From the 8 April 2020, individuals were ordered not to leave their residence 'without reasonable excuse'.⁹ A non-exhaustive list of reasonable excuses was listed and updated as new regulations were introduced (see box 1). The order imposes a far-reaching limitation on the right to private and family life. While there are many human rights issues at play, here we focus on the restrictions as they relate to elders.

Firstly, providing care or assistance to a 'vulnerable person' is expressly recognised as a reasonable excuse. However, it is not clear who is or is not a vulnerable person. Section 3 of S.I. No. 121/2020 suggests a medical model of vulnerability as the term is explained to include persons 'particularly susceptible to the risk posed to health by COVID-19.' The regulation does not define who is 'particularly susceptible', however. Separately, the Health Service Authority (HSE) issued guidance on who is at 'very high risk' and 'high risk'. There are many ways of understanding and framing vulnerability. It is unclear whether the regulation recognises other forms beyond medical vulnerability, for example, is a healthcare worker or a person at risk of violence also considered a vulnerable person? These persons can be at increased vulnerability to infection or harm as a result of the pandemic.

Box 1: Necessary purposes according to s. 31A Temporary Restrictions

Following the 8 April Regulations, necessary purposes include:

- providing an essential service
- procuring essential items/ services
- procuring essential items/ services for animals / vulnerable persons

⁶ S.I. No. 121/2020 - Health Act 1947 (Section 31A -Temporary Restrictions) (Covid-19) Regulations 2020.

⁷ The approach can be characterised as restrictive when compared to that adopted by Scandinavian countries.

⁸ For a comprehensive review of the Irish response see B. Kennelly, M. O'Callaghan, D. Coughlan, J. Cullinan, E. Doherty, L. Glynn, E. Moloney and M. Queally, 'The COVID-19 pandemic in Ireland: An overview of the health service and economic policy response', *Health Policy and Technology* 9(4) (2020) 419-429, <https://doi.org/10.1016/j.hlpt.2020.08.021> (in Press, available online 9 September 2020).

⁹ *Supra* note 6. In force until 'the 5th day of May 2020' (originally 'the 12th day of April 2020'). The Prime Minister asked individuals to stay at home from 23 March 2020, https://merrionstreet.ie/en/News-Room/Speeches/Post_Cabinet_Statement_An_Taoiseach_Leo_Varadkar_24_March_2020.html, retrieved 17 November 2020).

- attending a medical appointment or accompanying to a medical appointment or essential medical, health or emergency dental assistance
- seeking veterinary assistance
- exercising, either alone or with household, within a 2km radius
- attending to vital family matters (including to provide care to vulnerable persons)
- attending the funeral of housemate or close family
- fulfilling a legal obligation
- access to a child
- exemptions for religious personnel
- moving residence where necessary
- providing emergency assistance, avoiding injury or illness, or escaping a risk of harm, whether to the applicable person or another person.

For the second ‘lockdown’ (22 October), the following necessary purposes were added:

- Attending education or accompanying a vulnerable person/housemate
- Accessing childcare
- Returning to place of residence
- Leaving the state where the person is not ordinarily resident in the State
- Making an application for planning permission
- Exercising within a 5km radius

*Abridged for ease of reading

Secondly, exercise was restricted to specific group sizes/ kilometre radii (see box 2) which led to confusion.¹⁰ For example, citizens mistakenly interpreted the law to mean that the kilometre radius applied to all activities, such as assisting vulnerable persons, leading the Prime Minister to tweet in reassurance.¹¹ Including strict kilometre radiuses could on the one hand, be commended for transparency, as it sets a clear threshold instead of a more ambiguous order to stay close to home. Yet, it is not easy without assistance to calculate whether one is within the appropriate radii. As a result, a private company developed an app to help citizens calculate the distance,¹² but as smart phone use is substantially lower among the elderly, it may have been of limited value to that group.¹³ Moreover, the benefit of keeping people within a strict radius must be weighed against the limitation on their rights. The precise public health aim of keeping citizens close to their residence has not been explained by the government and must be balanced in light of the potential harm of not exercising, which for elders can lead to irreversible muscle wastage.¹⁴

Thirdly, in October, the government issued a press release stating that visiting a grave - a practice of cultural and emotional significance for many elders- was now a reasonable excuse

¹⁰ S.I. No. 153/2020 - Health Act 1947 (Section 31A – Temporary Restrictions) (Covid-19) (Amendment) (No. 2) Regulations 2020.

¹¹ RTE, ‘2km radius - how far is that exactly?’, 28 March 2020. Retrieved 17 November 2020, www.rte.ie/news/coronavirus/2020/0328/1127002-coronavirus-2km-limit/.

¹² KM From Home, ‘About KM From Home’. Retrieved 17 November 2020, https://2kmfromhome.com/about_

¹³ Government of Ireland, Department of Health, May 2020, Research Brief, S. Gibney and T. McCarthy, *Profile of Smartphone ownership and Use in Ireland*.

