Minister for Health

Statement of Reasons

**Pandemic Orders made Thursday 6 January 2022**

On 6 January 2022, I Martin Foley, Minister for Health, made the following pandemic orders under section 165AI of the *Public Health and Wellbeing Act 2008*:

|  |
| --- |
| Pandemic (Open Premises) Order 2022 (No. 2) |
| Pandemic (Workplace) Order 2022 (No. 2) |
| Pandemic (Additional Industry Obligations) Order 2022 (No. 2) |
| Pandemic (Quarantine Isolation and Testing) Order 2022 (No. 3) |

In this document, I provide a statement of my reasons for the making of each the above pandemic orders.  My statement of reasons for making each of the pandemic orders consists of the general reasons in [1]-[57] and the additional reasons set out in the applicable schedule for each order.

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**About the pandemic orders**

The pandemic orders were made under section 165AI of the Public Health and Wellbeing Act 2008 (PHW Act).

Statutory power to make pandemic orders

1. Under section 165AI of the PHW Act, I may, at any time on or after the making of a pandemic declaration by the Premier under s 165AB, make any order that I believe is reasonably necessary to protect public health. The Premier made a pandemic declaration on 10 December 2021, on the basis that he was satisfied on reasonable grounds that there is a serious risk to public health throughout Victoria arising from the coronavirus (COVID-19) pandemic disease.
2. Pursuant to section 165AL(1), before making a pandemic order, I must request the advice of the Chief Health Officer in relation to the serious risk to public health posed by the disease specified in the pandemic declaration, and the public health measures that the Chief Health Officer considers are necessary or appropriate to address this risk.
3. On 22 December 2021, I requested the advice of the Chief Health Officer in relation to additional measures that could be put in place in response to the Omicron variant of concern. I received the Chief Health Officer’s advice on 23 December 2021. This advice is supplemented by:
   1. the Chief Health Officer’s advice provided on 10 December 2021
   2. the verbal advice the Chief Health Officer provided on 14 December 2021
   3. the verbal advice the Acting Chief Health Officer provided on 29 December 2021
   4. the verbal advice the Acting Chief Health Officer provided on 30 December 2021
   5. the verbal advice the Acting Chief Health Officer provided on 4 January 2022
4. I have also confirmed that epidemiological data available to me on 6 January 2022 affirm my positions on the orders made on 6 January 2022.
5. On 30 December 2021, I met with the Acting Chief Health Officer for additional advice following the recommendations from The Australian Health Protection Principal Committee (AHPPC) and the outcomes of the meeting of National Cabinet on 30 December 2021.  The Acting Chief Health Officer advised that the reporting from National Cabinet has significant implications for Victoria and recommended that Victoria aligns to the nationally endorsed positions for self-isolation and quarantining periods in reflection of the changing nature of the COVID-19 epidemic.[[1]](#footnote-2)
6. On 4 January 2022, I requested confirmation from the Acting Chief Health Officer regarding whether the written advice that the Chief Health Officer provided to me on 23 December 2021 was still applicable in the current context. This included confirmation in relation to previous advice provided for density requirements for food and drink and entertainment premises, prohibiting indoor dancefloors, requiring seated service where possible for operators and shifting towards extending rapid antigen (RA) testing. [[2]](#footnote-3)
7. The Acting Chief Health Officer’s advice on 4 January 2022, considering the current context, advised that further measures such as mandating working from home, ceasing elective surgery, extending mandates for third vaccine doses, may be required in the immediate future.[[3]](#footnote-4)
8. Under s 165AL(2), in making a pandemic order, I must have regard to the advice of the Chief Health Officer and may have regard to any other matter that I consider relevant including, but not limited to, social and economic matters. I may also consult any other person that I consider appropriate before making a pandemic order.
9. On the basis of the material provided to me by the Department of Health and the advice of the Chief Health Officer and Acting Chief Health Officer, I am satisfied that the proposed pandemic orders are reasonably necessary to protect public health. I consider that the limitations on human rights that will be imposed by the proposed pandemic orders are reasonable and justified in a free and democratic society based on human dignity, equality and freedom. I therefore make these pandemic orders under s 165AI of the PHW Act.

Guiding principles

1. I have made this decision informed by the guiding principles in sections 5 to 10 of the PHW Act. I note that the Chief Health Officer and Acting Chief Health Officer also had regard to those principles when providing his advice.

*Principle of evidence-based decision-making*

1. This principle is that decisions as to the most effective and efficient public health and wellbeing interventions should be based on the evidence available in the circumstances that is relevant and reliable.[[4]](#footnote-5)
2. My decision to make the pandemic orders has been informed by the expert advice of the Chief Health Officer and Acting Chief Health Officer about the serious risk to public health posed by COVID-19 and the public health measures that the Chief Health Officer and Acting Chief Health Officer considers are necessary or appropriate to address this risk.

*Precautionary principle*

1. This principle is that if a public health risk poses a serious threat, lack of full scientific certainty should not be used as a reason for postponing measures to prevent or control the public health risk.
2. COVID-19 is a serious risk to public health, and it would not be appropriate to defer action on the basis that complete information is not yet available. In such circumstances, as the PHW Act sets out, a lack of full scientific certainty is not a reason for postponing measures to prevent or control the public health risks associated with COVID-19.

