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**EUROPEAN COMMITTEE OF SOCIAL RIGHTS
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Validity v. Finland
Complaint No. 197/2020

COMPLAINT

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**Department of the European Social Charter
Directorate General Human Rights and Rule of Law
Council of Europe
F-67075 Strasbourg Cedex
E-mail address: social.charter@coe.int**

COLLECTIVE COMPLAINT

Validity v. The Republic of Finland

**on the violation of the rights of persons with disabilities in institutions during the
pandemic**

**Violation of Articles 11, 14 and 15 in conj. with Article E
of European Social Charter**

COMPLAINANT:

Validity Foundation – Mental Disability Advocacy Centre

Address: Impact Hub, Ferenciek tere 2, 1053 Budapest, Hungary

Contact: tel.: + 36 1 780 5493; e-mail: validity@validity.ngo; ann@validity.ngo

Registered foundation number (Hungary): 8689

In partnership with:

Law Firm Kumpuvuori Ltd.

Address: Verkatehtaankatu 4, ap. 228, 20100 TURKU, Finland

Contact: tel.: +358 50 552 0024; e-mail: laki@kumpuvuori.fi

Registration number (Finland): 2715864-1

European Network on Independent Living - ENIL

Address: Mundo J, 7th Floor, Rue de l'Industrie, 1000 Brussels, Belgium

Contact: tel: + 32 2 893 25 83; e-mail: secretariat@enil.eu

Registration number (Belgium): 0628829521

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I. SUMMARY

1. The present complaint deals with a highly urgent topic for present-day Europe: the coronavirus pandemic and the measures adopted by Governments – specifically the Finnish Government – to contain its spread. In Finland, institutions for persons with disabilities shut their doors in reaction to the pandemic in March 2020 and from then until now, they have disabled most contact between their residents and the outside world. This common strategy among European states contradicts the overwhelming evidence that during the pandemic, closed social care facilities become death-traps. Because this issue determines the life and health of many residents of institutions in Finland (and, indeed will have implications across Europe) in the coming period, the complainants request the Committee to treat the current complaint as an urgent one and to adopt a clear stance against confining persons with disabilities inside residential services.
2. The complaint relies on Article 11 in conj. with Article E of the Charter in arguing that the Finnish Government has a positive obligation to protect the life and health of persons with disabilities in institutions. Because institutionalisation increases the likelihood of contracting and dying from the virus, to uphold this obligation, the Government should urgently accelerate deinstitutionalisation to support persons with disabilities in the community, instead of isolating them in confined spaces. Similarly, Article 11 in conj. with Article E of the Charter obliges Finland to adopt measures that ensure non-discriminatory access to health care for persons with disabilities during the pandemic. The Finnish Government adopted no such measures, thus violating Article 11 of the Charter.
3. Further, the complaint invokes Articles 14 and 15 in conj. with Article E of the Charter, which enshrine the rights of persons with disabilities to be provided with social services that foster their independence and inclusion in the community. The restrictive measures adopted by the Finnish Government strike at the core of these rights – they led to the isolation of persons in ‘housing service units’, away from their family, friends and community. They were not adopted in line with the conditions necessary to justify limitation of rights enshrined in the Charter and represent, likewise, an impermissible retrogression in the implementation of these rights. They are not based on law, cannot be considered reasonable or necessary in the given situation, and they are based on prejudiced and stereotypical portrayals of persons with disabilities, and thus discriminatory. Even though the measures affected almost solely persons with disabilities, the Government did not involve them in the planning of these measures, did not collect the necessary data showing how many persons will be affected by the measures and ultimately, did not consider their specific needs or the specific impact the

measures would have on them. Each of these failures amounted to a breach of Articles 14 and 15 in conj. with Article E of the Charter.

II. ADMISSIBILITY

a. Standing of Validity

4. Validity Foundation (hereinafter also ‘Validity’), formerly known as Mental Disability Advocacy Centre (MDAC), is an international non-profit, non-governmental organisation. Validity was established in 2002 as a legal advocacy organisation to tackle the generations of isolation, segregation and exclusion faced by people with intellectual disabilities and people with psychosocial disabilities (collectively sometimes referred to as people with mental disabilities). Validity has standing with the European Social Charter collective complaint mechanism until 31 December 2020 and a pending request for renewal of this status.
5. According to Article 3 of the Second Additional Protocol to the Charter, international non-governmental organisations referred to in Article 1(b) may submit complaints only with respect to those matters regarding which they have been recognised as having particular competence. One of Validity’s priorities is to protect, through legal means, the right to health and the right to live in the community of persons with disabilities. To this end, Validity has submitted various complaints to international bodies, including the UN treaty bodies, the European Court of Human Rights, the European Court of Justice, and the European Committee of Social Rights (see, among others, *ERRC and MDAC v. the Czech Republic*, complaint no. 157/2017, decision of 17 June 2020, and *MDAC v. the Czech Republic*, complaint no. 188/2019, pending).
6. Validity is assisted in this complaint by Jukka Kumpuvuori of Law Firm Kumpuvuori Ltd., a law firm specialised in the rights of persons with disabilities in Finland. The law firm was established in 2010. Today, it has around 1,500 ongoing social and health rights litigation cases before administrative courts around Finland. In addition to social and health rights cases, the firm handles discrimination cases for persons with disabilities. The law firm has also submitted the first case on independent living and personal assistance from Finland to the CRPD Committee in 2018, and successfully represented a Finnish case on personal assistance to study abroad before the Court of Justice of the European Union.
7. The complaint is also supported by the European Network on Independent Living (ENIL), an international organization defending the rights of persons with disabilities. ENIL is a Europe-wide network of disabled people, with members throughout Europe. ENIL advocates for Independent Living values, principles and practices, namely for a barrier-free environment, provision of personal assistance support and adequate technical aids, and access to mainstream services and facilities, together making full citizenship of disabled people possible. ENIL works to strengthen the empowerment of

disabled people, mainly through providing resources for peer support and peer-to-peer training.

b. Status of the Republic of Finland

8. This complaint is submitted in writing under Article 4 of the Additional Protocol to the European Social Charter Providing for a System of Collective Complaints and relates to Article 11 of the European Social Charter, which enshrines the right to protection of health, Article 14 regulating the right to social services, Article 15 which introduces the right to independence and inclusion in the community of persons with disabilities, and Article E which prohibits discrimination.
9. The Revised European Social Charter entered into force in Finland on 1 August 2002 and the Government accepted all provisions invoked in this complaint. The Additional Protocol providing for a system of Collective Complaints entered into force on 1 September 1998.

III. SUBJECT MATTER OF THE COMPLAINT

1. INTRODUCTION

10. Towards the end of February 2020, Europe began to be hit by the pandemic of COVID-19 virus (severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)), which has, to this day, affected more than 43 million people globally and caused more than 1 million deaths worldwide.¹
11. Not long after the outbreak of the pandemic, it became clear that the coronavirus pandemic poses particular danger to the health and life of persons with disabilities who live in social care facilities. Institutions have become COVID-19 hotbeds, increasing all risks associated with the spread of the virus.² The highest rates of infection and mortality from COVID-19 are among persons residing in these institutional settings,³ representing, according to available data, between 19-72 % of victims of the virus.⁴
12. The Finnish Government, just like several other Governments in Europe, reacted to this dire situation by shutting down nearly all contact between persons with disabilities in

¹ The current data is available at: <https://www.worldometers.info/coronavirus/>.

² OHCHR, Covid-19 and the rights of persons with disabilities: guidance, March 2020, available at: https://www.ohchr.org/Documents/Issues/Disability/COVID-19_and_The_Rights_of_Persons_with_Disabilities.pdf, p. 3; see also Fundamental Rights Agency, Coronavirus pandemic in the EU – fundamental rights implications, June 2020, available at: <https://fra.europa.eu/en/themes/covid-19>; and National Council on Disability, Preserving our freedom: ending institutionalization of persons with disabilities during disasters, p. 32-33.

³ A. Comas-Herrera et al. (2020), 'Mortality associated with COVID-19 outbreaks in care homes: early international evidence,' as cited in United Nations, Policy Brief, A Disability-Inclusive Response to COVID-19. May 2020. Available at: <https://www.un.org/en/coronavirus/disability-inclusion>, p. 5.

⁴ Ibid.

social care facilities and the outside world. They strictly and explicitly prohibited⁵ visits to the institutions, a measure which eventually led to prohibiting residents from leaving the institutions. Moreover, the prohibition of visits inside the institutions led to prohibition of contact by residents with the health and social service professionals who provide their services in residential units.

13. While the Government tried to justify the restrictive measures by the need to protect the lives and health of the residents and of society as a whole, their impact was the contrary: the isolation exposed persons with disabilities to higher risks of contracting the virus and death. This complaint presents reliable information demonstrating that congregate residential units are dangerous environments during the pandemic, not safe havens. Confined facilities make it impossible to physically distance and often, to implement basic hygiene measures. People living in such residences also have limited access to relevant information about protection against the virus. They have restricted access to testing. Often, they are discriminated against in accessing health care once they contract the virus.⁶ Rather than protecting the lives and health of people living in these settings, the measures placed them at increased risk.
14. Further, the measures led to an almost complete isolation of persons with disabilities in these facilities, depriving them of contact with their families, friends and communities, as well as necessary support services, personal assistance, rehabilitation, habilitation and medical services that helped them carry out their day to day lives. The situation was more difficult because the Finnish Government did not adopt any specific protective measures to support persons with disabilities in this situation. Arguably, this is largely because persons with disabilities were, for a long time, excluded from the planning for the pandemic response and there was no data related to the impact of the pandemic on persons with disabilities, including data on response measures. Relevant data has not been gathered and analysed by the Government.
15. This complaint first describes the measures adopted by the Finnish Government, both as presented in the legislation and applied in practice, and their impact on persons with disabilities in affected residential settings. The second part of the complaint details the legal argumentation, asserting that the Government did not uphold its obligations to protect and respect the life and health of persons with disabilities during the pandemic and ensure them equal access to health care services, as required by Article 11 of the Charter. Instead, the Government adopted discriminatory restrictive measures, targeting solely persons with disabilities, which violated their rights under Articles 14 and 15 in conjunction with Article E of the Charter.

⁵ 'Visits to housing service units of the elderly and other risk groups will be prohibited.' Press release of the Government on 16 March 2020. Available at: <https://valtioneuvosto.fi/-/10616/hallitus-totesi-suomen-olevan-pojikkeusoloissa-koronavirustilanteen-vuoksi>.

⁶ For example, there was a heated discussion in March-April 2020 in Finland on a case where the University Hospital of Tampere made a decision that an 8-year old child with multiple disabilities would not be given ventilation if their condition deteriorated. According to the family, when the decision was taken, the doctor referred to the Covid pandemic: <https://yle.fi/uutiset/3-11292537>.

16. The facts in this complaint are based on information communicated by the Government, and both public and private service providers, translated in their relevant parts from Finnish to English for the purposes of this complaint and annexed in Finnish. They are equally based on information received by the Law Firm Kumpuvuori Ltd. which has been receiving alarming messages of violations of the human rights of persons with disabilities during the pandemic.

2. THE MEASURES ADOPTED IN REACTION TO THE PANDEMIC

17. The COVID-19 pandemic began to spread in Finland at the end of January 2020. The Government adopted several measures as a response, including measures which aimed to prevent the spread of the disease in so-called ‘housing service units’, residential social-care facilities of institution-like character.
18. On 4 March 2020, the Ministry of Social Affairs and Health addressed an Information Note to municipalities related to the COVID-19 situation in which it emphasised the importance of protecting persons with disabilities in social services and informed the municipalities that forms were being prepared for decisions on quarantine and isolation. (Annex 1).
19. On 16 March 2020, the Finnish Government issued a strong recommendation for housing service units to introduce visiting prohibitions, which was in practice interpreted as a *de facto* prohibition to leave the units as well as a *de facto* prohibition on visits to the units by health care and social services professionals (Annex 1).⁷
20. Such prohibitions were only introduced (aside from in health care units such as hospitals) in residential social services – the housing service units. General quarantine, prohibiting all citizens from leaving their homes, or a general prohibition on visits, did not apply in Finland beyond these facilities. The general public was subject to temporary prohibition of public gatherings exceeding 10 persons and temporary closure of schools. The Government also issued a recommendation for persons above 70 to stay at home during the exceptional period (Annex 1).
21. It is worth noting that none of the below described measures adopted during the pandemic contain a definition of an ‘at-risk group’, although this formulation is often invoked in the information notes and guidance for services providers. The website of the National Healthcare Agency lists types of persons considered to be at risk, which does not include persons with disabilities.⁸ Similarly, the Minister of Justice, Anna-Maja Henriksson, declared in an interview in Helsingin Sanomat on 23 May 2020: “*Disabled persons do not as such belong to an at-risk group, unless the person specifically has a disease due to which that would be the case.*” (Annex 1).

⁷ ‘Visits to housing service units of the elderly and other risk groups will be prohibited.’ Available online at: <https://valtioneuvosto.fi/-/10616/hallitus-totesi-suomen-olevan-poikkeusoloissa-koronavirustilanteen-vuoksi> and <https://valtioneuvosto.fi/documents/10616/21411573/Hallituksen+linjaamat+toimet+1603.pdf/887504b5-4969-aa37-541e-645e3390f6fc/Hallituksen+linjaamat+toimet+1603.pdf?t=1584446492000>.