¹⁴ See, for example, B. Langhammer, A. Bergland and E. Rydwick, ‘The Importance of Physical Activity Exercise among Older People’, *Biomed Research International* (2018) DOI: 10.1155/2018/7856823.

for traveling beyond 5km.¹⁵ Earlier in the pandemic, visiting graves was not a necessary purpose and individuals reported having been stopped by the police while trying to visit the cemetery.¹⁶ Although from a proportionality standpoint the press release can be welcomed, as the purpose was not listed in the text of the regulation, it can hamper foreseeability.

Box 2: Restrictions on exercise (radius and grouping)
8 April 2020: may exercise alone within a 2km radius
5 May 2020: may exercise alone within a 5km radius
18 May 2020: may exercise outdoors with a maximum of 3 other persons
8 June 2020: movement within the county of residence or within a 20km radius with a maximum of 14 other persons who do not reside together permitted. Indoor gatherings permitted with up to five others
29 June until the 20 July 2020 (extended to 10 August 2020): indoor gatherings of up to fifty allowed and outdoor gatherings of up to 200
22 October: exercise within 5km of residence

The above examples could have implications for legal certainty, including elders' ability to orientate their behaviour to comply with the law. This is particularly concerning as the regulations were accompanied by criminal sanction (a fine to a maximum of €2,500 or imprisonment of up to six months).¹⁷ For example, individuals could have been fined for visiting their families' graves. It can be questioned whether criminal sanctions are an efficient public health tool.¹⁸ Furthermore, stigma, fear and stress may thrive in unpredictable criminal regulation, since the police have a broad discretionary competence. On the individual level, it can raise questions of discrimination, for example, communities living in social housing in Ireland alleged they were over policed during the pandemic.¹⁹ The Council for Civil Liberties has opposed the use of criminal sanctions, recommending that resources instead be directed at supporting the vulnerable, such as elderly.²⁰

¹⁵ Government of Ireland, 2020, Press Release, *Ireland placed on Level 5 of the Plan for Living with COVID-19*, 19 October 2020. Retrieved 19 November 2020, <https://www.gov.ie/en/press-release/66269-ireland-placed-on-level-5-of-the-plan-for-living-with-covid/#>.

¹⁶ Stephen McDermott, 'Chief Medical Officer: Visiting cemeteries 'not on list' of permitted reasons for leaving your home', *TheJournal.ie*, 27 April 2020. Retrieved 19 November 2020, <https://www.thejournal.ie/ireland-cemeteries-covid19-visiting-recommendations-5085422-Apr2020/>.

¹⁷ Criminal Justice (Enforcement Powers) (Covid-19) Act 2020, s. 3. S.I. No. 121/2020 - Health Act 1947 (Section 31A -Temporary Restrictions) (Covid-19) Regulations 2020, s. 4(2), s. 5(2). Criminal Justice (Enforcement Powers) (Covid-19) Act 2020, s. 13.

¹⁸ *Supra* note 5.

¹⁹ Policing Authority, 2020, *Policing Performance by the Garda Síochána in Relation to COVID-19 Regulations*, 2020 May 2020. Retrieved 19 November 2020, www.policingauthority.ie/assets/uploads/documents/Report_on_the_Policing_Performance_by_the_Garda_S%C3%ADoch%C3%A1na_in_relation_to_Covid-19_regulations_20_May_2020.pdf.

²⁰ Irish Council for Civil Liberties, 2020, *ICCL calls on government not to reintroduce garda powers*, 18 August 2020. Retrieved 19 November 2020, www.iccl.ie/news/iccl-calls-on-government-not-to-reintroduce-garda-powers/.

Finally, a positive development is that the regulations governing the second lockdown introduce the concept of ‘paired households’.²¹ This approach permits two households to act as one for the purposes of social gatherings and thereby comply with the regulations. Support bubbles are designed to support, inter alia, persons living alone and deter social isolation.

3.2. Cocooning Recommendations

While the regulations generally did not target elders, the Health Service Authority (HSE) advised elders, and others at risk, to ‘cocoon’. Cocooning means that persons who are high risk are advised to stay home as much as possible and limit social interactions to a very small network for short periods.²² However, the phrasing of this ‘advice’ can be critiqued as misleading. For example, the HSE website stated: ‘if you are in a very high-risk group, you need to cocoon’, while elsewhere on the website it said, ‘you are advised to cocoon’.²³ The guidance has changed often, depending on the status of COVID-19 in Ireland (see box 3).

Although the recommendations were neither legally mandated nor subject to sanction, the phrasing was liable to create confusion. It was not clear to all citizens whether cocooning was a legal mandate (and thereby subject to criminal sanctions) or a recommendation, given the directive phrasing and the many legal regulations that had been introduced to govern social interactions. This could lead to, for example, social stigma, e.g. ‘are you allowed out?’, fears of attracting the attention of the police, or, without adequate instruction, the police mistakenly perceiving the recommendations as law. At a societal level, confusion generated by unclear rules can undermine the population’s trust in COVID regulations.