*Principle of primacy of prevention*

1. This principle is that the prevention of disease, illness, injury, disability or premature death is preferable to remedial measures.
2. Despite high vaccination coverage across Victoria, many situations involve a higher level of risk. These settings include indoor spaces and events where there are 30,000 or more attendees. Given the continuing risk of surging case numbers and outbreaks, particularly with a highly mobile population compared to lockdown periods, it is appropriate that the Victorian Government takes a conservative and cautious approach to manage risk in a targeted and efficient manner. This approach is supported by the principle of primacy of prevention in the Act.[[5]](#footnote-6)

*Principle of accountability*

1. This principle is that persons who are engaged in the administration of this Act should as far as is practicable ensure that decisions are transparent, systematic and appropriate.
2. Consistent with this principle, members of the public should be given access to reliable information in appropriate forms to facilitate a good understanding of public health issues, as well as opportunities to participate in policy and program development.
3. To promote accountability in the making of pandemic orders, the Act requires that a copy or written record of the Chief Health Officer's advice, a statement of reasons, and a human rights statement are published in the case of the making, variation or extension of an order.
4. All the reasons I have made these orders and the advice that has informed those decisions, as well as the expert assessments of the potential human rights impacts of my decisions, have been published according to this principle.

*Principle of proportionality*

1. The principle is that decisions made, and actions taken in the administration of this Act should be proportionate to the risk sought to be prevented, minimised or controlled, and should not be made or taken in an arbitrary manner.
2. In deciding to make the pandemic orders, I am required to be satisfied that those orders are 'reasonably necessary' to protect public health, which requires consideration of the proportionality of those measures to the risk to public health.

*Principle of collaboration*.

1. The principle of collaboration is that public health and wellbeing, in Victoria and at a national and international level, can be enhanced through collaboration between all levels of Government and industry, business, communities and individuals.
2. In preparing the pandemic orders, I consulted with the Premier, my Coordinating Ministers Committee colleagues, the Victorian Chamber of Commerce and Industry and the combined Victorian Health Union Officials Group.
3. Throughout the pandemic, there has been ongoing consultation between the Deputy Chief Health Officers and the Chief Health Officers of the States and Territories, including through the Australian Health Protection Principal Committee.
4. Victoria continues to work with other jurisdictions through National Cabinet to talk through plans for managing COVID-19. *Victoria’s Roadmap: Delivering the National Plan* is aligned with vaccination targets set out in the *National Plan to transition Australia’s National COVID-19 Response*, as agreed by National Cabinet.

*Part 8A objectives*

1. I have also had regard to the objectives of Part 8A in section 165A(1) of the PHW Act, which is to protect public health and wellbeing in Victoria by establishing a regulatory framework that:
   1. prevents and manages the serious risk to life, public health and wellbeing presented by the outbreak and spread of pandemics and diseases with pandemic potential; and
   2. supports proactive and responsive decision-making for the purposes of preventing and managing the outbreak and spread of pandemics and diseases with pandemic potential; and
   3. ensures that decisions made and actions taken under Part 8A are informed by public health advice and other relevant information including, but not limited to, advice given by the Chief Health Officer; and
   4. promotes transparency and accountability in relation to decisions made and actions taken under Part 8A; and
   5. safeguards contact tracing information that is collected when a pandemic declaration is in force.

Human Rights

1. Under s 165A(2) of the PHW Act, the Parliament has recognised the importance of protecting human rights in managing the serious risk to life, public health and wellbeing presented by the outbreak or spread of pandemics and diseases of pandemic potential.
2. In addition, in making each pandemic order, I have proceeded on the basis that I should give proper consideration to relevant human rights under the *Charter* *of Human Rights and Responsibilities* *2006* (Vic) (**Charter**). I therefore proceeded on the basis that, in making each order, I was required to take the following four steps:
   1. first, understand in general terms which human rights are relevant to the making of a pandemic order and how those rights would be interfered with by a pandemic order;
   2. second, seriously turn my mind to the possible impact of the decision on human rights and the implications for affected persons;
   3. third, identify countervailing interests or obligations in a practical and common-sense way; and
   4. fourth, balance competing private and public interests as part of the exercise of ‘justification’.
3. This Statement of Reasons must be read together with the Human Rights Statement.

**Overview of public health advice**

Current context

1. Victoria is currently experiencing an outbreak both the Delta strain and Omicron strain of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus which causes COVID-19. There continues to be global uncertainty and growing concern about the rapid spread of the Omicron Variant of concern. When making these pandemic orders, I have had regard to the advice of the Chief Health Officer dated 23 December 2021, as well as the verbal advice of the Acting Chief Health Officer on 29 December 2021 and 30 December 2021, and 4 January, including current outbreak patterns, growth in case numbers, and vaccination rates.

Immediate situation: Phase D Settings for continued management of the COVID-19 Pandemic according to the Victorian Roadmap to deliver the National Plan

1. As of 6 January 2022, 21,997 new locally acquired cases and 0 new cases from overseas have been reported to the Department of Health (DH) within the preceding 24 hours. There were 64,861 test results received for this period. The state 7-day local case growth rate to 6 January 2022 was 328 per cent.
2. As of 6 January 2022, there were 61,120 active cases in Victoria and 1,815 cases being managed as close contacts.
3. 6 COVID-related deaths were reported in 24 hours preceding 6 January 2022, bringing the total number of COVID-19 related deaths in Victoria to 1,559.
4. From 6 January 2022, the majority of locally acquired cases associated with the current outbreaks have been associated with the Delta (B.1.617.2) variant of concern, with 173 locally acquired cases associated with the Omicron (B.1.1.529) Variant of concern and genomic sequencing was underway for all newly identified cases.
5. Due to processing labs being closed, the wastewater testing data is unavailable.