⁸ Available online at: <https://thl.fi/en/web/infectious-diseases-and-vaccinations/what-s-new/coronavirus-covid-19-latest-updates/risk-groups-for-severe-coronavirus-disease>.

a. Prohibition of visits by family members

'Clubs and meetings with friends were cancelled and weekly weekend visits with parents were denied'

A family member of a person with disability

22. On 16 March 2020, the Finnish Government issued a strong recommendation for housing service units to introduce visiting prohibitions for all their residents (Annex1).⁹
23. On 20 March 2020, the Ministry of Social Affairs and Health enacted instructions on COVID-19 tailored to the State of Emergency situation, clearly authorising institutions to install visiting prohibitions. The instructions invoke Section 17 of the Communicable Diseases Act as the legal basis for such prohibition (Annex 1).¹⁰
24. The visiting prohibitions factually entered into force immediately and stayed in force, through various instructions and recommendations, until at least the end of June 2020, and even beyond, in various forms.
25. On 1 April 2020, the Ministry of Social Affairs and Health enacted additional instructions which informed service providers that freedom of movement of persons with disabilities can be restricted on the basis of the Communicable Diseases Act (no. 1227/2016) and the Emergency Powers Act (no. 1552/2011). The instructions emphasised, at the same time, that such restrictions cannot be based on the Act of Services for Persons with Intellectual Disabilities (no. 519/1977) (Annex 1).
26. On 9 April 2020, the Ministry of Social Affairs and Health issued new instructions to municipalities and service providers, tightening prohibitions and the scope of decision of the concerned entities: *"The main rule is that visits are prohibited in the units. (...) The leader of the unit has the discretion and responsibility for the case-by-case assessment."* (...) *'Group activities need to be avoided and visits of residents of a unit to other units are prohibited, including inside the same unit. Close ones are encouraged*

⁹ 'Visits to housing service units of the elderly and other risk groups will be prohibited.' Available online at: <https://valtioneuvosto.fi/-/10616/hallitus-totesi-suomen-olevan-poikkeusoloissa-koronavirustilanteen-vuoksi> and <https://valtioneuvosto.fi/documents/10616/21411573/Hallituksen+linjaamat+toimet+1603.pdf/887504b5-4969-aa37-541e-645e3390f6fc/Hallituksen+linjaamat+toimet+1603.pdf?t=1584446492000>.

¹⁰ The text states:

'Prevention of infections in units of social and health care is regulated in Section 17 of the Communicable Diseases Act. (...) The head of the unit can set a visiting prohibition.'

'Visiting prohibition to 24/7 care units. Municipalities are urged to instruct, within their territories, both their own and private 24/7 care and service units on needed preventive measures in the units (The Communicable Diseases Act Section 17). As a specific preventive measure, municipalities are urged to instruct the heads of units of 24/7 care units in their territories to adopt visiting prohibitions to the units. Based on these visiting prohibitions, all other visits to units of social and health care (hospitals, care units, housing service units) that are not considered inevitable will be prohibited. It is possible to allow, on a case-by-case assessment, visits of closest ones of the critically ill, children or persons in palliative care (without symptoms), as well as the spouses or support persons to delivery ward. The visiting prohibition will come into force immediately and will be in force until the 13 April 2020, at this first stage. Clients with symptoms in units shall be taken care of in their own rooms unless their condition necessitates hospital ward.'

to be in touch with the client through phone, distance connection, e-mail, or letter.' (Annex 1).

27. On 16 April 2020, the Ministry of Social Affairs and Health, also referencing Section 17 of the Communicable Diseases Act, issued another instruction allowing heads of units to implement visiting prohibitions. Municipalities were urged to instruct the heads of housing service units in their territories to adopt visiting prohibitions. This resulted in the continuation of the prohibition of all visits except visits by closest ones to the critically ill, children or persons in palliative care - without symptoms - as well as spouses or support persons, which could be authorised on a case-by-case basis. The instruction given on 16 April was in force until 13 May 2020 (Annex 1).
28. On 4 May 2020, the Government website updates included information on the prohibition on visits: *'Visiting restrictions in units of social and health care are in force for the time being and the matter will be next evaluated by the end of June. For example, in care units, new practices to enable safe social contacts are being explored.'*
29. On 6 May 2020, the Government prolonged the visiting restrictions until June 2020, invoking Section 17 of the Communicable Diseases Act: *'Visits to units of social and health care are restricted based on units' own decisions as per Section 17 of the Communicable Diseases Act. The restrictions will be in force for the time being and the matter will be assessed again before the end of June. On a case-by-case assessment, visits by closest ones to the critically ill, children or those in palliative care (without symptoms), as well as the spouses or support persons to delivery ward can be authorised.'* (Annex 1).
30. On 15 May 2020, the Ministry of Social Affairs and Health issued an instruction to municipalities encouraging housing services units to enable residents to contact their loved ones as an exceptional measure, while emphasising the 'general rule' character of the visiting prohibition.¹¹
31. On 16 June 2020, the Ministry of Social Affairs and Health issued an instruction note on visits to units of social and health care. Even at this stage, the Ministry advised that the visiting prohibition is based on Section 17 of the Communicable Diseases Act. (Annex 1).

¹¹ *'It is the main rule still that visits to 24/7 care units are prohibited. (...) The abnormal situation has been going on for a long time, and therefore there is a need to establish mechanisms that enable the meeting of close ones to clients/patients face to face in safe environments arranged by the units. Close ones are encouraged to be in contact by phone, distance connections, e-mail or letter. The staff of the units need to support the clients in keeping connections. The elderly and part of persons with disabilities have, because of visiting prohibitions, been a long time separated from their close ones, which makes their quality of life lower in addition to being a phenomenon difficult to understand for many clients. The units need to adopt various measures to enable contacts between clients and their close ones. The units can, for example, establish sheltered meeting places/rooms, where contact with the close ones can be safely established. They can be, for example, separate modules, installed inside the unit in a safe place, such as the lobby or outdoor units.'* *'The mandate of the instruction is the obligation of the Communicable Diseases Act (1227/2016) to take measures that hinder the spread of infections.'*

32. Following the Cabinet's consistent rule-like 'advice' on visiting prohibition, since 16 March and repeatedly during the following period, six major Finnish cities – Helsinki¹², Espoo¹³, Tampere¹⁴, Vantaa¹⁵, Oulu¹⁶ and Turku¹⁷ - adopted and implemented the Cabinet's instructions on visiting prohibitions and clearly prohibited visits to persons with disabilities in housing service units in their own terms. Further, private service providers nationwide also adopted the Cabinet's instructions on visiting provisions prohibiting visits to the units (Annex 2).¹⁸

¹² 'Housing services of persons with disabilities. In housing service units all visits are prohibited.' (internet 19.3.20, last accessed 27.10.20) Annex 3.

¹³ 'Visits to care homes, housing units and the Hospital of Espoo are not allowed due to the prevention of corona infections, until further notice.' (internet 9.4.2020) Annex 3.

¹⁴ 'We strongly recommend housing service units to consider very seriously whether to welcome guests to group homes and wards.' (Information Note of disability services 12.3.20) Annex 3.

'Visiting prohibitions are in force in housing service units until further notice.' (Information Note 16.3.20)
'Visiting prohibitions based on corona are prolonged until 13.5, based on the information currently available' (22.4.20) Annex 3.

'Visits to housing service units are still prohibited, this is the main rule. Visits can be arranged outside or in designated facilities.' (4.6.20) Annex 3.

'All visits of outsiders to (...) housing service units (...) are prohibited.' (internet 31.5.20) Annex 3.

¹⁵ 'Based on the Government's exception law, visits to units are mainly prohibited.' (instruction of social care 17.4.20) Annex 3.

¹⁶ 'The City of Oulu mandates the service providers to obey the 20.3.20 Instruction of the Ministry of Social Affairs and Health on COVID-19 based State of emergency in basic level social and health care services.'

'As a special preventive measure, the City of Oulu urges the heads of the units to set a visiting prohibition.' (information note of the welfare services 26.3.20) Annex 3.

'According to the note to authorities by the Ministry of Social Affairs and Health visits to units are still mostly forbidden.' (instructions of the welfare services 24.6.20) Annex 3.

¹⁷ 'All types of visits are to be restricted, especially if the clients belong to a group at risk.' (welfare services 12.3.20) 'Meetings can be arranged in hallways of units or through windows at a given time given from and under the supervision of a nurse. The length of the meeting is ½ hours. Discussion takes places through window' (letter from the head of services of the elderly and persons with disabilities, 19.5.20) Annex 3.

¹⁸ The following are examples of such provisions:

'According to the instruction to authorities on 15.5. given by the Ministry of Social Affairs and Health, visiting prohibitions are still in use in units.' (instruction to supervisors, private service provider A, 29.5.20) Annex 2.

'Group visits from and to units are cancelled. Also, other visits need to be seriously considered and postpone all visits that are not of immediate necessity.' (instruction, private service provider B, 12.3.20) Annex 2.

'Group visits from and to the unit are cancelled. Other visits need to be seriously considered and move all such visits, that are not right now necessary, to a later stage.' (instruction, private service provider B, 12.3.20 > in every information note until 29.5.20) Annex 2.

'Dear visitor, based on the decision of the Cabinet on 16.3.2020: All visits to our housing service units are prohibited for the time being.' (note to visitors, private service provider C, 16.3.20) Annex 2.

'We are still careful, and the visiting prohibition is still in force in the units, according to the instructions of the Ministry of Social Affairs and Health.' (Corona-handbook, private service provider C, not dated) Annex 2.

'The visiting prohibition is still in force.' (e-mail to supervisors, private service provider C, 16.6.20) Annex 2.

'Visits to care homes are still mainly prohibited. (...) Visits are still arranged primarily outdoor, following safety measures, in separate meeting spaces or through electronic channels.' (e-mail to supervisors, private service provider C, 26.6.20) Annex 2.

'According to the information from the authorities, it might be necessary today to restrict the freedom of movement of those in housing service.' (e-mail to personnel, private service provider D, 20.3.20) Annex 2.

'The line of reasoning of E. Ltd. is to follow and obey the recommendations of the authorities that have the mandate'. (...) Visits to units will be prohibited.' (Information Note to customers and their close ones, private service provider E, 17.3.20) Annex 2.

'We confirm that based on the instructions of the Cabinet on 6.5.20, the binding instructions given by the Ministry of Social Affairs and Health on 13.5.20, and the instructions given earlier by the authorities and those paying for the services, the protective and restrictive measures in use at E. Ltd. will continue for the

b. Prohibition on leaving all housing service units

'Closing doors took place rapidly and it was a total lock-down.'

Family member of a person with disability¹⁹

33. In practice, the visiting prohibitions introduced on 16 March 2020 (see above § 22) were also applied, by both public and private service providers, as a prohibition on leaving the institutions or their surroundings.

34. The prohibition on leaving the residential premises of housing service units was consequently adopted in at least five cities: Helsinki²⁰, Espoo²¹, Tampere²², Vantaa²³ and Oulu²⁴ (Annex 3). The prohibitions were applied by public and private service providers service providers alike.²⁵

time being. (...) Visits in the units are prohibited. (Information Note to customers, private service provider E, 15.5.20) Annex 2.

'The Cabinet recommends that in 24/7 units, the access to client facilities are restricted to the personnel of the unit.' (Information Note to customers, private service provider E, 23.6.20) Annex 2.

'Visits to F-homes are prohibited for the time being.' (website of private service provider F, 17.3.20) Annex 2.

'The visiting prohibition concerning the housing service units of the elderly and other risk groups given by the Cabinet of Finland is still in force.' (Information Note of private service provider G, April-early May, undated) Annex 2.

'Other recommended outside meetings are coming to greet behind window, when connection can be made with phone between the client and the close one.' (Information Note of private service provider G, 13.5.20) Annex 2.

'Even though visits to our units are not possible at the moment (...).' (Information Note of private service provider H, undated, March-April 20) Annex 2.

'Visitors. For the time being, we do not welcome visitors from outside in our units' (Information Note of private service provider I, 2.4.20 Annex 2.

¹⁹ See Annex 4.

²⁰ *'Visits to malls and other places with increased risk of corona virus are to be avoided as well. One may be outside, if one can avoid near-by contacts and hold the recommended 2-meter safety distance to other people.'* (Note on disability services in exceptional circumstances, 3.4.20) Annex 3.

²¹ *'The city of Espoo strongly recommends to clients and their families not to take home leaves until the situation gets better.'* (internet 9.4.20) Annex 3.

²² *'It is also strongly recommended that residents do not visit their close ones. (...) It is wished that close ones tell the personnel where the resident has been during the leave and who she/he has met.'* (information note, 22. 4. 20) Annex 3.

²³ *'In care homes and hospitals there is a visiting prohibition, but we recommend the clients not take-home leaves in other housing service units, as well.'* (Information Note, date not available) Annex 3.

²⁴ *'The City of Oulu urges, for the time being, to avoid visits outside the units.'* (Information Note to service providers, 26.3.20)' Annex 3.

²⁵ Instructions from private service providers on the prohibition on leaving housing service units:

'The main rule is that visits outside homes are restricted' (...) Home leaves are cancelled during this exceptional period. In order to visit family members outside the unit, persons whose homes are located in a housing service unit, must consult with the service supervisor.' (instruction note, private service provider A, 3.4.20) Annex 2.

'Group visits from and to units are cancelled. Other visits, ones that are not of immediate necessity, need to be seriously considered and postponed.' (instruction, private service provider B, 12.3.20) Annex 2.

'Regarding special care groups, personnel insist on clients not to take home leaves and visit their homes located outside units, to avoid contaminating the unit with the virus. Clients are told that home leaves will not take place, for their own safety.' (Corona-guide, private service provider C, not dated) Annex 2.

'Close ones of clients are encouraged to keep in contact through phone and other communication forms.' (information note to clients and their close ones, private service provider E, 13.3.20) Annex 2.