From the standpoint of proportionality, cocooning can have a heavy toll on elders’ mental and physical health. ALONE, an Irish non-governmental organisation, reported an increase in calls from elders expressing loneliness to its helpline, as well as physical ailments.²⁴ Evidence from previous outbreaks have shown that isolation is linked to depression and anxiety.²⁵ Studies show that loneliness also impacts on physical health.²⁶ Where an elder lives alone, is not proficient with technology or is hard of hearing, they may be particularly vulnerable to loneliness and communication difficulties.

Cocooning risks placing the responsibility on elders to protect themselves from COVID through long term isolation. It can also increase elders’ dependency on family and community. Research suggests that elders often fear being a burden on their families and the

²¹ S.I. No. 448/2020 - Health Act 1947 (Section 31A - Temporary Restrictions) (Covid-19) (No. 8) Regulations 2020, s. 7.

²² Our Health Service, 2020, Coronavirus, *People at higher risk from COVID-19*, 10 November 2020. Retrieved 19 November 2020, www2.hse.ie/conditions/coronavirus/people-at-higher-risk.html.

²³ Our Health Service, 2020, Coronavirus, *How to cocoon*, 29 October 2020. Retrieved 19 November 2020, www2.hse.ie/conditions/coronavirus/cocooning.html.

²⁴ M. Ward, C. McGarrigle, A. Hever, P. O’Mahoney, S. Moynihan, G. Loughran and R. A. Kenny, ‘Loneliness and social isolation in the COVID-19 Pandemic among the over 70s: Data from The Irish Longitudinal Study on Ageing (TILDA) and ALONE’, *The Irish Longitudinal Study on Ageing*, July 2020.

²⁵ D. Lynch, M. Morgan, B. Leen and N. Cole, ‘Evidence summary: What impact is cocooning and the increased level of anxiety due to COVID-19 having on the mental health of those identified as at-risk due to a chronic disease [immunocompromised]? What interventions have been identified and deemed efficacious? [v1.0]’ *Health Service Executive*, 2020.

²⁶ T. Frawley, F. van Gelderen, S. Somanadhan, K. Coveney, A. Phelan, P. Lynam-Loane and A. De Brún, ‘The impact of COVID-19 on health systems, mental health and the potential for nursing’, *Irish Journal of Psychological Medicine* (2020), <https://doi.org/10.1017/ipm.2020.105>.

COVID pandemic may have intensified these concerns.²⁷ Furthermore, a myopic focus on COVID risks ignoring elders’ mental wellbeing. This approach can be contrasted with that of the Danish Health Authority, for example, which did not recommend cocooning, noting that:

It is important to balance measures to reduce the risk of infection with regard to quality of life. People at increased risk, who are in the last part of their lives, often have a great need to make the most of the last time with their loved ones. Here, the consideration of quality of life may outweigh the consideration of reducing the risk of infection, and it may be considered to follow the above precautions only to the extent that it is deemed not to go beyond personal contact.²⁸

Furthermore, the June 8 regulations govern vulnerable persons separately: individuals were ‘permitted’ to visit the home of a vulnerable person for social or recreational purposes and gather with a vulnerable person and a maximum of four other persons.²⁹ Although part of the regulation, these provisions are advisory and unenforceable but again risk inferring that cocooning was legally mandated by the regulations. Similarly, the advice from 15 June refers to cocooning ‘restrictions’, although they were not mandated by law. We also submit that the Act did not create a legal basis for prohibiting or permitting individuals from visiting the residences of specific groups.

Box 3. HSE Guidelines on movement directed at very high risk groups
27 March – 5 May 2020: ‘you should stay at home at all times for two weeks and avoid face to face contact. Do not go outside your home and garden. Do not have visitors, except for essential services or attend gatherings.’
10 April – 5 May 2020: ‘You need to cocoon if...’.
5 May 2020: those at very high risk are ‘strongly advised to stay at home and avoid face to face contact’.
7 May 2020: ‘you may go for a short drive if you stay within 5km from your home, only share a journey with someone who is also cocooning in your home’.
18 May 2020: vulnerable people can meet outdoors with small groups of up to four people for short periods
15 June 2020: ‘there has been some easing of the cocooning restrictions, Up to 6 people can now visit you or you can visit another household’, Wear a face covering when meeting indoors and ask others to wear a face covering.
20 July 2020: small group gatherings (no mention of 6) permitted.

²⁷ E. Cahill, L. M. Lewis, F. K. Barg, H. R. Bogner, ‘‘You Don’t want to Burden Them’: Older Adults’ Views in Family Involvement in Care’, *Journal of Family Nursing* 15(3) (2009) 295-317, <https://doi.org/10.1177/1074840709337247>.