*Test results*

1. Victorians have been tested at a rate of 13,470 per 100,000 people over the 14 days to 6 January 2022.

*Vaccinations*

1. As at 6 January 2022:
   1. a total of 5,075,530 doses have been administered through the state’s vaccination program, contributing to a total of 11,401,280 doses administered in Victoria.
   2. 93.0 per cent of Victorians over the age of 12 have been fully vaccinated.
   3. 94.5 per cent of Victorians over the age of 12 have been partially vaccinated.
   4. 12.0 per cent of eligible Victorians over the age of 12 have received their thirddose of a COVID-19 vaccination.

*The current global situation*

1. The following situation update and data have been taken from the World Health Organisation, published 28 December 2021.

|  |  |
| --- | --- |
| **Statistic** |  |
| Global confirmed cumulative cases of COVID-19 | Over 278 million |
| Global cumulative deaths | Under 5.4 million |
| Global trend in new weekly cases | Increasing: 11 per cent increase compared to the previous week. |
| Global regions reporting the highest weekly case incidence per 100 000 population | * European Region (304.6 per 100 000 population) * Region of the Americas (144.4 per 100 000 population); |
| Global regions reporting the highest weekly incidence in deaths | * European Region (2.6 per 100 000 population,) * Region of the Americas (1.2 per 100 000 population) |
| The highest numbers of new cases: | * United States of America (1 185 653 new cases; 34 per cent increase) * United Kingdom (611 864 new cases, 20 per cent increase) * France (504 642 new cases; 41 per cent increase) * Italy (257 579 new cases; 62 per cent increase) * Germany (197 845 new cases; 30 per cent decrease) |

Sources: World Health Organisation published 28 December 2021, WHO COVID-19 Weekly Epidemiology Update