35. Persons with disabilities residing in the housing service units, at least in the cities listed above, were prohibited from leaving the facilities or their surroundings even for a brief period. Factually, they were detained in the facility which was supposed to be their home. This situation lasted at least until the end of June 2020.

c. Prohibition of visits by professionals

'Physiotherapy ended; the visits of support person were denied.'
Family member of a person with disability

36. The general and absolute character of these measures led social care providers to implement them generally as no-exception measures, applying also to professionals providing health care and other forms of support. The service providers, again both public²⁶ and private²⁷, in the major cities in Finland interpreted the Government's instructions as mandatory and extended the prohibitions of visits to health professionals and personal assistance.
37. The provision of these basic services was factually disabled for a period of at least three months. This interference continued to be commonplace in practice, despite the Ministry of Social Affairs and Health's instruction of 1 April 2020 stating that the visiting

'Our clients' visits and leaves to their close ones and friends are postponed, until the corona virus epidemic spread slows down, and visiting is safe.' (information note, private service provider F, 17.3.20) Annex 2.

'Virtual meetings are priority, with phone or tablet' (information note private service provider G, 13.5.2020) Annex 2.

'We hope that you are in contact to your close ones through for example phone or video calls.' (information note of private service provider H, undated, March-April 20) Annex 2.

²⁶ Examples of these measures as formulated by the concerned authorities in different Finnish cities:

1. Helsinki

'The prohibition of visits applies also to personal assistance. Personal assistance must wait for the client outside the housing services unit on agreed time.' (internet 31.5.20) Annex 2.

2. Espoo

'The visiting prohibition does not apply to necessary rehabilitation services such as physiotherapy and occupational therapy services. The principle is that close-contact rehabilitation is used only when it is strictly necessary. Distance rehabilitation is primary'. (Decision of the Head of Disability Services, 29.4.20, referring to the guidance of the Ministry of Social Affairs and Health) Annex 2.

3. Tampere

'We strongly recommend that housing service units consider welcoming external visitors to group homes and wards. By external visitors we mean close ones, artists, barbers, foot carers etc., whose visit cancellation does not cause a situation of danger to the client.' (Information Note of disability services, 12.3.20) Annex 2.

4. Vantaa

'Also, the visits of personal assistants to housing service units are to be avoided.' (information note 23.3.20) Annex 2.

5. Turku

'Visits of personal assistants to housing service units are to be avoided.' (information note 24.4.20) Annex 2.

²⁷ Private service providers also restricted the access of key professionals to housing service units:

'The assistant cannot go inside the unit but needs to wait outside for the client.' (staff meeting brief, private service provider H, 18.3.20) Annex 2.

'Visitors. For the time being, we do not welcome visitors from outside in our units. This applies also to physiotherapists (...)' (Information Note of private service provider I, 2.4.20) Annex 2.

prohibitions should not apply to rehabilitation services, therapy, or personal assistance Annex 1).

d. The overall planning of the response to the pandemic

38. From the outset, persons with disabilities and civil society expressed their concern and disagreement with the above measures. Law Firm Kumpuvuori Ltd., which supports Validity in submitting the current complaint, received alarming messages about the living conditions of persons with disabilities in the housing service units due to the restrictive measures.

'My grandson has Asperger and intellectual disability, and he lives in a supported living apartment. Visiting prohibitions were introduced to the unit. Residents could go out only with staff. Family members were not allowed to visit. Earlier, he used to do their weekly grocery shopping with his mother. The prohibition led to an arrangement that family members took care of the shopping and then delivered the grocery to the door of the unit.'

E-mail to Law Firm Kumpuvuori Ltd. from the grandmother of a person with Asperger and intellectual disability on 28 May 2020.²⁸

'I am the mother of an adult with disability. She has lived in the same premises for 31 years. It hosts at the moment more than twenty residents. The closing of doors took place suddenly and it was a total lockdown. Us, parents, went a couple of times to deliver things and greetings through the crack of a door. Physiotherapy ended, the visits of support were denied, clubs and meetings with friends were cancelled and also regular weekly visits to parents were forbidden. It was not possible to visit a barber. The visiting prohibitions were justified by the UNCRPD Article 11, other Articles were not mentioned. Of course, we obeyed. Communication took place with phone. These conditions took place for 11 weeks.'

E-mail to Law Firm Kumpuvuori Ltd. from the parent of an adult with disability residing in a service housing unit on 29 May 2020.²⁹

'I live in a housing service unit, inside a normal apartment house, and we still have visiting prohibitions. In the beginning, they also attempted to forbid me from leaving and even now I am obliged to tell where I am going and with whom. In addition, I need to apply for permit from the head of the unit for special occasions.'

E-mail to Law Firm Kumpuvuori Ltd. from an adult with a disability on 3 June 2020.

39. Inclusion Finland KVTL, the Finnish Association of Intellectual and Developmental Disabilities, and Inclusion Finland FDUV posted their policy brief/statement on 8 May

²⁸ See Annex 4.

²⁹ See Annex 4.

2020: ‘Organisations of persons with intellectual disabilities: Movement restricted unlawfully in disability services’. According to the statement, ‘*Movement restrictions during the corona pandemic are applied in a very varying ways in disability services, partly unlawfully.*’³⁰

40. In May 2020, Law Firm Kumpuvuori Ltd. requested an estimate of the number of persons with disabilities affected by the prohibitions on visits to housing service units from the Finnish Institute for Health and Welfare as well as the Ministry of Social Affairs and Health information. Similarly, they requested information about whether the Government had such estimates prior to adopting the measures in March 2020. Both authorities redirected the complainants to public websites listing the number of clients in housing service units in the previous years: approximately 15,500 persons in 2018 and 15,660 persons in 2017.³¹ The current number of clients was not provided. The Finnish Institute for Health and Welfare admitted even as late as 29 May 2020 that they did not have information on the number and categories of housing service units affected by visiting prohibitions or the number of persons affected by such measures. Similarly, neither the Finnish Institute for Health and Welfare, nor the Ministry of Social Affairs and Health was able to present, upon the request of Law Firm Kumpuvuori Ltd., the number of infected people or deaths in housing service units as late as the date of submission of the instant collective complaint.³²
41. On 29 May 2020, Law Firm Kumpuvuori Ltd. requested that the Finnish Institute for Health and Welfare, and the Ministry of Social Affairs and Health gather the missing data. On 1 June 2020, the Ministry for Health and Social Affairs responded negatively, referring the firm to its previous answers. Also, the Finnish Institute for Health and Welfare has not been able to answer to the questions asked (Annex 4).
42. Public authorities did not have the most basic data to be able to ascertain how many people will be directly affected by their restrictive measures before acting. Based on the complainants’ estimates, however, the number of persons with disabilities using housing services is approximately 15,500. A small proportion, not larger than 1/3 of these users, are provided housing services in their own home, while the remaining users are provided services in the housing service units directly affected by the prohibitive measures. The complainants therefore estimate that the number of persons affected by the measures ranges between 10,000 and 15,000 persons.
43. Moreover, prior to the adoption and implementation of the measures in response to the pandemic, the Government did not consult persons with disabilities or their representative organisations. On 29 April 2020, the Ministry of Social Affairs and Health, and the Ministry of Economic Affairs and Employment created a consulting body to plan measures to contain the coronavirus pandemic. The body was constituted

³⁰ Available online in Finnish at: <https://www.kehitysvammaliitto.fi/liikkumista-rajoitetaan-lainvastaisesti-yammaispalveluissa/>. Also see Annex 4. The English quote is a direct, unofficial translation from Finnish.

³¹ The webpage is available in Finnish at: <https://sotkanet.fi/>. Also see Annex 4.

³² See Annex 5.

of seven experts from various fields. No person with disability was represented in the group. It was only after public discussion and a complaint submitted by a person with disability to the Chancellor of Justice, that the group was, in mid-May 2020, complemented by a representative from the Finnish Disability Forum.³³

3. THE DOMESTIC LEGAL AND POLICY FRAMEWORK

a. The legal framework

44. The provision of housing services to persons with disabilities in Finland is regulated mainly by the Intellectual Disabilities Act (no. 519/1977) and the Act on Disability Services (no. 380/1987).³⁴
45. During the pandemic, the Finnish Government referred to the Emergency Powers Act (no. 1080/1991) and used the ‘emergency’ terminology to justify its measures. The Emergency Powers Act, however, does not contain provisions that allow restriction of movement as announced by the Government.³⁵
46. Lastly, the Finnish Government explicitly invoked the Communicable Diseases Act (no. 1227/2016) as the basis for the adopted measures, namely the prohibition on visiting housing service units, in practice also interpreted as a prohibition on leaving. The objective of this Act is to prevent communicable diseases and their spread, as well as to prevent the harmful effects caused by these diseases to people and society. The Communicable Diseases Act includes several norms invoked by the Government in relation to the adopted measures, in particular: ³⁶

‘Section 17

Prevention of healthcare - associated infections

- (1) A health care and social welfare unit must systematically combat healthcare - associated infections. Measures must be harmonised with the measures of promoting patient safety laid down in section 8 of the Health Care Act.*
- (2) The head of the unit must implement surveillance for communicable diseases and extensively drug-resistant microbes and ensure of infection control. The unit must ensure that patients, clients and personnel are properly protected and placed, and that antimicrobial drugs are used appropriately.*
- (3) The head of the unit must enlist the support of health care professionals specialised in the control of communicable diseases and coordinate his or her activities with measures implemented by the municipality or joint municipal authority as well as with national control programmes on healthcare - associated infections.’*

³³ See Annex 4.

³⁴ The Intellectual Disabilities Act is available in English online at:
<https://www.kumpuvuori.fi/wp-content/uploads/2020/10/vpl-eng-amended-2008.pdf>.

³⁵ The Emergency Powers Act is available in English at:
https://www.finlex.fi/fi/laki/kaannokset/1991/en19911080_20030696.pdf.

³⁶ The Communicable Diseases Act is available in English at:
<https://www.finlex.fi/en/laki/kaannokset/2016/en20161227.pdf>.

47. The Government particularly referred to isolation and quarantine measures, which can be adopted under the specific conditions laid out in this Act in Sections 58, 60, 63 and 67:

‘Section 58

Measures related to extensive risk of infection

(1) When a generally hazardous communicable disease or a disease that is justifiably suspected of being generally hazardous constituting an extensive risk of infection has been diagnosed or can justifiably be expected to occur, the municipal body responsible for the control of communicable diseases may in its area decide on closing social and health care units, educational institutions, day care centres, residential apartments, and other similar facilities, as well as on prohibiting general meetings and public events. In addition, it is required that the measure must be essential for preventing the spread of a generally hazardous communicable disease or a disease that is justifiably suspected of being generally hazardous. The Regional State Administrative Agency may make the corresponding decisions in its area, when the decisions are needed for an area covering several municipalities.

(2) If a communicable disease other than a disease referred to in sub-section 1 constitutes an extensive risk of infection, the municipal body responsible for the control of communicable diseases and the Regional State Administrative Agency may decide on closing educational institutions and day care centres in their area, if it is necessary for preventing the spread of the disease.

(3) The decisions referred to in sub-sections 1 and 2 above are made for a period of one month at the most. The measures must be discontinued at once when the risk of infection no longer exists.

Section 60 Quarantine

(1) If there is an obvious risk of the spread of a generally hazardous communicable disease or a disease that is justifiably suspected of being generally hazardous, and the spread of the disease cannot be prevented by other means, the physician in charge of communicable diseases in a public service employment relationship either with the municipality or joint municipal authority for hospital district may order a person into quarantine for a maximum of one month. The decision on quarantine can be made for a person who has been exposed, or is justifiably suspected of having been exposed, to a generally hazardous communicable disease.

(2) The physician in charge of communicable diseases in a public service employment relationship either with the municipality or joint municipal authority for hospital district may order the person referred to in sub-section 1 into quarantine also against his or her will.

Section 63

Isolation

(1) The physician in charge of communicable diseases in a public service employment relationship either with the municipality or joint municipal authority for hospital district may order a person, who has or is justifiably suspected of having a generally hazardous communicable disease or a disease that is justifiably suspected of being generally hazardous, to be isolated in a health care unit for a maximum of two months, if there is an obvious risk of the spread of the disease and it cannot be prevented by other means. The physician deciding on the isolation must provide the isolated person and the treating personnel instructions necessary to prevent the spread of the infection.

(2) The physician in charge of communicable diseases in a public service employment relationship either with the municipality or joint municipal authority for hospital district may order the person referred to in sub-section 1 into isolation also against his or her will.

Section 67

Quarantine and isolation in a space locked from outside

(1) The door of a quarantine or isolation room may be kept locked from the outside, when it is necessary to prevent the spread of an communicable disease that spreads via air or as droplet and contact transmission and meets the prerequisites for a generally hazardous communicable disease or a disease that is justifiably suspected of being generally hazardous.

(2) A person participating in the care of the patient must monitor the patient, so that he or she can reach contact with the patient immediately. The patient must also be able to immediately reach contact with the personnel.

(3) The decision on locking the door from the outside is made by the physician in charge of communicable diseases in a public service employment relationship either with the municipality or joint municipal authority for hospital district.

48. The Communicable Diseases Act also introduces the oversight of the Regional State Administrative Agencies who are responsible, within their respective jurisdictions, for monitoring the legality of the measures for prevention of communicable diseases and providing related guidance.

Section 12

Monitoring the control activities

(1) It is the duty of the Regional State Administrative Agencies within their respective areas to monitor the legality of the prevention work on communicable diseases and provide related guidance.

(2) The National Supervisory Authority for Welfare and Health steers the operation of Regional State Administrative Agencies in the implementation, coordination and harmonisation of the monitoring and related guidance.

(3) In addition, the National Supervisory Authority for Welfare and Health monitors the legality of the control activities on communicable diseases and provides relevant guidance, especially in matters that:

- 1) are fundamentally important or far-reaching;*
- 2) pertain to the remit of several Regional State Administrative Agencies or to the whole country;*
- 3) are closely linked to another supervisory matter regarding social welfare or health care or a health care professional, which is handled by the National Supervisory Authority for Welfare and Health;*
- 4) the Regional State Administrative Agency is disqualified to process.*

b. The policy framework

49. On 21 January 2010, based on a Government Resolution, Finland started an extensive transition period to close institutions of persons with intellectual disabilities. The transition should have been achieved in 2020 resulting in a total absence of persons with disabilities living in institutions.