²⁸ Sundhedsstyrelsen, Håndtering af COVID-19, *Anbefalinger til personer i øget risiko*, 4 May 2020, NACL Sagsnr. 04-0100-380 p. 9.

²⁹ S.I. No. 206/2020 - Health Act 1947 (Section 31A - Temporary Restrictions) (Covid-19) (No. 2) Regulations 2020.

31 August 2020: persons at high risk were advised to try to limit contacts to six people.

Finally, we suggest that cocooning must be viewed in light of the (neo)liberal welfare state model that the Irish state has adopted, where availability of hospital beds and doctors are below the OECD average.³⁰ For example, the state has previously been warned that more healthcare personnel need to be employed to meet demand.³¹ Universal healthcare is not guaranteed and it has been consistently stated that the healthcare system is in need of drastic reform.³² These governance failures can heighten dependencies and the need to ‘cocoon’; citizens are forced to retreat indoors as the healthcare system cannot meet its purpose. With better investment in health systems and home care, would elders have needed to cocoon?

Likewise, although since the 1960s the political intention purports to be keeping individuals at home for as long as possible, there is a documented lack of homecare support from the state. State aid is targeted at basic needs, such as mobility and ability to feed and bathe oneself unaided. It has been suggested that the average hours of public home help provided is a mere 4 hours a week.³³ There is no right to home help; once the home help budget is exceeded, elders often wait many months before the care begins.³⁴ This eerily coincides with the British approach to poor relief in the 1700s, while in England the destitute had a right to care, the Irish did not.³⁵ Timonen et al. align the lack of home care supports with the influence of Catholicism on Irish society, in particular the principle of subsidiarity, whereby care is the responsibility of the family, not the state.³⁶ While we recognise the desire of family to care and be cared for, we suggest that the lack of state support can have implications for the level of medical care that elders receive and gendered costs for family carers. In Ireland, lack of home help has long been blamed for ‘delayed discharge’, i.e. persons staying in hospital longer than needed, which places strain on the health system.³⁷

3.3. Preliminary Conclusion

From 8 April 2020, all individuals present in Ireland were ordered to remain in their residence unless they had a necessary purpose for leaving. We have highlighted that from the perspective of foreseeability, this approach raised several concerns that could breed confusion

³⁰ OECD (2019), ‘Hospital beds, 2000 and 2017 (or nearest year)’, in *Health care activities*, OECD Publishing, Paris, <https://doi.org/10.1787/b5fdb5fe-en>; OECD (2019), ‘Doctors (overall number)’, in *Health at a Glance 2019: OECD Indicators*, OECD Publishing, Paris, <https://doi.org/10.1787/b33ab4c1-en>.

³¹ C. Keegan, A. Brick, B. Walsh, A. Bergin, J. Eighan and M.A. Wren, ‘How many beds? Capacity implications of hospital care demand projections in the Irish hospital system, 2015-2030’, *ESRI research Bulletin*, November 2018.

³² S. Connolly and M.A. Wren, ‘Universal Health Care in Ireland—What Are the Prospects for Reform?’, *Health Systems & Reform* 5(2) (2019) 94-99, <https://doi.org/10.1080/23288604.2018.1551700>.

³³ L. Carter, S. O’Neill, F. Keogh, M. Pierce and E. O’Shea, ‘Intensive home care supports, informal care and private provision for people with dementia in Ireland’, *Dementia* (2019) p. 3, DOI 10.1177/1471301219863580

³⁴ Christina Finn, ‘Home help care supports: How many people are waiting in your country?’, *TheJournal.ie*, 22 July 2019. Retrieved 19 November 2020, www.thejournal.ie/home-help-hour-freeze-4731208-Jul2019/.

³⁵ V. Timonen and M. Doyle, ‘From the workhouse to the home: evolution of care policy for older people in Ireland’, *International Journal of Sociology and Social Policy* (2008) (Available online, www.emerald.com/insight/content/doi/10.1108/01443330810862151/full/html?casa_token=bK6iO7Gb0h8AAA:AA:kXqwJV9gq0qyNO_tz_OnuMojCgwSczzqkSNoleVAutnLhTAptxawLh7l4q-QUTtUA0CVJS3Pb_HgOGwNH1XtfjuT7fGfBmaW15SAmrP5INh4PrdPh_5h, retrieved 19 November 2020).

³⁶ V. Timonen, M. Doyle and C. O’Dwyer, ‘Expanded, but not regulated: ambiguity in home-care policy in Ireland’, *Health and Social Care in the community* 20(3) (2012) 301-318, <https://doi.org/10.1111/j.1365-2524.2011.01048.x>.

³⁷ *Ibid.*

and incorrect application of the law. From a proportionality perspective, the legislation was restrictive of private life, for example, curtailing exercise without outlining the basis for doing so.