**Reasons for decision to make pandemic orders**

Overview

1. Protecting public health and wellbeing in Victoria from the risks posed by the COVID-19 pandemic is of primary importance when I am deciding whether or not to issue pandemic orders. This is a priority supported by the PHW Act.
2. Section 165AL(2)(a) of the Act requires me to have regard to the advice of the Chief Health Officer, and I confirm that I have done so. That advice includes public measures that the Chief Health Officer recommends or considers reasonable.
3. Section 165AL(2)(b) permits me to have regard to any other matter I consider relevant, including (but not limited to) social and economic factors. Section 165AL(3) permits me to consult with any other person I consider appropriate before making pandemic orders.
4. In making the decision to issue each of the pandemic orders, I have had regard to current, detailed health advice. On the basis of that health advice, I believe that it is reasonably necessary for me to make the pandemic orders to protect public health.[[6]](#footnote-7) In assessing what is 'reasonably necessary', I have had regard to Gleeson CJ's observation in *Thomas v Mowbray* (2007) 233 CLR 307 at [22] that *“the [decision-maker] has to consider whether the relevant obligation, prohibition or restriction imposes a greater degree of restraint than the reasonable protection of the public requires”*.
5. The new orders I have made recognise that, although 93.0 per cent of the Victoria population aged 12 and above are fully vaccinated, other measures are still required to control the spread of COVID-19. It is still necessary to maintain safeguards to control the rate at which COVID-19 can spread given high levels of community transmission are still evident.[[7]](#footnote-8)
6. The measures that I recommend are necessary and appropriate to manage the risk that COVID-19 presents, especially in light of the need to gather more information and evidence about the Omicron variant of concern; the potential waning of vaccine-induced immunity and the need for third-dose vaccination; and how effectively similar public health measures appear to be in containing COVID-19 in Northern Hemisphere countries as they enter winter.[[8]](#footnote-9)
7. The correlation between the imposition of an immediate and strong public health response and case numbers has been evidenced not only in Australia but across the world. Although restrictions have been successful in preventing the significant numbers of deaths predicted by modelling in the absence of intervention, there is a clear link between unrestricted movement in the community, growth in case numbers, and the resulting number of deaths.[[9]](#footnote-10)
8. Having had regard to the advice of the Chief Health Officer and Acting Chief Health Officer and after having consulted with the Premier, my Coordinating Ministers Committee colleagues and others as set out in clause 24, it is my view that making these pandemic orders is reasonably necessary to reduce the risk that COVID-‑19 poses by:
   1. Improving Victorians’ understanding of the transmissibility of COVID-19, and the actions that they can take to reduce the risk of transmission.
   2. Modifying some of the environments within which people live and interact, to lower the likelihood of transmission, by introducing density limits indoors for food and drink and high-risk entertainment venues including arcades, nightclub, karaoke, gaming, casino and adult entertainment. This will be a density quotient of 1 person per 2 square metres in indoor spaces.
   3. Restricting elective surgery to Category 1 and 2 procedures, therefore postponing non-urgent elective surgery in private hospitals, day procedure centres and public health services, with limited exceptions.
   4. Narrowing the carve out from elective surgery restrictions for IVF procedures.
   5. Requiring employers to advise workers who have symptoms to comply with any requirements that may be relevant in the document “Testing Requirements for Contacts and Exposed Persons” as amended from time to time, and support a worker to do so.
   6. Introducing a new category of person subject to isolation and testing requirements: the probable case, who is someone who has received a positive result on a COVID-19 RA test.
   7. Requiring probable cases to notify the Department and self-isolate and take reasonable steps to notify relevant contacts of their COVID-19 status.
9. The Chief Health Officer has relevantly advised:
   1. In the context of ongoing community transmission of the Delta variant, and the likely increase in transmission of Omicron, it is advisable that the role of RA testing be urgently expanded in Victoria. RA tests show moderate sensitivity and high specificity for the detection of SARS-CoV-2 and are an appropriate asymptomatic screening tool in the setting of high community prevalence.[[10]](#footnote-11)
   2. Better access to and awareness of RA testing will arm Victorians with a more proactive preventative tool, particularly for those who may experience asymptomatic infection and unwittingly pass this on to their friends and family.[[11]](#footnote-12)
   3. The use of RA testing as an asymptomatic screening tool in the context of high community prevalence is consistent with previous advice, but their use should be expanded now given the increased risk posed by the Omicron variant.[[12]](#footnote-13)
   4. Visitors to hospitals and care facilities be required to undertake a self-administered RA test prior to their visit, bring the test to the facility for examination by the entry monitors, and then discarded on site.[[13]](#footnote-14)
10. The Acting Chief Health Officer has relevantly advised that:
    1. The epidemiology in Victoria has shifted significantly since the previous formal advice. On 23 December there were approximately 14,800 confirmed active cases in the community. As of 4 January, there are approximately 48,000. Omicron had increased from 3 per cent of test isolates in the first half of December, to 30 per cent of isolates by 20 December, to more than 75 per cent by 31 December 2021. [[14]](#footnote-15)
    2. Public health and social measures such as those recommended do have a downward impact on transmission and on health system pressures. The impact on acute health services, while necessarily delayed due to the incubation period of COVID-19 and the time taken from onset of symptoms to more severe illness in those cases where this occurs, could be anticipated to be in effect from two weeks’ time onward.[[15]](#footnote-16)
    3. The Minister should consider mandating the third dose of the COVID-19 vaccine for the following workers: health care workers, aged care workers, disability care workers, emergency services workers, workers in correctional facilities, hotel quarantine workers, and workers in abattoirs and meat and poultry processing facilities.[[16]](#footnote-17)
    4. High levels of third dose COVID-19 vaccination coverage for early childhood learning staff is highly desirable, but in the first instance there should be a strong engagement program for this industry and workers to promote high levels of vaccination uptake.[[17]](#footnote-18)
    5. There are substantial pressures on the testing system, and hospitalisations moved from 398 inpatients and falling on 23 December to 516 inpatients and going up. There is a need to shift away from PCR to RA testing in order to preserve and reduce the pressure on the testing system. Changes to case definition are required to facilitate this shift.[[18]](#footnote-19)
    6. The measures recommended by the Chief Health Officer on 23 December for isolation and testing are still applicable.[[19]](#footnote-20)
    7. Some changes are necessary to the Workplace Order for consistency with the Quarantine, Isolation and Testing Order.[[20]](#footnote-21)
    8. A mandate for working from home could be implemented excluding early learning centres, primary or secondary schools. However, the Minister could consider waiting and reviewing progress of the next two weeks with the recommended restrictions, as many people are not currently working on-site during this time of year.[[21]](#footnote-22)
    9. In making the recommendations to the Minister to consider a range of public health and social measures – including introducing DQ4 indoors (including cinemas and seated theatres), the closure of indoor dancefloors, seated service requirement in indoor hospitality settings, and a requirement to work or study from home where possible (excluding early childhood learning, primary and secondary schools) – these are considered the least restrictive measures to achieve maximum public health intent had been considered. [[22]](#footnote-23)
    10. Previous advice from 23 December 2021[[23]](#footnote-24) to mandate seated service in hospitality and entertainment and prohibiting dancefloors is still applicable in indoor settings. [[24]](#footnote-25)
    11. Limiting all outdoor entertainment to 50 per cent capacity with the intent of capturing both larger and smaller events. There are pinch points at the start or end of events, with crowds congregating at an entry or exit point and increasing transmission risk[[25]](#footnote-26)  RA tests in particular present a significant opportunity that can be harnessed to reduce the risk of COVID-19 incursion and transmission in a range of contexts including sensitive settings, as well as major events. However, supply and implementation issues pose significant constraints to taking this approach. If supply and implementation issues could be addressed, then deployment of RA tests could achieve the public health objective of reducing risk of amplification of COVID-19 transmission posed by major events with lesser, or even avoidance of capacity caps.[[26]](#footnote-27)
    12. Extending mask use to include while patrons are seated at outdoor events (except while eating or drinking) could be an additional risk mitigant.[[27]](#footnote-28)
    13. The cessation of elective surgery is recommended given the increased hospitalisation rates and pressure on the health system caused by the Omicron surge.[[28]](#footnote-29)
    14. The advice covers changes split over 6 and 12 January and includes consideration of RA test availability. It is proportionate on that basis. Further, all changes are recommended over 6 and 12 January given the delay of impact of the changes. It is better to move earlier as a change in Orders would not have an immediate effect, but would have a profound effect on case numbers approximately two weeks after the changes occurred.[[29]](#footnote-30)
    15. Less restrictive measures were considered, particularly considering the human rights objective of favouring less restrictive options whenever possible. These were not recommended given the transmissibility of the Omicron variant and the increasing pressures on the health system. Other measures for vulnerable communities should continue in tandem.
    16. I accept the Chief Health Officer and Acting Chief Health Officer advice outlined above. Given the escalating case numbers and the seven-day local COVID-19 case average rising to 11,730 people per day, I now consider it necessary to implement further measures through pandemic orders.
11. I believe these measures are reasonably necessary and proportionate to the current risk of transmission in the community. I continue to consider the following settings the Chief Health Officer and Acting Chief Health Officer have advised to mandate, and in the current context have opted to ‘strongly recommend’ to operators to introduce these measures where possible. This is to best protect the community and vulnerable populations, while balancing the social and economic impacts to the broader community. The ‘strongly recommended’ measures are:
    1. seated services at indoor food, drink, entertainment premises and events; and
    2. prohibiting indoor dancefloors.
12. With regard to the density quotient requirement, I believe a density requirement of 1 person per 2 square metres for indoor areas of food and drink premises and high risk entertainment venues such as arcades, nightclub, karaoke, gaming, casino and sex on premises venues is a proportionate measure to mitigate transmission at this stage. In making this decision I have considered the broader social and economic factors in parallel to the public health advice, also acknowledged by the Acting Chief Health Officer.[[30]](#footnote-31)
13. The Department of Jobs, Precincts and Regions has provided estimates on impacts of proposed restrictions on hospitality and events.
    1. Applying a density quotient to indoor hospitality and closing dancefloors, if adopted, could have severe immediate and long-term economic impact on Victoria’s economic recovery and the economic wellbeing of Victorians.
    2. People working in the affected sectors have a higher representation from economically vulnerable cohorts – such as younger people, women and CALD communities – who will be disproportionately impacted by these public health measures.
14. The introduction of density quotient requirements for indoor spaces for food and drink and high-risk entertainment venues reduces the risk of transmission in these environments, and I therefore believe that a mandate for the above measures is not necessary at this time. The Acting Chief Health Officer also noted that in considering any restrictions for outdoor settings, it was important to be encouraging outdoor activities rather than introducing restrictions that could incentivise people into private residences and indoor spaces, which would ultimately increase the risk of transmission of COVID-19.[[31]](#footnote-32)
15. I also consider it ‘recommended’ that individual undertake a RA test prior to attending private gathering, events, entertainment, care facilities and hospitals. This is in recognition of the implementation and operational challenges posed by RA testing at this time.