50. In 2012, the Government adopted a decision allowing persons with intellectual disabilities to live in the same housing conditions as other citizens of the municipality.³⁷ This was to be implemented through new housing service arrangements: housing service units, a residential service, and housing services provided in a person's own home. The housing service units, however, are still based on the model of care prevalent in larger institutions: they are regulated from a position of power vis-à-vis the person concerned and do not allow for an individualised approach to each client. The care is based on a contract, in which the client must agree to all rules and conditions of operation of the housing service unit. While a client may request to be discharged from the housing service unit, the processing of such applications may take up to three months. Housing service units are, at the same time, the only existing means by which supports are provided to persons with intellectual disabilities with more complex needs, particularly those who require 24-hour assistance due to a co-occurring physical disability. In contrast to the previous large-scale institutions, however, these smaller institutions do not provide health care services. Clients can receive health care and rehabilitation services from external providers.
51. Housing services are provided by municipalities and federations of municipalities which oversee the implementation of the Act on Disability Services and Assistance, and the Act on Intellectual Disabilities. Implementation is handled directly by the municipalities or through private-sector service providers. While local authorities may rely on private entities to provide housing services, public authorities supervise the provision of services by private providers and are ultimately responsible for ensuring their quality and the delivery of services that cater to the personal needs of persons with disabilities, and finally for the realisation of the human and fundamental rights of persons with disabilities.

4. GROUNDS OF THE COMPLAINT

A. Failure to protect the life of persons with disabilities during the pandemic

52. The Finnish response to the pandemic engages the right to health of persons with disabilities as enshrined in Article 11 of the Charter. This provision entails positive obligations to adopt appropriate measures to protect persons with disabilities against the spread of the disease. According to overwhelming evidence available soon after the outbreak of the pandemic, institution-like environments, such as the housing service units, have become hotbeds of COVID-19. Based on the informed recommendations of a number of international bodies, the complainants argue that the Finnish Government was obliged to ensure that persons with disabilities are immediately provided the opportunity to move from these units into the community with appropriate supports.

³⁷ Government Resolution on Securing Individual Housing and Services for Persons with Intellectual Disabilities, available at: <https://julkaisut.valtioneuvosto.fi/bitstream/handle/10024/71490/URN%3aNBN%3afi-fe201504226062.pdf?sequence=1&isAllowed=y>, see summary p. 5.

Similarly, persons with disabilities have under Article 11 in conj. with Article E of the Charter the right to equal access to health care services, including disability-specific services, such as rehabilitation. They have the right to be provided with appropriate and accessible information and guidance on how to protect themselves against the spread of the virus. The Finnish Government failed to adopt any of these required measures, violating Article 11 and Article E of the Charter.

53. Secondly, the Finnish Government adopted several measures with the ostensible aim of protecting persons in housing service units. All of these measures were restrictive by nature and consisted of isolating persons with disabilities in their housing units: the prohibition on leaving the institution and prohibition of visits, including visits by family members and social service and health care professionals. These measures directly interfered with the right of persons with disabilities to be provided social services (Article 14) and ensuring independence, social integration and participation in the life of the community (Article 15). In essence, they constituted deprivation of liberty of the residents of housing service units, deprivation of all social contacts outside of the institution, including with their families, and deprivation of the social and medical assistance that they needed and to which they were entitled. These measures were not based on law and did not comply with the requirements necessary to justify a limitation of rights as enshrined in Article 31 of the Charter, nor with the conditions necessary to render these retrogressive steps permissible. They were only adopted in relation to persons with disabilities in housing service units and were based on a prejudicial view of persons with disabilities as inherently vulnerable and in need of imposed care. They constitute a violation of Articles 14 and 15 in conj. with Article E of the Charter.

i. Legal standards

a) The obligation to adopt measures to protect life

54. Article 11 of the Charter stipulates: *‘With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed inter alia: (1) to remove as far as possible the causes of ill-health and (3) to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.’* The Committee reiterates that under this Article, states are not only obliged to ensure for their citizens the highest attainable standard of health, but also to respond appropriately to avoidable health risks, including risks that can be controlled by human action (*Marangopoulos Foundation for Human Rights ((MFHR) v. Greece*, complaint no. 30/2005, § 202).
55. Article 11 of the Charter imposes a range of positive obligations to ensure effective exercise of the right to health. States must adopt appropriate measures to prevent as much as possible causes that are detrimental to human health, such as diseases and accidents. States must guarantee the best possible results in line with available knowledge (Conclusions XV-2, Denmark, p. 126-129). Lack of full scientific certainty

should not be used as a reason for postponing appropriate measures where there are threats of serious damage to human health (*International Federation of Human Rights Leagues (FIDH) v. Greece*, complaint no. 72/2011, § 145).

56. The Committee has regularly interpreted the provisions of the Charter in line with other international human rights documents, both regional and international. In line with the 1969 Vienna Convention on the Law of Treaties, the Committee interprets its standards in the context of other human rights instruments, mindful of the fact that, all human rights are ‘*universal, indivisible and interdependent and interrelated*’.³⁸ The Committee therefore regularly seeks inspiration in the legal standards adopted by various international bodies, interpreting relevant conventions adopted at the United Nations as well as regional instruments adopted at the Council of Europe. The Committee particularly relies on the symbiotic relationship between the European Convention on Human Rights and the Charter, and regularly translates the Convention’s standards, stemming from the European Court of Human Rights’ jurisprudence into the Charter’s provisions (see, for example, *FIDH v. France*, complaint no. 14/2003, § 31). While applying the Charter’s provisions to persons with disabilities, the Committee similarly relies on the standards enshrined in the United Nations Convention on the Rights of Persons with Disabilities (the UN CRPD) as the most up-to-date instrument on the rights of persons with disabilities. In the case of *Fédération Internationale des Ligues des Droits de l’Homme (FIDH) v. Belgium*, complaint no. 75/2011, the Committee reiterated that the UN CRPD reflects existing trends in comparative European law in the sphere of disability rights and policies.
57. The right to health is regularly understood as containing both immediate obligations – core obligations, the obligation to take immediate steps towards full implementation of the right, and the obligation of non-discrimination – and obligations of progressive realisation.³⁹ The obligations to respect and protect the right in question are obligations of immediate effect and are not subject to progressive realisation.⁴⁰ Core obligations under the right to health are generally adjudicated under the right to life, which obliges states to ensure the necessities for life.⁴¹ The Committee’s view of states’ obligations under the right to health as protected by Article 11 align with the view of the UN Human Rights Committee in terms of the obligation to adopt necessary measures to protect the life of persons during the pandemic.⁴²

³⁸ As reiterated in § 5 of the Vienna Declaration adopted during the World Conference on Human Rights in 1993, available at: <https://www.ohchr.org/en/professionalinterest/pages/vienna.aspx>.

³⁹ Report of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, 11 August 2014, A/69/299, § 10.

⁴⁰ Ibid.

⁴¹ Report of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, 11 August 2014, A/69/299, § 15.

⁴² *FIDH v. France*, complaint no. 14/2003, § 31; and UN Human Rights Committee General Comment no. 6, 30 April 1982, § 5

58. The right to health as enshrined in Article 11 of the Charter is indeed intimately related to the right to life protected by Article 2 of the European Convention on Human Rights (“the Convention”) (*FIDH v. France*, complaint no. 14/2003, § 31; *International Planned Parenthood Federation – European Network (IPPF EN) v. Italy*, complaint no. 87/2012, § 66).⁴³ Article 2 of the Convention, as interpreted by the case-law of the European Court of Human Rights, thus provides certain specifications as to the range of positive obligations designed to effectively implement the right to health under Article 11 of the Charter (Conclusions 2005, Interpretative Statement on Article 11 of the Charter).
59. Article 2 of the Convention obliges a state to protect and ensure the right to life for individuals under their jurisdiction. This due diligence duty is triggered when state officials know or should have known of the threat to life (ECtHR *Osman v. the United Kingdom*, application no. 23452/94, § 115-116) whether it is caused by the deliberate act of a person or any other activity in which the right to life may be at stake, including natural disasters (ECtHR *Oneryildiz v Turkey*, application no. 48939/99, § 71). The duty to protect life implies adopting necessary measures to safeguard life and prevent situations where a person’s life would be avoidably put at risk (ECtHR *L.C.B. v. the United Kingdom*, application no.14/1997/798/1001, § 36; *Brincat et al. v Malta*, applications no. 60908/11, 62110/11, 62129/11, 62312/11 and 62338/11, § 79-80).
60. Similar standards are applied under the International Covenant on Civil and Political Rights, according to which states have the duty to protect life by adopting appropriate measures to prevent direct threats to life, including life-threatening diseases.⁴⁴ To fulfil this duty, states must also adopt appropriate measures for the elimination of epidemics.⁴⁵ This means applying targeted protection to people whose lives might be put at risk, including health care provision and effective access, on a non-discriminatory basis, to essential goods and services.⁴⁶
61. It results that, in times of a life-threatening pandemic, states have a positive duty to protect the right to life by immediately adopting measures to prevent the spread of the disease. This duty is mirrored in Article 11 § 1 of the Charter, which, at its core, includes also the obligation to adopt measures to protect the life of an individual from avoidable health-risks, including pandemics, on a non-discriminatory basis.
62. According to the jurisprudence of the European Court of Human Rights, such protection of life must be practical and effective (ECtHR *Valiulienė v. Lithuania*, application no. 33234/07, § 75; *Rantsev v. Cyprus and Russia*, application no. 25965/04, § 284) and the measures adopted by states must be reasonable and adequate (ECtHR *Opuz v. Turkey*, application no. 33401/02, § 136, 153). Further, the Committee reiterates that, with a view to protecting the fundamental values of dignity, equality and solidarity, the

⁴³ See a similar approach in the UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment no. 14 on the Right to the Highest Attainable Standard of Health, E/C.12/2000/4, § 3.

⁴⁴ UN Human Rights Committee, General Comment no. 36, 30 October 2018, CCPR/C/GC/36, § 26.

⁴⁵ UN Human Rights Committee General Comment no. 6, 30 April 1982, § 5.

⁴⁶ UN Human Rights Committee, General Comment no. 36, 30 October 2018, CCPR/C/GC/36, § 26.

measures must be discharged without discrimination and with particular caution in relation to how they affect vulnerable or disadvantaged groups (ECSR Conclusions XVII-2 – General Introduction, also *DCI v. Belgium*, complaint no. 69/2011, § 30).

63. Various forms of detention have long been considered by many states as acceptable measures of protection against the spread of contentious diseases. However, with the evolution of scientific knowledge and increased focus on the impact on persons in specifically vulnerable situations, this view is changing. In 2018, the UN Special Rapporteur on the right to the enjoyment of the highest attainable standard of physical and mental health ('the Rapporteur') warned about the dangers of using confinement as the principal strategy to contain the spread of infectious diseases and viruses.⁴⁷ The Rapporteur explicitly warned that such policies *entrap these groups in criminal or public-health detention regimes on the basis of a health condition, despite mounting evidence that health outcomes for these groups, and for the communities in which they live, are better with health care and support in community settings.*⁴⁸
64. In relation to the spread of tuberculosis, the Rapporteur emphasised that people deprived of liberty are in fact at significantly heightened risk of contracting the disease, owing to a number of factors relating to their deprivation of liberty: from poor nutrition and unhygienic conditions to poor medical care. Isolation, coercion and forced hospitalisation are among the other factors contributing to the increased risk of the spread of disease. Apart from that, they give rise to other human rights violations.⁴⁹ The Rapporteur concluded that state obligations under the right to health imply instead developing responses in the community and eliminating confinement as a response.⁵⁰
65. These conclusions are equally applicable to the COVID-19 pandemic and are specifically relevant to persons with disabilities residing in institutional settings, such as housing service units in Finland. It must be noted that during the pandemic, the obligations to protect the life and health of persons with disabilities are strengthened by Article 11 of the UN CRPD, which obliges states to take, in accordance with their obligations under international law, including international humanitarian law and international human rights law, all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters.
66. In order to protect the health of persons with disabilities in institutional settings, it is essential to recognise that it is the institutions themselves, which put the lives and health of their residents at increased risk. These confined facilities make it impossible to physically distance and often to implement necessary hygienic measures.⁵¹ People

⁴⁷ Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 10 April 2018, A/HRC/38/36, § 85.

⁴⁸ Ibid.

⁴⁹ Ibid., § 84.

⁵⁰ Ibid., also § 99.

⁵¹ United Nations, Policy Brief, A Disability-Inclusive Response to COVID-19. May 2020. Available at: <https://www.un.org/en/coronavirus/disability-inclusion>, p. 5.

residing in institutions also have limited access to relevant information about protection against the virus. They have restricted access to testing. Often, they are discriminated against in access to health care once they contract the virus.⁵² These elements are coupled with other abuses in institutional settings, such as the use of restraints and isolation from the outside world.⁵³ These facts arise from the nature of institutions in and of themselves and cannot be eliminated simply by changing conditions inside these congregate residential settings.

67. It became known shortly after the outbreak of the pandemic that institutional settings increase the risk of contracting and dying from the virus.⁵⁴ The UN High Commissioner for Human Rights warned already in March 2020 that the pandemic had begun to strike residential care homes and risked rampaging through such institutions' extremely vulnerable populations. She urged the Governments to '*act now to prevent further loss of life among detainees and staff.*'⁵⁵
68. Indeed, the COVID-19 pandemic soon showed that instead of being places of safety, institutions have become places of danger for their residents.⁵⁶ Dunja Milatović, the Council of Europe Commissioner for Human Rights, took a clear stance on this issue, stating that COVID-19 has illuminated '*the failings of large, institutional settings,*' also due to the additional health-risks to which persons with disabilities are exposed because they are in institutions.⁵⁷ In May 2020, when most of the world was already aware of the fact that the pandemic most severely impacts populations living in residential facilities and that thousands of persons in institutions were dying of the virus, Dunja Milatović concluded: '*The tragedy that Europe has experienced over the past weeks in its long-term care facilities is a stark reminder that member states ignore international human rights standards and expertise, and the recommendations of their own national human rights structures, at the peril of the lives of their own citizens. The absolute priority right now must be to make sure that this experience is never again repeated over the course of the COVID-19 pandemic. But this should not detract from the urgency of the social care reforms that all European countries must undertake without fail to*

⁵² Ibid, p. 5-6.