Furthermore, the policy of cocooning, although neither mandatory nor subject to sanction, was not transparent. It risked elders being socially stigmatised due to their age (or appearance of old age). We submit that the government and HSE should have intervened earlier to clarify that cocooning was not required but a recommendation. Furthermore, we consider that the risks of cocooning to physical and emotional health are such that it should not be government mandated. Moreover, imposing restrictions is unlikely to protect the health of elders from a long-term perspective. The overarching structures, such as the adequacy of the healthcare system and home help, should not be divorced from discussions on elders during and beyond COVID-19 as they have implications for the need to cocoon.

4. COVID in Nursing Homes

In this section, we examine restrictions on visiting nursing homes before introducing some of the long running structural problems that we argue must also be addressed to ensure a proportionate approach to private and family life.

4.1. Restrictions on Visits

In response to COVID-19, visiting was limited in all nursing homes, which is an interference in the right to private and family life. Visiting restrictions can be a legitimate public health measure however, as the risk of transmission is reduced by limiting the number of persons coming in and out of a residence. At the same time, the limitations on visits appear to have had a deep impact on the elderly, their families and carers. Furthermore, prohibiting visitors does not eradicate *all* risk. Again, we suggest that the proportionality of limitations on private and family life must be reviewed in light of the structural weaknesses that rendered such measures necessary, yet inadequate.

Nursing home residents normally decide who visits them in line with their rights to family and private life. However, nursing homes can prohibit visits that would ‘pose a risk to the resident’ or any other resident, or the resident could request that visits are restricted.³⁸ From 13 March until 15 June 2020 far reaching restrictions were imposed on visits to nursing homes to limit COVID transmission (see box 4).

Box 4 – Restrictions on visiting Nursing Homes
6 March 2020: Private nursing homes ban all visits with exceptions for compassionate purposes
13 March: all nursing homes prohibit visitors except for compassionate purposes
15 June 2020: Each resident can name two visitors, but only one can visit at any one time (should be scheduled)

³⁸ S.I. No. 415/2013 - Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, s. 11(1)-(2).

29 June 2020: Grandchildren may visit but are advised not to hug grandparents ³⁹
21 July 2020: Visits should usually be limited to one hour; 2 visitors at a time
24 August 2020: Visits of up to 4, visitors should wear masks
11 September: 5 level framework released
5 October: all counties enter level 3- visits suspended besides critical/compassionate reasons with window and remote contact advised; critical & compassionate visits open to interpretation, including distress/ exceptional need
22 October: all counties enter level 5- visits suspended besides critical-compassionate reasons; Window and remote contact

4.2. Impacts on Residents

The proportionality of the interference on Article 8 must be examined in light of the burden imposed on elders. While the full impacts are unknown at present, studying the supervisory reports released by the nursing home regulator, HIQA, paints a picture of severe emotional impacts.

Both residents and staff reported experiencing stress. Some residents feared not seeing loved ones again and missed human contact. Meanwhile, staff were no longer able to have physical contact with residents as before. The changes and new barriers between the carers and residents created struggles:

Some residents commented that while it was initially very frightening because they did not know what to expect, now, they have got used to the way things are. For example, they and their carers wearing masks. For others, they considered that as time passed and the pandemic continued it became more frightening because they did not know what the future would be like.⁴⁰

Absolute prohibitions have a heavy toll on residents who are used to regular visits from friends and family:

One resident informed the inspector that she had her first visit from one of her daughters, and while it was wonderful to see her ...the last time she saw her family was in March and as this visit was so short, she said she cried all night following the visit.⁴¹

Alongside restrictions on visits, social events and visits from the community were also cancelled, rendering residents under stimulated and alone. To mitigate the impact, nursing homes organised contactless visits (through windows and remotely). However, these

³⁹ RTE, 'New guidance allows children to visit grandparents in nursing homes', 29 July 2020. Retrieved 19 November 2020, <https://www.rte.ie/news/2020/0729/1156301-nursing-homes-covid-visits/>.

⁴⁰ Health Information and Quality Authority, 'Report of an inspection of a Designated Centre for Older People, Kilbrew Recuberation and Nursing Care', 4 June 2020. Retrieved 19 November 2020, www.hiqa.ie/system/files?file=inspectionreports/143-kilbrew-recuperation-and-nursing-care-04-june-2020.pdf.

⁴¹ Health Information and Quality Authority, 'Report of an inspection of a Designated Centre for Older People, Beaumont Residential Care', 8 July 2020. Retrieved 19 November 2020, www.hiqa.ie/system/files?file=inspectionreports/198-beaumont-residential-care-08-july-2020.pdf p. 5.

measures were not entitlements and were nursing home and resource dependent. Therefore, it was not always possible to facilitate contact due to staffing issues.

We underscore that resident autonomy must be respected, for example, visits should not be surveilled by staff to monitor compliance with guidelines. Likewise, recommendations on distancing/ close contact can and should not be enforced by nursing homes. The approach from June appears more proportionate, allowing individuals to receive visits from at least one family member/friend. This approach, we submit, should be prioritized to avoid violations of family and private life and given that complete isolation from the outside world is neither feasible nor recommendable. In assessing the proportionality of these prohibitions, it must be asked whether the aim of avoiding transmission justifies the emotional and physical harms to elders.