Risks of no action taken

55 Given all the above, if pandemic management measures had not been introduced and maintained in Victoria since early in the pandemic, the likely impact of COVID-19, particularly for older people, people with certain chronic medical conditions and other vulnerable groups would have been far greater. In turn, an even more significant pressure would have been (and still could be) placed on the Victorian health system, to respond at a scale that has little precedent in the modern era. As Taylor and colleagues (2021) note:

56 “If Australia had experienced the same crude case and death rates as three comparable countries - Canada, Sweden and the United Kingdom - there would have been between 680,000 and 2 million cases instead of the 28,500 that did occur [during 2020], and between 15 and 46 times the number of deaths.”[[32]](#footnote-33)

Schedules

1. The specific Reasons for Decision for each Pandemic Order are set out in the Schedules.

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**The Hon. Martin Foley**

Minister for Health

6 January 2022

**Schedule 1 – Reasons for Decision – Pandemic (Open Premises) Order**

Summary of Order

1. This Order imposes obligations upon operators of certain open premises in Victoria and their patrons in relation to vaccination against COVID-19 and other requirements, in order to address the serious public health risk posed to Victoria by COVID-19.

*Purpose*

1. The objective of this Order is to impose obligations in relation to vaccination against COVID-19 and other requirements, in order to address the serious public health risk posed to Victoria by COVID-19 upon:
   1. operators of certain open premises in the State of Victoria; and
   2. patrons that attend those premises.

*Obligations*

1. The premises to which this order applies ('open premises') are:
   1. adult education or higher education premises
   2. arcades, escape rooms, bingo centres
   3. casino
   4. community premises
   5. creative arts premises
   6. drive-in cinemas
   7. food and drink premises
   8. gaming machine premises
   9. karaoke and nightclubs
   10. physical recreation premises
   11. restricted retail premises
   12. sex on premises, brothels and sexually explicit venue
   13. swimming pools, spas, saunas, steam rooms and springs
   14. tours
   15. premises used for tourism services
2. Operators of an open premises must (unless an exception applies):
   1. maintain a system which requires all patrons above 18 years of age to show an employee acceptable evidence that the person is fully vaccinated or an excepted person on every occasion a person attends the premises. This system must include a worker placed at each accessible entrance of the premises;
   2. take reasonable steps to exclude patrons who do not comply with the operator’s system, or are not fully vaccinated or exempt;
   3. not permit any person to work at the premises unless that person is fully vaccinated, or an excepted person. A partially vaccinated worker may work on the premises when no patrons are present at the time. The operator must collect, record and hold vaccination information for all workers;
   4. not permit the number of patrons to exceed the patron limits as specified in the Order, unless an exception has been permitted under the Order;
3. Operators of food, drink and high-risk entertainment premises must apply a density quotient of 1 person per 2 square metres in indoor areas.
4. Patrons of an open premises must comply with the operator’s system.
5. Exceptional circumstances are listed under which an operator is not required to comply with this Order. Otherwise, failure to comply with this Order may result in penalties.

*Changes from Pandemic (Open Premises) Order 2021 (No. 1)*

1. Operators of food, drink and high-risk entertainment premises must apply a density quotient of 1 person per 2 square metres in indoor areas.
2. Amendment included that a COVID Safe event plan is required for entertainment and function premises which operate primarily in outdoor spaces where the number of patrons exceeds 30,000.
3. Amendment included that workers above 12 years and 2 months of age must be fully vaccinated in order to work at an open premises. This is a clarification based on agreed 15 December 2021 policy settings, the intent being that workers aged over 12 years and 2 months must be vaccinated to work at an open premises, however patrons aged over 18 years must be vaccinated to attend an open premises. Exceptions apply to the vaccination requirement for both patrons and workers.
4. A definition of an excepted worker has been included. This is similar to that of an excepted person, however with the age exception being below 12 years and 2 months.