⁵³ National Council on Disability, Preserving our freedom: ending institutionalization of persons with disabilities during disasters, p. 32-33, available at: <https://ncd.gov/publications/2019/preserving-our-freedom>.

⁵⁴ International Disability Alliance, "Toward a disability-inclusive COVID19 response: 10 recommendations", 19 March 2020, available at: <http://www.internationaldisabilityalliance.org/content/covid-19-and-disability-movement>; WHO, "Disability considerations during the COVID-19 outbreak", 26 March 2020; A. Guterres, UN Secretary-General, "Policy Brief on Persons with Disabilities and COVID-19", 6 May 2020, available at: <https://www.un.org/en/coronavirus/un-secretary-general>.

⁵⁵ The UN High Commissioner for Human Rights Michelle Bachelet, Urgent action needed to prevent COVID-19 "rampaging through places of detention", 25 March 2020, available at: <https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=25745&LangID=E>

⁵⁶ OHCHR, Covid-19 and the rights of persons with disabilities: guidance, March 2020, available at: https://www.ohchr.org/Documents/Issues/Disability/COVID-9_and_The_Rights_of_Persons_with_Disabilities.pdf, p. 3.

⁵⁷ D. Mijatović, "Lessons to be drawn from the ravages of the COVID-19 pandemic in long-term care facilities, 20 May 2020", available at: <https://www.coe.int/en/web/commissioner/-/lessons-to-be-drawn-from-the-ravages-of-the-covid-19-pandemic-in-long-term-care-facilities>.

*eliminate the root causes of this tragedy in the long run, and transition to long-term care systems which put persons' needs and dignity at their heart.*⁵⁸

69. Several international bodies have therefore called on governments in the past months to adopt immediate steps to discharge persons from institutions, whether they are social-care settings, psychiatric institutions, or other places of detention. The Council of Europe Committee for the Prevention of Torture (CPT) advised states to *'reassess the need to continue involuntary placement of psychiatric patients; discharge or release to community care, wherever appropriate, residents of social care homes.*⁵⁹ Soon after this statement, a similar recommendation was published by the UN Subcommittee for the Prevention of Torture (SPT), which called for a reduction of the number of patients who are involuntarily admitted to psychiatric hospitals.⁶⁰ The World Health Organization similarly recommended that governments *'reduce the number of people in psychiatric hospitals, wherever possible, by implementing schemes of early discharge, together with provision of adequate support for living in the community.*⁶¹
70. The Office of the High Commissioner for Human Rights also strongly recommended emergency discharge of residents of institutions as the appropriate measure to protect life and health during the pandemic.⁶² In April 2020, it called on states to *'close institutions and return people to the community and strengthening supports and services for persons with disabilities and older persons;*⁶³ and to *'discharge and release persons with disabilities from institutions and promptly ensure provision of support in the community through family and/or informal networks, and fund support services by public or private service providers.*⁶⁴
71. The UN Disability policy brief published in response to the pandemic in May 2020 similarly called for a reduction in the number of persons in institutions and *'immediate action to discharge and release persons with disabilities from institutions, whenever possible. Deinstitutionalization strategies need to be accelerated and reinforced with clear timelines and concrete benchmarks.*⁶⁵ Statements calling on states to invest in community-based services and prevent institutionalisation were also published in

⁵⁸ Ibid.

⁵⁹ CPT, 20 March 2020, CPT/Inf(2020)13, available at: <https://rm.coe.int/16809cfa4b>.

⁶⁰ SPT, 7 April 2020, above, § 9(b) and (t), available at: <https://undocs.org/CAT/OP/10>.

⁶¹ WHO Europe, 29 May 2020, p.12, 15, available at: <https://bit.ly/3lp7RVT>.

⁶² OHCHR, Covid-19 and the rights of persons with disabilities: guidance, March 2020, p. 3, available at: https://www.ohchr.org/Documents/Issues/Disability/COVID-19_and_The_Rights_of_Persons_with_Disabilities.pdf.

⁶³ OHCHR, "COVID-19 and the rights of persons with disabilities: guidance", 29 April 2020, https://www.ohchr.org/Documents/Issues/Disability/COVID-19_and_The_Rights_of_Persons_with_Disabilities.pdf?fbclid=IwAR2k4WVrFvgLiKXDUAnfRb509X_NDFux_wYm1L0oXBW1tyNfKwBWOHYtYk4, p. 3.

⁶⁴ Ibid.; also United Nations, Policy Brief, A Disability-Inclusive Response to COVID-19. May 2020. Available at: <https://www.un.org/en/coronavirus/disability-inclusion>, p. 17, p. 32-34.

⁶⁵ A. Guterres, UN Secretary-General, "Policy Brief on Persons with Disabilities and COVID-19", 6 May 2020, available at: <https://www.un.org/en/coronavirus/un-secretary-general>, p. 12.

reaction to the pandemic by the UN Secretary General,⁶⁶ repeating long-held obligations of states iterated, for example, in the UN disability policy.⁶⁷ The UN mental health policy brief published in May 2020 called on states to take the opportunity of the pandemic to *'shift care away from institutions to community services.'*⁶⁸ The Chair of the CRPD Committee with the Special Envoy of the UN Secretary-General on Disability and Accessibility also called on governments to *'accelerate measures of deinstitutionalisation of persons with disabilities from all types of institutions.'*⁶⁹

72. Immediate discharge from institutions into the community as the appropriate measure to protect the lives of persons with disabilities during the pandemic is consistently recommended also by the UN CRPD Committee under article 11 in its concluding observations towards Bosnia and Herzegovina prior to the COVID-19 pandemic, in a context of emergency. The UN CRPD Committee recommended that the state *'require all public services to develop plans for the evacuation of persons with disabilities in consultation with representative organizations of persons with disabilities, including at the local level.'*⁷⁰ Similar concerns about the lack of evacuation plans in cases of public emergency were raised in relation to Ukraine⁷¹ and Turkmenistan.⁷² The UN CRPD Committee raised these concerns in the context of Article 11 of the UN CRPD which obliges states to adopt all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including the pandemic. As in the case of other natural disasters, or all easily spreadable diseases, congregate living facilities greatly increase the risk faced by the resident populations, many of whom may already be at additional risk.
73. There is an overwhelming international consensus that the obligation to protect the life and health of persons with disabilities in institutions during the pandemic means releasing them from institutions into the community with appropriate supports.⁷³ States' failure to evacuate residents from dangerous institutional settings and provide them with support in the community, which would prevent institutionalisation, has resulted in

⁶⁶ UN News, "COVID-19 should not herald rollback in rights for people with autism: UN chief", 2 April 2020, available at <https://news.un.org/en/story/2020/04/1060912>.

⁶⁷ A. Guterres, UN Secretary-General, "Policy Brief on Persons with Disabilities and COVID-19", 6 May 2020, available at: <https://www.un.org/en/coronavirus/un-secretary-general>, p. 17.

⁶⁸ A. Guterres, "Policy Brief: COVID-19 and the Need or Action on Mental Health", 13 May 2020, p. 4, <https://www.un.org/en/coronavirus/un-secretary-general>.

⁶⁹ Chair of the CRPD Committee on behalf of the CRPD Committee and the Special Envoy of the UNSG on Disability and Accessibility, "Persons with Disabilities and COVID-19", 1 April 2020, available at: <https://www.ohchr.org/EN/HRBodies/CRPD/Pages/CRPDStatements.aspx>.

⁷⁰ CRPD Committee, Concluding observations on Bosnia and Herzegovina, CRPD/C/BIH/CO/1, 2 May 2017, § 20–21.

⁷¹ CRPD Committee, Concluding observations on the initial report of Ukraine, CRPD/C/UKR/CO/1, 2 October 2015, § 22.

⁷² CRPD Committee, Concluding observations on the initial report of Turkmenistan, CRPD/C/TKM/CO/1, 17 April 2015, § 24.

⁷³ Ibid., p. 12; OHCHR, Covid-19 and the rights of persons with disabilities: guidance, March 2020, p. 3, available at: https://www.ohchr.org/Documents/Issues/Disability/COVID-19_and_The_Rights_of_Persons_with_Disabilities.pdf.

thousands of preventable deaths and health impairments.⁷⁴ As has been noted by the Secretary General of the Council of Europe, these omissions of the state engage Articles 2 and 3 of the European Convention on Human Rights: *'the exposure to the disease and the extreme level of suffering may be found incompatible with the state's positive obligations to protect life and prevent ill-treatment.'*⁷⁵

b) *Obligations to ensure non-discriminatory access to health care facilities and services and to collect data*

74. As outlined above, states have, in line with Article 11 of the Charter, a positive obligation to adopt appropriate measures to prevent, as far as possible, the spread of epidemic diseases. With this aim, it must adequately plan for the response to avoidable health risks (*Marangopoulos Foundation for Human Rights ((MFHR) v. Greece*, complaint no. 30/2005, § 202). Such planning must be in line with available scientific knowledge, but lack thereof cannot justify postponing appropriate planning if the threat to life or health is imminent (*International Federation of Human Rights Leagues (FIDH) v. Greece*, complaint no. 72/2011, § 145). These measures must pay particular attention to how they affect vulnerable or disadvantaged groups (ECSR Conclusions XVII-2 – General Introduction). In this light, the Government must collect the relevant data to be able to make informed and justified decisions properly weighing the public interest related to the health of general population and the protection of the rights and health of particularly affected populations, such as persons with disabilities (*MDAC v. Belgium*, complaint no. 109/2014, § 50).
75. The right to health also includes the obligation of states to ensure timely and effective access to health care on a basis of equality. According to Resolution 1642 (2009) of the Parliamentary Assembly of the Council of Europe, persons with disabilities must be ensured equal access to health care,⁷⁶ including, full, accessible and appropriate rehabilitation services to enable people with disabilities to achieve maximum independence and to make the greatest possible use of their physical, mental, occupational and social capacities.⁷⁷ Read in light of Article 25 of the UN CRPD, persons with disabilities must be provided appropriate health care services on an equal basis with others. This includes general health care services accessible to others, as well as specific health care services needed by them as a result of their impairment. These services must include, in line with Article 26 of the UN CRPD, habilitation and rehabilitation and services provided with a view to attaining and maintaining maximum

⁷⁴ A. Guterres, UN Secretary-General, "Policy Brief on Persons with Disabilities and COVID-19", 6 May 2020, available at: <https://www.un.org/en/coronavirus/un-secretary-general>, p. 5.

⁷⁵ Marija Pejčinović, Secretary General of the Council of Europe, "Respecting democracy, rule of law and human rights in the framework of the COVID-19 sanitary crisis: A toolkit for member states", SG/Inf (2020)11, 7 April 2020, <https://www.coe.int/en/web/portal/-/coronavirus-guidance-to-governments-on-respecting-human-rights-democracy-and-the-rule-of-law>, p. 5

⁷⁶ Available at: <https://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=17697&lang=en>, § 15.

⁷⁷ *Ibid.*, § 15.6.

independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life.

76. In line with the above, the Government must adopt appropriate measures which pay particular attention to the needs of specific groups. This implies, at a minimum, 1) ensuring that general health care facilities are equally accessible to persons with disabilities, and 2) that the pandemic response takes into account the specific needs of persons with disabilities and the impact on them. Ensuring access to health care facilities and services on a non-discriminatory basis to vulnerable or marginalised groups is commonly considered to be a core obligation of the right to health.⁷⁸
77. All essential health services must therefore also be accessible to persons with disabilities during the pandemic. This includes not only pandemic response measures, such as testing, but also mental health interventions.⁷⁹ These services can be facilitated by various methods, including telehealth programmes or home care, including in-home testing for persons with disabilities.⁸⁰ Risk situations must lead to higher prioritisation of treatment for persons with disabilities, not the contrary.⁸¹ Support services must also be accessible to enable persons with disabilities timely access and transportation to health services, interpretation, where needed, and to enable them to purchase necessary goods or medicines. Many persons with disabilities rely on these services for their day to day living needs.⁸² An important element of such accessibility is providing accessible and timely information about how to protect one's health and how to access health services.⁸³
78. It must be recognised that persons still residing in institutions face not only increased danger due to the institutional setting (see above § 38 to 42), but also additional barriers in accessing information, protection against the virus, health care services and essential supports due to their residence in the institution. The state must ensure that people are provided accessible information and guidance in appropriate formats, which is up to date, and keeps pace with the rapidly changing knowledge evidenced during the pandemic.⁸⁴ Prevention of contracting the virus and regular testing must be ensured.⁸⁵

⁷⁸ UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment no. 14 on the Right to the Highest Attainable Standard of Health, E/C.12/2000/4, § 43-44.

⁷⁹ World Health Organization, Disability considerations during the COVID-19 outbreak, available at: <https://www.who.int/publications/i/item/WHO-2019-nCoV-Disability-2020-1>, p. 12-13.

⁸⁰ Ibid.

⁸¹ Ibid.

⁸² OHCHR, Covid-19 and the rights of persons with disabilities: guidance, March 2020, available at: https://www.ohchr.org/Documents/Issues/Disability/COVID-19_and_The_Rights_of_Persons_with_Disabilities.pdf, p. 8.

⁸³ UN CESCR General Comment no. 14 on the Right to the Highest Attainable Standard of Health, E/C.12/2000/4, § 17-19.

⁸⁴ United Nations, Policy Brief, A Disability-Inclusive Response to COVID-19. May 2020. Available at: <https://www.un.org/en/coronavirus/disability-inclusion>, p. 7.