Further, in the assessment of proportionality, one should take into account the structural issues at stake in the elder care sector in general when reflecting on whether less intrusive measures could have replaced visiting restrictions. One should reflect on whether positive measures were (and can be) possible to reduce the individual burden of the visiting restrictions. While not being exhaustive, next we will reflect on several structural issues that may have exacerbated the conditions in nursing home during the COVID-19 pandemic.

4.3. Structural weaknesses

In this section, we emphasise known weakness in Irish nursing homes that should and could have been tackled long before the pandemic and thereby have avoided the perceived ‘need’ to isolate residents. However, our analysis does not claim to comprehensively account for the complex violations that led to an egregious number of deaths in Irish nursing homes.

The reasons underlying the high numbers of deaths in Irish nursing homes are currently not adequately established. However, important variables have been identified: access to personal protective equipment (PPE) and testing, regular screening of staff and residents, rapid isolation, adequate sick leave, training and decent pay for staff and sufficient cleaning and hygiene.⁴² There is disagreement between private nursing homes and the HSE as to the reasons behind the failures. Private nursing homes have suggested they were abandoned by the state, while government ministers inferred that private nursing homes did not use their resources to adequately invest in the necessary provisions.⁴³

The immense loss of lives in Irish nursing homes must be scrutinised and redressed in years to come. For example, the situation in one nursing home was so out of control that the HSE considered calling in the army to meet the needs of the residents. Seventy-one residents were suffering from dehydration due to lack of staff.⁴⁴ Due to self-isolation because of exposure to the virus, the staff was reduced from 104 to 34. A later report found that staff were unable to

⁴² Government of Ireland, Department of Health, 2020, Publication, *COVID-19 Nursing Homes Expert Panel Examination of Measures to 2021 Report to the Minister for Health*, 19 August 2020. Retrieved 19 November 2020 www.gov.ie/en/publication/3af5a-covid-19-nursing-homes-expert-panel-final-report/.

⁴³ Broadsheet.ie, 2020, *Left To Die: Nursing Homes*, 24 June 2020. Retrieved 19 November 2020, www.broadsheet.ie/2020/06/24/left-to-die-nursing-home-timeline/.

⁴⁴ Simon Carswell, ‘HSE considered calling in Army and Red Cross to nursing home Covid-19 outbreak’, *The Irish Times*, 12 October 2020. Retrieved 19 November 2020, www.irishtimes.com/news/health/coronavirus-weekly-testing-of-nursing-home-staff-considered-1.4381071.

work due to long delays in testing.⁴⁵ A subsequent inspection by HIQA identified several staffing issues. Firstly, agency housekeeping was used, meaning that the nursing home was serviced by constantly changing staff who lacked adequate training. Secondly, because of inadequate housekeeping the facility was visibly unclean in May 2020 during an inspection. Thirdly, there was insufficient staff to ensure that residents were self-isolating and residents could have contact with their families or meaningful activities.⁴⁶ Furthermore, HIQA found that there was a delay in reporting the unexpected deaths of residents during the outbreak, contrary to the rules. The (traumatised)⁴⁷ families of the 23 residents who died in early 2020 have requested a public inquiry.⁴⁸

While loved ones were prohibited, employees, such as care workers but also catering staff, continued to come in and out of residential settings. In its report, HIQA noted that ‘inward transmission by staff’ was likely a key source of introduction.⁴⁹ Notably, some staff in nursing homes are asylum seekers who live in ‘direct provision’ (institutional accommodation where residents share rooms and bathrooms).⁵⁰ Thereby, persons living in cramped institutions (the conditions of which have been subject to sustained criticism), with high risks of transmission spent their days caring for elders in similar conditions. Recognising the potential for transmission, the HSE offered a scheme whereby health workers, including asylum seekers, could apply for temporary accommodation.⁵¹ However, this short-term solution fails to address the structures that perpetuate transmission.

The limited possibilities for resident self-isolation may also have been a factor in disease transmission. HIQA has repeatedly raised concerns regarding the standard of care given to elders. For example, in 2017 it underscored that ‘privacy and dignity, safeguarding, good governance and fire safety still need to be addressed among many services’.⁵² Notably, the physical environments sometimes lack privacy for intimate care and personal space to meet visitors. Furthermore, even patients with their own rooms, may be required to sit in communal areas to be monitored by staff due to low staffing levels. In 2015, HIQA commented that residents continue to live in ‘large and outdated open-plan style wards, which give residents little privacy and dignity’.⁵³ While regulations prescribe that all

⁴⁵ Health Information and Quality Authority, ‘Report of an inspection of a Designated Centre for Older People, Dealgan House Nursing Home’, 27 May 2020. Retrieved 19 November 2020, <https://www.hiqa.ie/system/files?file=inspectionreports/130-dealgan-house-nursing-home-27-may-2020.pdf>.