*Period*

1. This Order will commence at 11:59:00pm on 6 January 2022 and end at 11:59:00pm on 12 January 2022.

Relevant human rights

*Human rights that are limited*

1. For the purposes of section 165AP(2)(c), in my opinion, the obligations imposed by the order will limit the human rights identified in paragraph 49 of the Human Rights Statement.
2. My explanation for why those rights are limited by the order is set out in the Human Rights Statement.
3. The Human Rights Statement also sets out:
   1. my explanation of the nature of the human rights limited (as required by section 165AP(2)(i)); and
   2. my explanation of the nature and extent of the limitations (as required by section 165AP(2)(iii)).

*Human rights that are affected, but not limited*

1. Further, in my opinion, the obligations imposed by the order will affect, but not limit, the human rights identified in paragraph 50 of the Human Rights Statement.
2. My explanation for why those rights are affected, but not limited, by the Order is set out in the Human Rights Statement.

How the obligations imposed by the Order will protect public health

1. I carefully read and considered the Chief Health Officer's advice provided to me on 10 December 2021 and 23 December 2021, the verbal advice provided on 14 December 2021, and the verbal advice provided to me by the Acting Chief Health Officer on 29 December 2021, 30 December 2021 4 January 2022.
2. In relation to the restrictions that will be imposed by this Order, the Chief Health Officer and Acting Chief Health Officer relevantly advised:
   1. Businesses are and will continue to be a primary area in which both workers and patrons interact. People from different parts of Victoria meet in these settings, and any infections that occur can be carried back to different parts of the community.[[33]](#footnote-34)
   2. Vaccination requirements to enter open premises serve to protect the health of all who access these settings, including customers/patrons, workers and visitors, and in particular those who are in a vulnerable population group.[[34]](#footnote-35)
   3. Despite Victoria achieving the 90 per cent double dose vaccination threshold in people aged 12 years and over, it would be necessary and appropriate that patron vaccination mandates should remain in place for all open premises in the context of ongoing elevated rates of community transmission.[[35]](#footnote-36)
   4. Venues should have a system in place to enable patrons or visitors to check in using either the Services Victoria QR code or manual record keeping process. This information is necessary to facilitate contact tracing.[[36]](#footnote-37)
   5. The requirement for an operator to ensure a system is in place to be able to collect vaccination information for patrons aged 18 years and over each time they enter these settings should therefore also be retained in accordance with the vaccination requirement before entry.[[37]](#footnote-38)
   6. Imposing density quotients and requiring seated service in indoor areas of food, drink, and high-risk entertainment premises reduces the number of patrons potentially exposed in a venue, allows for individuals and operators to practice physical distancing, and reduce the risk of transmission across various groups. Specific application to indoor areas should also incentivise the use of outdoor areas and settings, where the risk of transmission is lower.[[38]](#footnote-39)
   7. Reintroducing density quotients for specified indoor settings also reflects the need to allow economic activity to continue, balanced against the public health evidence that outdoor environments are fundamentally lower risk than indoor environments.[[39]](#footnote-40)
3. Patrons must be prohibited from entering open premises unless fully vaccinated (or medically exempt or ineligible for COVID-19 vaccination), except the following settings:[[40]](#footnote-41)
   1. non-essential retail (excluding hair, beauty and personal care services);
   2. religious services, weddings and funerals; and
   3. real estate inspections and auctions.
4. The Chief Health Officer advised that the below settings could be excluded from the open premises requirements:
   1. Non-essential retail is excluded from this vaccine requirement due to the high vaccination rates in the community and the need for people to access goods and services. However, it is reasonable for hair, beauty and personal care services to continue with a vaccine requirement due to the close and prolonged contact that occurs between clients and workers who will not be required to wear face masks due to the nature of the activities.[[41]](#footnote-42)
   2. The interactions that arise from real estate activities are be considered lower risk and therefore not necessitate a vaccine requirement due to the relatively small numbers of patrons, who only attend for a short duration, and spend a portion of the visit in outdoor settings with good ventilation and lower risk of transmission.[[42]](#footnote-43)
   3. Religious gatherings, weddings and funerals, are important for the wellbeing needs of the attendees who are participating in religious and spiritual activities, attending important social milestones.[[43]](#footnote-44)
   4. As the risk from such activities is mitigated by the benefits of natural ventilation in outdoor settings, I do not believe that the Minister needs to consider these restrictions for outdoor spaces or venues.[[44]](#footnote-45)
5. I acknowledge the Chief Health Officer’s advice regarding density quotients in hospitality and high-risk entertainment indoor venues. However, I believe a density requirement of 1 person per 2 square metres for indoor areas of food and drink premises and high-risk entertainment venues such as arcades, nightclub, karaoke, gaming, casino and sex on premises venues is a proportionate measure to mitigate transmission at this stage in considering both the public health advice and the broader social and economic factors.