⁸⁵ World Health Organization, Disability considerations during the COVID-19 outbreak, available at: <https://www.who.int/publications/i/item/WHO-2019-nCoV-Disability-2020-1>, p. 12-13.

Personal protective equipment must be distributed, tailored to the needs and impairment of the individual.⁸⁶

79. To ensure all of the above and in order to be able to formulate a reasonable policy taking into account the impact both of the pandemic and of the response measures on persons with disabilities, the Government must collect appropriate data (*ERRC v. Italy*, complaint no. 27/2004, §23). Such data must, at minimum, include data on the number of persons with disabilities in the housing service units affected by the adopted measures, on their specific support needs and on their ability to access different health care services listed above.

ii. Application of the standards

a) *The obligation to adopt measures to protect life*

80. The positive obligations under Article 11 of the Charter read together with Article 2 of the Convention and Articles 11 and 19 of the UN CRPD imply immediate discharge of persons with disabilities from institutions with appropriate supports. While the requirement to discharge residents from institutional-like settings as a measure of protection during the pandemic may appear to be too ambitious, in practice it certainly is not illusory: other European Governments, including Switzerland and Spain,⁸⁷ have achieved the release of persons with disabilities into the community as a measure to prevent infections and deaths in institutions.
81. There are no other appropriate measures, which would effectively ensure that the virus is not spread uncontrollably in confined institutional settings. However, the Finnish Government adopted no such steps. In fact, the deinstitutionalisation strategy in Finland has been inactive since 2010, despite the ambitious plans adopted at the time. The housing service units remain the only option available to persons with disabilities with more complex needs who need support throughout the day. During the pandemic, because of the restrictive measures adopted by the Finnish Government, these places have become prisons which put their residents at additional risk. Finland therefore failed to adopt appropriate steps to protect the health of residents of housing service units by ensuring their immediate discharge into the community with necessary supports, violating its obligations under Article 11 of the Charter.

b) *Obligation to ensure non-discriminatory access to health care facilities and services*

⁸⁶ Ibid.; also United Nations, Policy Brief, A Disability-Inclusive Response to COVID-19. May 2020. Available at: <https://www.un.org/en/coronavirus/disability-inclusion>, p. 7.

⁸⁷ OHCHR, Covid-19 and the rights of persons with disabilities: guidance, March 2020, available at: https://www.ohchr.org/Documents/Issues/Disability/COVID-19_and_The_Rights_of_Persons_with_Disabilities.pdf, p. 8.

82. The visiting prohibition imposed in the housing service units was, in the vast majority of these services, an imposition of complete isolation, prohibiting all contact between their residents and the outside world (see above § 32-37). It applied also to the professionals who provide health care services to persons with disabilities in the housing units, personal assistance and rehabilitation services (§ 38-39). The prohibition of visits as adopted in the housing service units therefore also *de facto* disabled access by persons with disabilities living in these facilities to a range of in-house social and medical services, including rehabilitation and personal assistance. The prohibition on leaving the institution, similarly, hampered their timely access to health care facilities outside the housing service units, and their access to other services and necessary medications. These measures meant a denial to persons with disabilities of access to health care, social, habilitative and rehabilitative services on equal basis with others (see above § 19 and 20).
83. Moreover, whilst aware of the risks the pandemic poses particularly for persons with disabilities in institutions, the Government did not adopt further measures to ensure their protection: accessible information and guidance in accessible formats were not distributed, regular testing was not facilitated, and personal protective equipment was, for the large part, not distributed (see above § 40-42).
84. These shortcomings, essentially denying persons with disabilities effective access to health care during the pandemic, arguably took place also in part because persons with disabilities were not included and accounted for in planning the pandemic response. This means that the Government did not take their needs and views into account when planning and implementing the measures. This is also demonstrated by the complete lack of data regarding the number of persons with disabilities in the housing service units affected by the Government measures, which was not collected even following civil society requests (see above § 40-42).
85. Finland failed to ensure that persons with disabilities have equal access to health care during the pandemic and, moreover, implemented discriminatory measures specifically targeting persons in housing service units which further disabled their access to health care. Moreover, Finland failed to collect the necessary data to ensure that the Government took account of the needs of and impact on persons with disabilities. The complainants submit that such shortcomings amount to a breach of obligations stemming from Article 11 of the Charter.

B. The impermissibility of restrictive measures adopted by the Government

86. The complainants further invoke Articles 14 and 15 of the Charter which enshrine the right to be provided with social services to promote the independence and inclusion of persons with disabilities in the community. In reaction to the COVID-19 pandemic, the Finnish Government adopted measures with the ostensible aim of protecting persons in housing units from the virus: the prohibition of visits and the prohibition of leaving the housing service units and their immediate surroundings (§ 19-20). The complaint

explains above why these measures are, in fact, contrary to this goal. This part of the complaint details how such measures lead only to the total isolation of persons with disabilities from their family, friends and community, in breach of the country's obligations under Articles 14 and 15 of the Charter, separately and in conjunction with Article E.

87. While the Charter allows for the lawful limitation of the rights enshrined therein under conditions detailed in Article 31, the Finnish Government has not met these conditions, as the measures were not adopted in accordance with law and were neither reasonable nor necessary in a democratic society. Moreover, they only targeted persons with disabilities in housing service units based on their stereotypical portrayal as vulnerable and in need of imposed protection, in violation of Article E of the charter.
88. The complainants also argue that the limitation on rights introduced by the Government's restrictive measures *de facto* represent a retrogression in the fulfilment of the rights enshrined in the Articles 14 and 15 of the Charter. They argue that if retrogression is inevitable in the times of crisis, the Government must prove that the following conditions had been met: the retrogression should (i) *be temporary in nature and in effect and limited to the duration of the crisis*; (ii) *be necessary and proportionate (and alternative measures comprehensively examined)*; (iii) *be reasonable*; (iv) *not be directly or indirectly discriminatory*; (v) *accord particular attention to the rights of disadvantaged and marginalised individuals and groups and ensure that they are not disproportionately affected*; (vi) *identify the minimum core content of the right(s) in question and ensure the protection of this core content at all times*; (vii) *involve genuine and meaningful participation of affected groups in creation of the proposed measures and examination of alternatives*; and (viii) *be subject to meaningful review procedures at the national level*.⁸⁸ The complainants argue that the Government did not meet these conditions for retrogressive steps either.
89. While the adopted measures were, arguably, temporary (i), they were not necessary and proportionate (ii) nor reasonable (iii) and were, moreover discriminatory (iv). These latter three elements also apply to limitations of rights and are analysed as a part of the complainants' argumentation outlining why the Finnish Government has not met the conditions for limitation of rights in violation of Article 31 and Article E in conj. with Articles 14 and 15 of the Charter (see §. 62-63 and 74-76). However, Finland did not, in addition, respect the remaining criteria required to render these retrogressive measures permissible. The Government failed to consider the rights and needs of persons with disabilities during the pandemic or the impact of the adopted measures on their lives (v). This was exacerbated by the fact that they also failed to ensure the minimum core content of the rights in Articles 14 and 15 of the Charter, in particular insofar as they failed in the minimum core obligation to collect appropriate data in relation to persons with disabilities (vi) and they did not plan the measures with the

⁸⁸ AOIFE NOLAN, NICHOLAS J. LUSIANI and CHRISTIAN COURTIS. Two Step Forwards, No Steps Back? Evolving Criteria on the Prohibition of Retrogression in Economic and Social Rights. In: A. NOLAN, ed., *Economic and Social Rights after the Global Financial Crisis* Cambridge University Press, 2014, p. 140.

effective involvement of persons with disabilities (vii). Finally, Finland also failed to afford persons with disabilities an effective means to challenge and seek review of the adopted measures, denying them access to justice and redress (viii).

i. Legal standards

90. Article 14 of the Charter binds contracting Parties by the obligation '*to promote or provide services which, by using methods of social work, would contribute to the welfare and development of both individuals and groups in the community, and to their adjustment to the social environment.*' According to Article 14 of the Charter, persons with disabilities have the right to benefit from social welfare services. The overall organisation and functioning of social services are usually assessed under the prism of Article 14 § 1 of the Charter (*The Central Association of Carers in Finland v. Finland*, complaint no. 71/2011, § 56).
91. The Committee in its conclusions towards Finland in 2005 in assessing compliance with Article 14 of the Charter (XVII-2/def/FIN/14/1/EN) emphasised that the goal of welfare services is the well-being, the capability to become self-sufficient and the adjustment to the social environment of the individual. The protection of the rights of the client is an important element of assessing the quality of the service. Any decisions which may interfere with clients' rights must be made in consultation with the client and not against his or her will. Measures that deprive the services offered of the possibility of ensuring the well-being, capability of becoming self-sufficient and of adjusting to the social environment, must be seen to deprive those affected of the minimum core normative content of Article 14. Remedies must be available for those who wish to complain. The Committee has also reiterated that the use of social services must not interfere with people's right to privacy (*Ibid.*).
92. As stipulated in Article 15 of the Charter, persons with disabilities, including those who use social services, such as the housing service units, have the right to independence, social integration, and participation in the life of the community. As explained by the Committee in the *European Action of the Disabled (AEH) v. France* (complaint no. 81/2012), Article 15 reflects and takes forward the shift in values that has occurred in Europe with regard to rights of persons with disabilities: ideas of welfare and segregation have given way to an approach based on inclusion and choice (*Ibid.*, § 75). The underlying vision of Article 15 is that of equal citizenship for persons with disabilities. The primary rights through which this vision is upheld are those of '*independence, social integration and participation in the life of the community*' (*Ibid.*). The complainants submit that measures that explicitly remove independence, social integration and the possibility of participation in community life must be examined to determine whether they thereby undermine the minimum core normative content of the rights in Article 15 of the Charter.
93. The Committee in its interpretation of this provision relies on other Council of Europe documents, such as the decisions and declarations of the Council of Ministers or the

Parliamentary Assembly of the Council of Europe (see *Fédération Internationale des Ligues des Droits de l'Homme (FIDH) v. Belgium*, complaint no. 75/2011). There are several such documents emphasising the right of persons with disabilities to be provided community-based services with the aim of ensuring their inclusion in the community and their full and active participation in society. These include Recommendation 1592 (2003) of the Parliamentary Assembly of the Council of Europe '*Towards full social inclusion of persons with disabilities*';⁸⁹ Recommendation Rec(2006)5 of the Committee of Ministers to member states on the Council of Europe Action Plan to promote the rights and full participation of people with disabilities in society: improving the quality of life of people with disabilities in Europe 2006-2015;⁹⁰ and the Issue Paper by the Council of Europe Commissioner for Human Rights: '*The right of people with disabilities to live independently and be included in the community*'.⁹¹

94. Similarly, the Committee also draws on the standards enshrined in the UN CRPD, which has been ratified by all but one Council of Europe member state⁹² (*Fédération Internationale des Ligues des Droits de l'Homme (FIDH) v. Belgium*, complaint no. 75/2011). According to Article 19 of the UN CRPD, all persons with disabilities have the right to live in the community, with choices equal to others. The core of the right to live independently is the right not to be forced to live in a particular arrangement and to be able to choose one's own place of residence. In the view of the UN CRPD Committee, this core element of the right to live independently is a civil and political right, which is not subject to progressive realisation. It creates an immediate negative obligation of the state not to interfere with the individual choice of persons with disabilities.⁹³ This includes both the choice how, where and with whom to live but also the daily schedule, and the lifestyle of a person, covering the private and public spheres, every day and in the long term.⁹⁴

95. The civil and political element of the right to live independently and be included in the community is based on the notion of dignity, which explicitly requires respect for both personal liberty (Article 14 of the CRPD)⁹⁵ and personal privacy (Article 22 of the UN CRPD).⁹⁶ According to the UN CRPD Committee, particular attention must be paid to disability-specific deprivations of liberty, i.e. situations when individuals are detained against their will in medical or social care facilities.⁹⁷ The state has an obligation to ensure that persons with disabilities are not of their liberty unlawfully or arbitrarily, that

⁸⁹ See Doc. 9632, 10 December 2002, report of the Social, Health and Family Affairs Committee Towards full social inclusion of persons with disabilities, available online at: <https://assembly.coe.int/nw/xml/XRef/X2H-Xref-ViewHTML.asp?FileID=9935&lang=EN>

⁹⁰ Available online at: <https://rm.coe.int/16806994a0>.

⁹¹ Published on 13 March 2012, available online at: https://wcd.coe.int/ViewDoc.jsp?id=1931307#P257_34995.

⁹² Liechtenstein signed the UN CRPD in September 2020 and has expressed an intention to ratify it.

⁹³ UN CRPD General Comment no. 5 on living independently and being included in the community, CRPD/C/GC/5, 2017, § 39.

⁹⁴ Ibid.

⁹⁵ Ibid., § 9, § 47 and § 48.

⁹⁶ Ibid., § 86.

⁹⁷ Ibid., § 48.

any deprivation of liberty is in conformity with the law, and that the existence of a disability is in no case a reason for such deprivation of liberty.⁹⁸ Similarly, persons with disabilities cannot be subject to arbitrary or unlawful interference with their privacy, family or correspondence, and have the right to be protected by law against such interferences.⁹⁹ Respect for private and family life implies that persons with disabilities shall have an opportunity to meet their family and close ones when and how they choose.