⁴⁶ *Ibid.*

⁴⁷ *Ibid* p. 16.

⁴⁸ Statement from families whose loved ones died during the Covid-19 outbreak in Dealgan House Nursing Home, Dundalk, Co. Louth on the report from the Nursing Home Expert Panel Review Group, see M. O’Driscoll, ‘Families say new report sheds no light on Covid-19 deaths at Dealgan House’, LMFM 2020, 21 August 2020. Retrieved 19 November 2020, www.lmfm.ie/news/lmfm-news/families-say-new-report-sheds-no-light-on-covid-19-deaths-at-dealgan-house/.

⁴⁹ *Supra* note 2 p. 11.

⁵⁰ E. Gusciute, ‘Leaving the most vulnerable behind: Reflection on the Covid-19 pandemic and Direct Provision in Ireland’, *Irish Journal of Sociology* 28(2) (2020) 237-241, DOI 10.1177/0791603520940145.

⁵¹ RTE, ‘85 healthcare workers seek to move out of Direct Provision’, 12 April 2020. Retrieved 19 November 2020, www.rte.ie/news/2020/04/12/1130155-healthcare-workers-direct-provision/.

⁵² Health Information and Quality Authority, *Overview of HIQA regulation of social care and healthcare services 2017*, May 2018 p. 5. Retrieved 19 November 2020, https://www.hiqa.ie/sites/default/files/2018-06/Regulation-overview-2017_0.pdf.

⁵³ Health Information and Quality Authority, *Annual overview report on the regulation of designated centres for older people – 2015*, April 2016 p. 23. Retrieved 19 November 2020, www.hiqa.ie/sites/default/files/2017-02/2016-Overview-Centres-Older-People.pdf.

residents must each have a space of 7.4m² floor space in their rooms, older nursing homes have until 1 January 2022 to comply. From then on, no nursing home bedroom may have more than 4 residents, except high dependency rooms which may not have more than 6 residents.⁵⁴ Many residents do not, and under these regulations will continue not to, have their own room. Cramped facilities can make isolating suspected cases difficult.

The extent to which nursing home residents and their families have access to genuine remedies regarding poor conditions can be questioned. The conditions in one public nursing home are jarring - residents live in two 11-bedded wards with eight residents accommodated in one room, a seven-bedded ward and an eight-bedded room. The centre is permitted to accommodate 38 residents; two showers are available, many residents in shared rooms use bedpans. HIQA has in its last ten inspections found the home 'unfit for purpose'. A strange formulation notes, 'Overall, the arrangements to enable and ensure the provision of residents' rights, privacy and dignity could not be facilitated'. Yet, instead of drastic action, the nursing home (in this case the HSE) has been given deadline upon deadline to improve facilities and failed to do so. As the Ombudsman recently noted, 'there is a big gap in the complaints landscape'; HIQA cannot investigate individual complaints and the Ombudsman's review is limited to administrative law.⁵⁵

The state's failure to meet its obligations in respect to above nursing home is a violation of the residents' private life, and potentially articles 2 and 3 ECHR. The standard of review and sanctions imposed by HIQA are also worryingly light, given that HIQA has the power the close centres. HIQA was established in 2007 in response to institutional abuse in nursing homes and it is vital for elders that the Authority lives up to its mandate. Notably, the size of nursing homes has been associated with higher COVID mortality, not HIQA compliance, which it could be suggested infers that HIQA reviews are not effective in identifying structural problems.⁵⁶

Likewise, there has been a lack of action at the political level; while the Minister has the power to set standards, no regulation has been introduced to specify minimum staffing levels. Instead, facilities determine the number and skill of staff 'is appropriate to the needs of the residents'.⁵⁷ Most staff are not trained nurses and may have been lacking knowledge of infectious disease control. In its COVID review, HIQA found 50% of nursing homes inspected were non-compliant with infection prevention and control.⁵⁸ It can furthermore be questioned whether nursing homes are adequately placed to provide care for those too ill to remain at home. Research suggests that the general standard of medical care in European nursing homes is sub par.⁵⁹

⁵⁴ S.I. No. 293/2016 - Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2016, s. 4.

⁵⁵ Simon Carswell, 'Covid-19: Further powers to investigate complaints over deaths in care sought', *The Irish Times*, 8 September 2020. Retrieved 19 November 2020, www.irishtimes.com/news/health/covid-19-further-powers-to-investigate-complaints-over-deaths-in-care-sought-1.4348808.

⁵⁶ Irish Gerontological Society, 2020, *COVID-19 Deaths in Irish Nursing Homes (new research)*, 6 April 2020. Retrieved 19 November 2020 <https://www.irishgerontology.com/news/latest-news/Covid-19-deaths-irish-nursing-homes-new-research>.

⁵⁷ *Supra* note 38 s. 15(1).