Countervailing possible impacts that the obligations imposed by the Order may have on individuals and the community

1. In making this decision, I have seriously considered the possible negative impacts of the Order on the individuals and the community.
2. In particular, as noted above, in the Human Rights Statement, I have considered how people’s human rights will be affected and limited by the Order.
3. In addition, I have also considered the following additional potential negative impacts:
   1. Some individuals may object to receiving a COVID-19 vaccine for a variety of reasons, including religious, cultural and personal health views and other belief systems. “There are some belief systems which disagree with aspects of the way that certain vaccinations are made if they are made with human tissues, and some have beliefs, associated with the body of a person being sacred, that the human body should not be in receipt of foreign chemicals or compounds.”[[45]](#footnote-46)
   2. The “practical effect [of the order] is to require a person to choose between being vaccinated or not being able to attend open premises, which includes a variety of venues including cinemas, restaurants, swimming pools and gyms.”[[46]](#footnote-47)
   3. The order limits freedom of movement “because it prevents a person from attending a particular place — namely, open premises — if they are unvaccinated.”[[47]](#footnote-48)
4. In addition, as advised by the Acting Chief Health Officer I will be recommending the following positions for operators of open premises:
   1. The Order does not physically force anyone to receive a COVID-19 vaccine.
   2. The Order contains an exception for people who have certification from a medical practitioner that they are unable to receive a dose or a further dose of a relevant vaccine due to a medical contraindication.

Whether there are any less restrictive alternatives that are reasonably available to protect public health

1. In his advice, the Chief Health Officer sets out a range of measures, including measures which do not have a restrictive element (such as health promotion, education, epidemiology and monitoring).[[48]](#footnote-49)
2. The Chief Health Officer clearly states that such measures alone will not be sufficient to manage the serious risk to public health posed by COVID-19.[[49]](#footnote-50)
3. Public education and health promotion can provide community members with an understanding of COVIDSafe behaviours and actions, such as hand hygiene, staying home when unwell and testing when symptomatic.[[50]](#footnote-51) However, onsite work for specified workers typically involves a significant amount of workforce interaction and movement.[[51]](#footnote-52) In addition, it is possible for individuals to be asymptomatic and infectious.[[52]](#footnote-53) Education and practicing of COVIDSafe behaviours are consequently not sufficient to manage the risk high levels of workforce interaction poses to public health.
4. While epidemiology and monitoring is necessary to facilitate contact tracing to reduce the onward spread of COVID-19, the high levels of transmission currently in Victoria indicates there may be an ongoing substantial proportion of undiagnosed COVID-19 cases in the community. Ensuring high vaccination coverage for workers and patrons reduces the risk of individuals transmitting COVID-19 to others.
5. There are a number of challenges that prevent the combination of mask wearing and testing being an equally robust solution to the risks of exposure and transmission compared to vaccines.[[53]](#footnote-54)
6. The effectiveness of face mask use in communities is influenced by the general compliance and appropriate monitoring and wearing of masks, in addition to education, communication and guidance campaigns.[[54]](#footnote-55) There would be significant problems with providing sufficient resources to upscale and maintain the auditing processes across the general community to a level that is sufficient to ensure correct PPE use.
7. Proof of a past recent infection is not currently considered an acceptable reason for exemption from vaccination because immune response to natural infection is known to wane over time.[[55]](#footnote-56) Reinfection following both infection and vaccination is likely to be of increasing concern with emerging variants, as already demonstrated with the Delta variant of concern, and increasingly with the Omicron variant of concern.
8. Surveillance testing is used in certain high-risk industries to increase the likelihood of early detection of cases,[[56]](#footnote-57) however surveillance testing as an alternative to mandatory vaccination requirements for specified workers has operational challenges and resource constraints and is therefore not suited as a replacement to protect the community from COVID-19.[[57]](#footnote-58)
9. Negative point in time test results for COVID-19, while less onerous than a mandatory vaccination requirement, fails to provide the same protection for workforces.[[58]](#footnote-59) Currently, polymerase chain reaction (PCR) and RA tests are approved for use in Australia.
10. PCR is the gold standard diagnostic test. However, it is more resource intensive to deliver, requiring dedicated testing sites, healthcare worker administration, laboratory resources, and result-reporting pathways. PCR testing capacity is finite and can be overwhelmed as seen during the recent peak in cases driven by the Delta Variant of concern. Increased use would increase the burden on the system and contribute to increased waiting times at pathology testing sites and turnaround times for results for the entire community.
11. Generally, there is a minimum turnaround time of 6-24 hours between a test being administered and a result being received. During this period between the test being undertaken and received and then attendance at the venue, further infectious exposures could occur. [[59]](#footnote-60) Due to the operational issues (essentially, delays and bottlenecks) associated with performing a RA test, settings and workplaces have been unable or unwilling to utilise on-site RA tests and have allowed individuals to provide proof of a RA test.  People would have to take a RA test every day and there are real challenges in overseeing compliance with the result.[[60]](#footnote-61)  Further, proof of a negative test result as a point-in-time indicator is not a perfect indicator of infectiveness. In a setting with high community transmission, proof of negative test results may provide a delayed and therefore inaccurate indication of an individual’s actual status. [[61]](#footnote-62)
12. RA tests are also subject to potential false negative resulting from the assay itself.[[62]](#footnote-63) While the sensitivity and specificity of RA testing varies by the assay being used, a recent prospective study of nearly 5000 cases found that the overall sensitivity of RA testing was 74 per cent, however lower pick-up rates were observed in cases who were asymptomatic (estimated 55 per cent). Systematic reviews, including a recent Cochrane review, have yielded similar findings – sensitivity varied markedly across studies, however, the average sensitivity for RA tests was 56.2 per cent (95 per cent confidence interval: 29.5-79.8 per cent).
13. In considering whether a combination of testing, distancing and screening might be sufficiently effective, although the risk of transmission is less in some settings – especially outdoors or places that were highly ventilated – not all workplaces and settings are organised, outdoors or highly ventilated. It is necessary to protect Victorians in all the settings they visit, whether shopping, working or engaging in essential activities. No other mitigation than vaccination applies universally in all settings and circumstances. A vaccine, once administered, provides continuous protection that does not require compliance (albeit in a manner that wanes over time).[[63]](#footnote-64)