96. These freedoms are similarly protected under Articles 5 and 8 of the European Convention on Human Rights. Deprivations of liberty in social care facilities must be lawful, follow a legitimate aim, and be proportionate to that aim (*Stanev v. Bulgaria* (GC), application no. 36760/06, § 132; *Červenka v. the Czech Republic*, application no. 62507/12, § 105-106). Similarly, interferences with the right to private and family life need to be based on law, follow a legitimate aim and be necessary in a democratic society (for instance, *A.-M.V. v. Finland*, application no. 53251/13, particularly § 73-74). No measures interfering with these provisions can be discriminatory in effect on the basis of disability (see, for instance, *Glor v. Switzerland*, application no. 13444/04, § 80). This applies also to situations where measures are based on prejudiced or stereotypical portrayals of the group in question, even if they were not adopted with the intent to discriminate (*Munteanu v. the Republic of Moldova*, application no. 34168/11).
97. The United Nations adopts a similar approach. Admittedly, the adoption of measures to protect the lives and health of individuals during the pandemic may at times allow for interferences with rights of individuals or retrogression in the implementation of those rights. However, as stipulated by the United Nations High Commissioner for Human Rights in a report to the Economic and Social Council, any retrogressive measures are presumptively a violation of state obligations.¹⁰⁰ The burden is on the state to demonstrate that such limitation of rights was in accordance with the law, including international human rights standards, in the interest of a legitimate aim, and strictly necessary for the promotion of the general welfare in a democratic society.¹⁰¹ However, any limitation or retrogression must never infringe the minimum core normative content of the right in question.
98. The Charter similarly recognises that the rights protected by Articles 14 and 15 of the Charter are not absolute. Deliberate limitations of these rights must, in line with Article 31 of the Charter, be prescribed by law and necessary in a democratic society for the protection of the rights and freedoms of others or for the protection of public interest, national security, public health, or morals. This approach corresponds to a widely

⁹⁸ Article 14 of the UN CRPD.

⁹⁹ Article 22 of the UN CRPD.

¹⁰⁰ Report of the United Nations High Commissioner for Human Rights to the Economic and Social Council E/2007/82, 25 June 2007, § 19; see for the same standard UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment no. 14 on the Right to the Highest Attainable Standard of Health, E/C.12/2000/4, § 32.

¹⁰¹ UN CESCR General Comment no. 14 on the Right to the Highest Attainable Standard of Health, E/C.12/2000/4, § 28; see similarly the Report of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, 11 August 2014, A/69/299.

accepted test for limitation of rights, as prescribed, for example, in Article 2 of the International Covenant on Economic, Social and Cultural Rights, and also mirrors the tests for permissible interference with rights used in the above-outlined jurisprudence of the European Court of Human Rights (§ 89).

99. Further, following the non-discrimination provision of Article E of the Charter, any limitation on the rights enshrined in the Charter or any retrogression in their implementation must not constitute discrimination on the basis of disability (*European Action of the Disabled (AEH) v. France*, complaint no. 81/2012, § 132), which also implies that they must not be based solely on prejudiced or stereotypical portrayals of persons with disabilities (*Munteanu v. the Republic of Moldova*, application no. 34168/11).
100. Any wide ranging limitation and any interference with rights protected in the Charter affecting a significant number of people, however, also inevitably constitutes retrogression in the implementation of these rights, as they have the practical effect of decreasing the actual level of enjoyment of these rights, contrary to the obligation of progressive implementation.¹⁰² Limitations on the rights enshrined in the Charter must therefore also comply with the conditions for rebutting the presumption that a retrogressive measure violates the Charter. These conditions will also apply in times of health crisis, such as the COVID-19 pandemic.
101. While under which an unlawful retrogression in the implementation of social rights may exceptionally be permissible are fragmented, the practice of international bodies nevertheless provides reliable guidance, which has been summarised in academic literature, with reference to relevant soft-law. This guidance was set out in paragraph 88 above and is repeated here for clarity:¹⁰³ the retrogressive measures should *i) be temporary by nature and in effect and limited to the duration of the crisis; (ii) be necessary and proportionate (and alternative measures comprehensively examined); (iii) be reasonable; (iv) not be directly or indirectly discriminatory; (v) accord particular attention to the rights of disadvantaged and marginalised individuals and groups and ensure that they are not disproportionately affected; (vi) identify the minimum core content of the right(s) in question and ensure the protection of this core content at all times; (vii) have involved genuine participation of affected groups in examining the proposed measures and alternatives; and (viii) be subject to meaningful review procedures at the national level.*¹⁰⁴

¹⁰² Compare with AOIFE NOLAN, NICHOLAS J. LUSIANI and CHRISTIAN COURTIS. Two Step Forwards, No Steps Back? Evolving Criteria on the Prohibition of Retrogression in Economic and Social Rights. In: A. NOLAN, ed., *Economic and Social Rights after the Global Financial Crisis* Cambridge University Press, 2014, p. 136.

¹⁰³ AOIFE NOLAN, NICHOLAS J. LUSIANI and CHRISTIAN COURTIS. Two Step Forwards, No Steps Back? Evolving Criteria on the Prohibition of Retrogression in Economic and Social Rights. In: A. NOLAN, ed., *Economic and Social Rights after the Global Financial Crisis* Cambridge University Press, 2014, p. 139-141.

¹⁰⁴ *Ibid.*, p. 140.

102. The conditions of (ii) necessity and proportionality, (iii) reasonableness and (iv) absence of direct and indirect discrimination are mirrored in the conditions for limitation of rights (outlined in § 101 above), as enshrined in Article 31 and Article E of the Convention. However, the remaining conditions are equally important in the present case: measures which have a retrogressive impact on the implementation of social rights must equally (v) *accord particular attention to the rights of disadvantaged individuals and groups*;¹⁰⁵ (vi) *identify the minimum core content of the right(s) and ensure at all times its protection*;¹⁰⁶ (vii) *involve genuine participation of affected groups in examining the proposed measures and alternatives*;¹⁰⁷ and (viii) *be subject to meaningful review procedures at the national level*.¹⁰⁸

103. Most of the above requirements find direct reflection in the Committee's jurisprudence. First, the Committee has previously stated that all measures adopted with a view to implementing or limiting Charter rights must pay particular attention to how they affect vulnerable or disadvantaged groups (ECSR Conclusions XVII-2 – General Introduction).

104. The measures must also be introduced with the awareness of the core content of the rights in question and ensure at all times their protection.¹⁰⁹ The core elements of the right to live independently and to be provided services in the community, as outlined by the UN CRPD Committee concerning choice of residence and control of one's own daily life have been set out above. If the effect of the measures is to deprive the services provided under Article 14 of their primary goal by harming the well-being of the recipients, actively denying them access to the social environment and hindering their self-sufficiency, they must be considered to undermine the minimum core normative content of that Article. Likewise in relation to Article 15, if the measures explicitly restrict and deny the possibility for persons with disabilities participate in the life of the community, deny them the ability to exercise any independence and explicitly prohibit them from any social integration, the minimum core normative content of that Article must be found to be violated.

105. The core obligations of the right to live independently and to be provided services in the community, as outlined by the UN CRPD Committee, include the collection of consistent quantitative and qualitative data on people with disabilities, including those still living in institutions. The Government must collect the relevant data to be able to make informed and justified decisions properly weighing the public interest related to the health of general population and the protection of the rights and health of particularly

¹⁰⁵ Ibid.

¹⁰⁶ UN CESCR General Comment no. 19 on the Right to Social Security, E/C.12/GC/19, § 42.

¹⁰⁷ Ibid.

¹⁰⁸ Ibid.; also, AOIFE NOLAN, NICHOLAS J. LUSIANI and CHRISTIAN COURTIS. Two Step Forwards, No Steps Back? Evolving Criteria on the Prohibition of Retrogression in Economic and Social Rights. In: A. NOLAN, ed., *Economic and Social Rights after the Global Financial Crisis* Cambridge University Press, 2014, p. 140.

¹⁰⁹ UN CESCR General Comment no. 19 on the Right to Social Security, E/C.12/GC/19, § 42.

affected populations, such as persons with disabilities.¹¹⁰ Again, this obligation is also repeatedly emphasised in the jurisprudence of the Committee (*ERRC v. Italy*, complaint no. 27/2004, §23; *MDAC v. Belgium*, complaint no. 109/2014, § 50).

106. Further, each policy, which has the effect of retrogression in the implementation of rights must be adopted with the participation of persons affected by these measures.¹¹¹ Drawing on the basic obligations stemming from the UN CRPD, this means that persons with disabilities must be included in planning for the response.¹¹² Without consulting persons with disabilities and their representative organisations, it is impossible to appropriately consider the impact of general measures on the population of persons with disabilities and to take into account the possible specific human rights violations they may suffer on account of those measures.
107. Lastly, all interventions which interfere with the human rights and freedoms of persons with disabilities must be subject to review with the possibility for victims to obtain an effective remedy. This applies also to restrictive measures adopted with a view to protecting public health during the pandemic. Access to an effective remedy in case of interference with human rights is an essential and inherent element of every human right. Only with effective access to justice can the protection of human rights be practical and effective, as opposed to only theoretical and illusory (*ECtHR Airey v. Ireland*, application no. 6289/73, § 24). Similarly, according to the UN Committee on Social, Economic and Cultural Rights, even if limitations on human rights on grounds of protecting public health are basically permitted, they should be of limited duration and subject to review.¹¹³
108. The obligations under Article 14 and 15 of the Charter therefore imply also ensuring that persons with disabilities have effective access to judicial review of retrogressive measures and of interferences with their rights with the possibility of obtaining redress. In *MDAC v. Belgium* (complaint no. 109/2014, § 80), the Committee considered that the lack of information for parents of children with disabilities in relation to available legal proceedings for protection of their children's right to education amounted to a violation of Article 15§1 of the Charter.
109. In relation to persons with disabilities and in line with Article 13 of the UN CRPD, this means that persons with disabilities must be given a real and effective opportunity to initiate and participate in judicial proceedings with a view to protecting their rights and achieving redress. This implies the provision of accessible information about how to access such review, appropriate assistances and accommodations in the process as well accessible and effective legal aid.¹¹⁴

¹¹⁰ UN CRPD General Comment no. 5 on living independently and being included in the community, CRPD/C/GC/5, 2017, § 38.

¹¹¹ UN CESCR General Comment no. 19 on the Right to Social Security, E/C.12/GC/19, § 42.

¹¹² Article 4 § 3 of the UN CRPD.

¹¹³ UN CESCR General Comment no. 14 on the Right to the Highest Attainable Standard of Health, E/C.12/2000/4, § 29.

¹¹⁴ UN CRPD Concluding Observations towards India, CRPD/C/IND/CO/1, 2019, paras 28-19; towards Greece, CRPD/C/GR/CO/1, 2019, para 20; towards Turkey, CRPD/C/TUR/CO/1, 2019, para 27; and many others.

110. Lastly, it is necessary to bear in mind that, for assessing compliance with the Charter, both legal regulations and practice must be taken into account (*Autism-Europe v. France*, complaint no. 13/2002, §53). As the Committee has stated in the past, this is consistent with the purpose and aim of the Charter to protect rights not merely theoretically, but also effectively in practice (*International Commission of Jurists (ICJ) v. Portugal*, complaint no. 1/1998, §32).

ii. Application of the standards

a) Unlawfulness of the restrictive measures

111. Finland adopted, with the ostensible aim of protecting persons with disabilities in housing service units, two principal measures: the prohibition of visits (including visits by health care or social care professionals) and the prohibition on leaving the institution. The only measures adopted in relation to the pandemic towards persons with disabilities in housing service units were therefore restrictive in nature. They essentially led to the isolation of persons with disabilities in these housing units, leaving them without appropriate health care and essential supports and services. While persons in institutions already face heightened risks stemming from the nature of the institutional setting which makes them vulnerable to the impact of the pandemic (§38 above), the imposed lockdown measures only exacerbated these barriers: they left persons with disabilities isolated, with no effective access to appropriate information, protection, social services, health care or support.

112. All the measures were based on Government recommendations or instructions, not decisions or legal regulations. However, in practice, they were applied by service providers, public and private alike, virtually without exceptions. They were considered a firm rule and were implemented by public as well as by private service providers in six major Finnish cities: Helsinki, Espoo, Tampere, Vantaa, Turku and Oulu (see above §§ 36-37). After the major cities, many smaller municipalities implemented the same measures. State authorities are responsible for the oversight of the exercise of public powers in social care facilities, and the fact that the restrictive measures were factually applied by service providers does not exempt the Government from its liability. The delegation of power and exercise of a fraction of public authority is not synonymous with a lack of accountability on the part of public authorities.

113. The prohibition on leaving the housing service units deprived persons with disabilities of their personal liberty and literally locked them inside the units. The factual blanket prohibitions on all visits worsened this dire situation. It left them isolated, unable to contact their friends, family and community or to reach out for appropriate help and support. For many, the denial of these basic services led to an inability to perform basic daily tasks of self-care or to alleviate pain. This must have caused a considerable amount of suffering and despair, arguably at times reaching the level of ill-treatment prohibited by Article 3 of the European Convention on Human Rights.