⁵⁸ *Supra* note 2 p. 28.

⁵⁹ R. Briggs, S. Robinson, F. Martin and D. O'Neil, 'Standards of medical care for nursing home residents in Europe', *European Geriatric Medicine* 3(6) (2020) 365-367, <https://doi.org/10.1016/j.eurger.2012.07.455>.

Furthermore, the lack of connection between the public and private systems seems to have hampered communication. As of July 2020, there were 576 registered nursing homes in Ireland, with approximately 32,000 places.⁶⁰ The majority of these homes are privately owned (80%), fuelled by tax incentives provided to developers between 1997 and 2010.⁶¹ This increasing privatisation can be of concern as, in Ireland, as in other countries, privatisation of nursing homes is associated with lower quality of care.⁶² Public nursing homes are run by the HSE, which does not have regulatory powers over private nursing homes. The HSE does not monitor the clinical care provided to residents. Public nursing homes are more expensive for the state due to higher nursing ratios and better working conditions for staff.⁶³ In 2017, HIQA noted that privately owned small, more ‘homely’ care environments are being forced to close as they are not financially feasible.⁶⁴

Side by side the inadequate care for elders, archaic legislation governs the rights of elders without capacity. Five years after adoption by parliament, the majority of the Assisted Decision-Making (Capacity) Act 2015 has still not been commenced.⁶⁵ When commenced, the Act will provide for co-decision making and enduring power of attorney. Until then, in practice, persons with dementia or other cognitive impairments have to be made wards of court, in other words, stripped of the majority of their legal rights, for their affairs to be administrated. HIQA acknowledges that the elderly often end up in institutional care against their will due to lack of support.⁶⁶

5. Conclusions

We write this article as the pandemic continues and the death toll rises. In Ireland, the elderly, in particular those in nursing homes, have been disproportionately affected. While it is too early to draw firm conclusions, we have sought to highlight issues pertaining to foreseeability and proportionality, and how COVID exposes known governance failures.

Firstly, elders living at home and in care settings were subjected to a restrictive approach. The policy of cocooning, as well as a general order to stay at home, is likely to have resulted in loneliness and isolation with potential public health impacts. In the case of those living in adequate conditions, it may however have saved lives. But for many nursing home residents in conditions lacking dignity, they were dangerously exposed.

Secondly, the foreseeability of regulations must be improved. Recommendations must be unambiguously worded as such to avoid misunderstandings. Guidance regarding flexible

⁶⁰ Nursing Homes Ireland (NHI) is the national representative body for the private and voluntary nursing home sector.

⁶¹ J. Mercille, ‘Neoliberalism and health care: the case of the Irish nursing home sector’, *Critical Public Health* 28(5) (2018) 546-559, <https://doi.org/10.1080/09581596.2017.1371277>.

⁶² C. Harrington, F. F. Jacobsen, J. Panos, A. Pollock, S. Sutaria and M. Szebehely, ‘Marketization in Long-Term Care: A Cross-Country Comparison of Large For-Profit Nursing Home Chains’, *Health Services Insights* 10(1-23) (2017), DOI 10.1177/1178632917710533.

⁶³ *Supra* note 61.

⁶⁴ *Supra* note 52 p. 6.

⁶⁵ Assisted Decision-Making (Capacity) Act 2015, 64 of 2015. See further M. Donnelly, ‘The Assisted Decision-Making (Capacity) Act 2015: Implications for Healthcare Decision-Making’, *Medico-Legal Journal of Ireland* 22(2) (2016) 65-77.

⁶⁶ Health Information and Quality Authority, *Exploring the regulation of health and social care services – Older People’s services*, March 2017 p. 13. Retrieved 19 November 2020 <https://www.hiqa.ie/sites/default/files/2017-05/exploring-the-regulation-of-health-and-social-care-services-op.pdf>.

rules must be clear to avoid the same rules being applied differently in comparable situations. Consultation with the public is thereby needed. For example, the prohibition on visiting cemeteries is difficult to justify. The anguish of not being able to perform the ritual of tending to a family member's grave does not seem proportionate in light of the public health aim.

Thirdly, although nursing homes sought to find solutions to the visiting restrictions, such as outdoor visits and remote contact, these approaches are dependent on staffing resources and other underlying structures. The undignified conditions in many nursing homes are not new but were compounded by the pandemic. A long list of recommendations predated the pandemic, such as adequate staffing and improved living conditions. Will they now be addressed?

Finally, we submit that residents' rights should be strengthened. For example, while nursing homes sought to accommodate outdoor visits, these were not always possible due the staffing shortages. Yet, residents have a right to family and private life, which nursing homes have an obligation to respect. Moreover, the state is obligated to protect elder's rights through positive measures. Despite the poor conditions being well known, nursing homes were neglected and instead visitation rights were restricted, instead of immediate investments in adequate infrastructure. When nursing home residents' rights are limited, we note the limited means of redress available.