114. The deprivation of personal liberty in a social care home and disablement of all contacts with family and with the outside world strike at the very essence of the rights protected in Articles 14 and 15 of the Charter. Both provisions are based on the notion of human dignity and liberty: the right to personal liberty and private life. While in fact, it is undeniable that prohibitions on visits took place based on the instructions of the authorities (see above § 31-33) and were widely followed by social service providers across the country, there was no legal basis for such interference.
115. The prohibition on visits was not based on the Emergency Powers Act, as none of the recommendations issued by the Government referred to statute. Similarly, the prohibition on visits cannot be justified by the legislation governing social services and assistance, namely the Act on Intellectual Disabilities. There is no provision of this Act which could allow for blanket prohibitions on visits (see § 45).
116. The Ministry of Social Affairs and Health instruction of 20 March 2020, first introducing the recommendation of prohibitions on visits, refers to Section 17 § 2 of the Communicable Diseases Act. The instruction explicitly states: *‘The head of unit can introduce a visiting prohibition to tackle infection. Visiting prohibitions need to be in line with the principle of proportionality in administrative law and be proportionate to the goal that the prohibition aims to reach. The prohibition and its practical implementation need to be constantly evaluated and prohibitions modified when needed if the circumstances necessitate.’*
117. Section 17, subsection 2, of the Communicable Diseases Act was later also invoked by other authorities introducing further measures (see above §§ 46-47). However, this provision stipulates that the head of the unit of a social service must implement measures for surveillance of possible spread of communicable diseases and their efficient control. This decision must be made by the head of the unit based on an individual assessment of the case. In certain individual cases, it may even enable restrictions on freedom of movement, such as isolating particular individuals based on reasons listed in the law. It does not enable blanket general prohibitions on leaving the institution nor on visits to the institution (see above § 46). The prohibitions were, on the contrary, introduced as a blanket general measure, without an evaluation of concrete circumstances, their necessity and proportionality.
118. The conclusion that Section 17(2) of the Communicable Diseases Act cannot be a lawful basis for the restrictive measures was also confirmed by the Administrative Court of Eastern Finland in its decision of 16 October 2020, no: 20/1059/1 (Annex 4). The court stated that Section 17 of the Communicable Diseases Act does not give the authorities the mandate to give legally binding visiting prohibitions to housing service units. The Communicable Diseases Act therefore cannot be used to legally justify the general visiting prohibitions to housing service units.
119. It is worth noting that even after being informed of this decision, the Ministry of Social Affairs considers that housing service units can be closed as it is evident from the e-mail to Mr. Jukka Kumpuvuori on 20 October 2020 from the Permanent Secretary of the

Ministry of Social Affairs and Health, Mrs. Kirsi Varhila: *'(...) In practice a unit, to where the virus has managed to spread, needs to be, in a way "set to quarantine, because such units cannot be closed and its residents cannot be moved away from there. We do not have precise legislation for this, as you rightly noted.'* (...) *'the constitution obliges the public actor to protect life and health and this is rather strong obligation to the authority.'* (Annex4)

120. The aforementioned instruction of the Ministry of Social Affairs and Health of 20 March 2020 also refers to Section 58 of the Communicable Diseases Act which allows the local municipal body responsible for the control of communicable diseases to close a social care unit; to Section 60 which allows the physician in charge of communicable diseases in a public employment relationship either with the municipality or joint municipal authority for the hospital district to impose a quarantine in the units; and, finally, to Section 63 which allows the imposition of isolation on persons in housing service units. However, the law only allows these decisions to be taken by the above-mentioned physician in charge of communicable diseases. Only in urgent cases, can it be taken by another licensed physician working in a public health care unit (Section 70 of the Communicable Diseases Act 'Urgent decisions on a restrictive measure'). No one other than a physician specifically listed in the Act can therefore adopt such decision.
121. These decisions, moreover, have to be individualised and based on concrete information justifying their legitimacy. Quarantine pursuant to Section 60 of the Communicable Diseases Act can be imposed only if there is an obvious risk of the spread and it is impossible to prevent the spread of the disease by other means. Imposing isolation pursuant to Section 63 of the Communicable Diseases Act is only possible in relation to a concrete person justifiably suspected of having the disease. The application of both measures needs to be examined and executed on a case-by-case basis, thus individually, and by a medical doctor mandated to apply such measures according to the Communicable Diseases Act. It is not possible, according to the Communicable Diseases Act, to introduce a *de facto* 'general quarantine and isolation' of all persons in housing units. Only Regional Administrations and municipalities can adopt wide-scale general decisions such as the closure of housing service units (Section 58 of the Communicable Diseases Act).
122. None of the above-mentioned legislation therefore provides a legal basis for the restrictions on leaving and the visiting prohibitions imposed in the housing service units. The interference with the core of the right to be provided social services pursuant to Article 14 of the Charter and the right to independence, social integration and participation in the life of the community pursuant to Article 15 of the Charter was therefore unlawful. In essence, it constituted unlawful deprivation of liberty and unlawful interference with the private life of the residents of these units.

- b) Lack of relationship of reasonableness and necessity between the measures and the sought aim*

123. In addition to being unlawful, the measures were also not compatible with the nature of the rights enshrined in Articles 14 and 15 of the Charter and were not reasonably necessary and proportionate to the aim of promoting the general welfare in a democratic society. The restrictions struck at the very essence of the rights enshrined in Articles 14 and 15 of the Charter. Persons with disabilities in the housing units were, on account of these restrictions, *de facto* deprived of their liberty, private and family life, participation in the society as well as of their independence. They were left lonely and deprived of human contact, moreover in a crisis situation, when the support of a family, friends and our communities, is an essential part of surviving and coping with the emotional and psychological impacts of the pandemic.

124. While the limitations were rhetorically justified by the protection of the lives and health of persons with disabilities during the pandemic, as was detailed in the first part of the complaint, they had the opposite effect: they placed persons with disabilities in additional danger of contracting the virus and dying from it. On the contrary, no measures which would actually serve to protect the life of persons with disabilities or ensure their equal access to health services were adopted (see above, § 22-29).

c) Discrimination

125. The restrictive measures introduced by the Finnish Government were based on a stereotypical and prejudiced view of persons with disabilities as vulnerable and in need of imposed protection. Indeed, the measures prohibiting leaving the institution and banning visits inside institutions were based on a presumption that all persons with disabilities living in housing service units belong to a vulnerable group which is at high risk of being severely affected by the virus. However, although some persons with disabilities in housing units may belong to a vulnerable, at-risk group, many do not. As in the wider community, persons with disabilities living in housing service units include persons who live an active, healthy and independent life and some with underlying physical conditions that may increase susceptibility to or the severity of COVID-19 infection. Both those persons with disabilities who live in housing service units and are not at heightened risk, and those who are at heightened risk, have the right to take active and independent decisions about their lives, including decisions about when and whom they want to accept as a visitor in their home. Portraying all persons with disabilities using these services as vulnerable and regulating their everyday lives under the assumption that they require imposed protection at the expense of their autonomy and personal liberties, supports the prejudice against persons with disabilities as passive and helpless, a stigma already all too present in our societies.

126. The blanket prohibition on visits is clearly based on this presumption of vulnerability: it is worth noting that the Government did not provide any definition of an “at-risk group”, and even explicitly denied that persons with disabilities in general are at heightened risk of contracting the virus (§ 21). No rational or objective justification as to why these restrictive measures had to be adopted in relation to all persons with disabilities in housing service units can be identified in any of the texts or measures

issued by any national authorities nor by either the public or private service providers. The blanket prohibitions were imposed almost exclusively on persons with disabilities due to the fact that they are users of social services, motivated by the stigmatising presumption that all persons with disabilities are a group at risk in the pandemic.

d) Lack of consideration of the needs and rights of persons with disabilities and failure to include them in planning of the measures

127. None of the prohibitive measures adopted by the Finnish Government in relation to persons with disabilities residing in housing service units actually properly considered and weighed the general interests of the protection of public health against the protection of the rights of the affected population. This is illustrated not only by the lack of any data in relation to the affected population (see § 39-42), but also by the fact that persons with disabilities were not included in decision-making nor consulted in the process of planning and adopting the restrictive measures (see above § 43).

128. Had the Government consulted persons with disabilities or their representative organisations prior to adopting these measures, or within a reasonable time after their imposition, they would have learnt that the assumption that persons with disabilities living in housing service units are all vulnerable is simply scientifically wrong. Similarly, they would have learnt that, as was known soon after the onset of the pandemic, closing down the doors to institutions cannot be considered a measure of protection for those populations residing in them (see § 79). Consulting persons with disabilities on policy measures which affect their rights is not only the state's obligation (see above, § 87), but it is also a prerequisite for effective planning of such policies and responses.

129. Indeed, persons with disabilities constitute a large and diverse group with different needs and lifestyles, and who require different forms of support. This also means that different measures impact them differently, and it is simply impossible to properly evaluate the impact of restrictive measures – and weigh it against the public interest of protecting public health – without such consultations. The approach of the Finnish Government was based on a prejudiced and paternalistic view of persons with disabilities, which has no place in effective public administration in the 21st century. This applies even more urgently when it concerns such important interests as the protection of the lives and health of those affected.

e) Failure to ensure at least the minimum core of the right in question

130. The deprivation of liberty, interference with the right to privacy, and the resulting denial of basic human dignity described above (see § 91 and 95) undermine and contradict the very purpose of the rights in Articles 14 and 15. As set out above concerning the reasonableness and necessity of the restrictions (see above § 86-89), the effect of the restrictions was that persons with disabilities in housing service units could no longer access necessary social and medical services, including personal assistance. They were

explicitly denied the right to choose to reside at home with their families when visits home, including weekend visits, were prohibited, exacerbating the existing restrictions on their right to choose their place of residence reflected in the up to three month time period for processing requests for discharge from the housing service units. The deprivation of choice and control over their daily lives that is inherent in institutionalisation, was exacerbated to the extent that residents were no longer free even to visit friends in another unit. The evidence is clear and overwhelming that the inability to leave institutions, the separation from family and friends and the withdrawal of essential social and medical services with no alternative means of accessing these, harmed the well-being of residents. It put their lives directly at risk and may have led to an increased death toll from the virus (although this cannot be statistically confirmed because the Government has failed to record any data in this regard). It is clear that, even if the system of institutionalisation may have been argued to be established for the purpose of ensuring the independence of persons with disabilities, and facilitating their access to the social environment and integration in the community (which the complainants vigorously deny), this argument is self-evidently unsustainable under the restrictive measures imposed in the context of the COVID-19 pandemic: these institutions became explicitly places of isolation, segregation and exclusion while the wider society was not locked down or similarly restricted. The minimum core or essence of the rights in both Article 14 and Article 15 was therefore completely deprived of any content for persons in housing service units.

131. Moreover, the Finnish Government adopted wide-scale measures isolating persons with disabilities in their housing service units without having conducted the basic mapping as to how they would be affected by these measures. Indeed, the Finnish Government unable to provide basic data on the number of users of these units even after several requests by civil society organisations (see above § 39-42). This implies that the Government did not inquire about the impact of those measures and whether they were, in view of the situation, necessary and proportionate. It demonstrates a fundamental failure by the Government in planning of the pandemic response and a failure to meet the minimum core obligation to collect relevant data.

f) Availability of meaningful review processes at the domestic level

132. The restrictive measures interfered with the basic human rights of persons with disabilities residing in housing service units. Nevertheless, those affected were not given any information as to whether and how it was possible to challenge the measures. No complaint mechanism was put in place. No provision in any of the published decisions indicated any administrative or judicial review mechanisms that those affected could invoke to challenge the decisions, nor were any procedures for compensation in case of damages inflicted on persons of concern. Although in theory administrative courts are competent to examine legal challenges against these *de facto* interferences, persons with disabilities have not been provided with any information or instruction on this possibility. Legal aid was not put in place to help them access potential legal recourses.

133. For many persons with disabilities, accessible information and provision of support and accommodations are an essential element of access to justice. This applies with much greater urgency if they are isolated in social care facilities, with no personal contact with the outside world and only limited access to information. For many of them, at the same time, information needs to be provided in accessible formats and support needs to be provided to enable them to effectively access available procedures.

e) *Conclusion*

134. In the adoption of the restrictive measures concerning persons with disabilities in housing service units, Finland has *de facto* limited their rights protected under Articles 14 and 15 of the Charter. This section detailed that Finland failed to do so in a manner consistent with the rules for limitation of rights under the Charter as well as with the conditions for rebutting the presumption that retrogressive measures violate the Charter. While being, supposedly, temporary, the measures were not lawful, they were not necessary or reasonable, and they were discriminatory against persons with disabilities. Moreover, the Government failed to plan with appropriate regard to the impact on persons with disabilities and to their needs, failing to include them in the planning, and impermissibly undermined the minimum core normative content of the rights, as well as failing to collect the elementary data needed to be able to assess the extent of the impact. Lastly, the Government failed to provide persons with disabilities effective access to review and remedy for the violation of their rights. Finland thus failed to uphold its obligations under Articles 14 and 15 in conj. with Article E of the Charter.

5. CONCLUSION

135. The present complaint argues that the response of the Finnish Government to the coronavirus pandemic in spring 2020 violates the rights of persons with disabilities under Article 11 (right to health), Article 14 (right to social services) and Article 15 (right to independence and inclusion in the community) in conj. with Article E of the Charter.

136. The Finnish Government did not adopt appropriate measures to protect the life and health of persons with disabilities, as required by Article 11 of the Charter. Because during a pandemic, institutions become hotbeds of spread of the virus, the state was under an obligation to immediately discharge persons with disabilities into the community with appropriate supports. Further, the Government also failed to ensure that persons with disabilities have, during the pandemic, access to health care services and facilities on a basis of non-discrimination. Both failures amount to a violation of Article 11 in conj. with Article E of the Charter.

137. Moreover, the Finnish Government adopted restrictive measures, which led to the complete isolation of persons with disabilities in housing service units: the prohibition to leave the institution and the prohibition to accept any visits in the institution. These prohibitions limiting their right to social services, and independence and inclusion in the community enshrined in Articles 14 and 15 of the Charter were not adopted in

accordance with the law and were imposed on the basis of a paternalistic and prejudiced view of persons with disabilities. These violations were all linked to the Government's failures in planning the response: its failures to include persons with disabilities in planning, to collect the necessary data to be able to properly consider their needs and implications of their needs for their rights, and failure to ensure that persons with disabilities have access to appropriate remedies for the violation of their rights. The accumulation these acts, and failures constitute a breach of Finland's obligations under Articles 14 and 15 in conj. with Article E of the Charter.

IV. Annexes

Annex no. 1: The instructions and measures introduced by the Finnish Government in relation to persons with disabilities in institutions during the COVID-19 pandemic

Annex no. 2: Instructions and practices adopted by selected major social service providers in six major Finnish cities

Annex no. 3: Instructions adopted in relation to social service providers in six major Finnish cities

Annex no. 4: Testimonies of organizations and persons with disabilities in relation to the planning of the pandemic response by the Government and the impact of the measures

Annex no. 5: Response of the Finnish Institute of Health and Welfare to requests for data