Other considerations

1. The mandatory vaccination requirement for open premises reduces the risk of transmission within those settings and the broader community. This provides greater workforce protection and certainty. Importantly, patrons will have renewed confidence in entering these settings which will assist consumer spending during its typical peak period, which will assist the state’s economic recovery from the unprecedented impact of the pandemic.[[64]](#footnote-65)
2. In making this order, I consider it reasonably necessary to retain the mandatory vaccination requirements for open premises to assist with public confidence in the overall administration of public health and results in overall improvements in community compliance for prosocial behaviours such as self-isolation when symptomatic, wearing a face covering in certain settings and maintaining social distancing.[[65]](#footnote-66)
3. Applying a density quotient to outdoor entertainment, if adopted, could have severe immediate and long-term economic impact on Victoria’s economic recovery and the economic wellbeing of Victorians. Outdoor environments are fundamentally lower risk than indoor environments, and therefore is important to encourage outdoor activities, rather than in higher risk environment of transmission such as private residences and indoor spaces.[[66]](#footnote-67)

Conclusion

1. Taking into account all of the above factors (including those contained in the Human Rights Statement) and weighing the public health benefits of the Order against the countervailing potential impacts on individuals and the community, I believed it was reasonably necessary to make the Order to protect public health.
2. For the same reasons, I formed the opinion that the limits placed on human rights by the Order are demonstrably justified for the purposes of the Charter.

**Schedule 2 – Reasons for Decision – Pandemic (****Workplace) Order**

Summary of Order

1. This Order imposes restrictions on the number of Victorians attending work premises and imposing obligations on employers in managing the risk of COVID-19 in the workplace.

*Purpose*

1. The purpose of the Order is to limit the number of Victorians attending work premises to assist in reducing the frequency and scale of outbreaks of COVID-19 in Victorian workplaces and to establish more specific obligations on employers and workers in relation to managing the risk associated with COVID-19 transmission in the work premises.

*Obligations*

1. The Order restricts the number of Victorians attending work premises and imposes specific obligations on employers to assist in reducing the frequency of outbreaks of COVID-19 in Victorian workplaces.
2. A worker must not attend a work premises if:
   1. they have undertaken a COVID-19 PCR test or a COVID-19 rapid antigen test and they are awaiting the result of that test, or
   2. within their seven days of self-isolation or quarantine period, whichever is earliest.
3. An employer must take reasonable steps to ensure:
   1. all workers carry and wear a face covering where appropriate; and
   2. implement a COVIDSafe Plan which addresses health and safety issues arising from COVID-19; and
   3. keep a record of all persons who attend the work premises, including the person’s name, date and time, contact number and areas of the work premises the person attended; and
   4. comply with the Victorian Government QR code system and display appropriate signage for the type of work premises as specified by this Order.
4. An employer must advise workers who are symptomatic persons that they are required to comply with any requirements that may be relevant in the document “Testing Requirements for Contacts and Exposed Persons” as amended from time to time, and support a worker to do so.
5. The Order imposes additional work premises specific obligations on employers determined by the type of Premises and specifies the appropriate response of an employer in the circumstance of a suspected or confirmed case of COVID-19 in the work premises.
6. A worker who has received a positive result from a COVID-19 PCR test or a COVID-19 rapid antigen test is obliged to notify the operator of their work premises of their status as a diagnosed person or probable case if they attended an indoor space at the work premises during their Infectious Period.
7. After becoming aware of a diagnosed person or a probable case who has attended the work premises in the Infectious Period, the operator must notify all workers who were present at the same indoor space that they may have been exposed to COVID-19 and advise the employer to comply with relevant obligations under the “Testing Requirements for Contacts and Exposed Persons” as amended from time to time, and support a worker to do so.
8. Failure to comply with the Order may result in penalties.

*Changes from Pandemic (Workplace) Order 2021 (No. 1)*

1. A worker must not attend a work premises if they:
   1. have undertaken a COVID-19 PCR test or a COVID-19 rapid antigen test because they are symptomatic and they are awaiting the result of that test, or
   2. have received a positive RA test.
2. A probable case is obliged to notify the operator of their work premises of their status as a probable case if they attended an indoor space at the work premises during their Infectious Period.
3. After becoming aware of a diagnosed person or a probable case who has attended the work premises in the Infectious Period, the operator must notify all workers who were present at the same indoor space that they may have been exposed to COVID-19 and advise the employer to comply with relevant obligations under the “Testing Requirements for Contacts and Exposed Persons” as amended from time to time, and support a worker to do so.

*Period*

1. The Order will commence at 11:59:00pm on 6 January 2022 and end at 11:59:00pm on 12 January 2022.

Relevant human rights

*Human rights that are limited*

1. For the purposes of section 165AP(2)(c), in my opinion, the obligations imposed by the order will limit the human rights specified in paragraph 71 of the Human Rights Statement.
2. My explanation for why those rights are limited by the order is set out in the Human Rights Statement.
3. The Human Rights Statement also sets out:
   1. my explanation of the nature of the human rights limited (as required by section 165AP(2)(i)); and
   2. my explanation of the nature and extent of the limitations (as required by section 165AP(2)(iii)).

*Human rights that are affected, but not limited*

1. Further, in my opinion, the obligations imposed by the order will affect, but not limit, the human rights specified in paragraph 72 of the Human Rights Statement.
2. My explanation for why those rights are affected, but not limited, by the Order is set out in the Human Rights Statement.

How the obligations imposed by the Order will protect public health

1. I have carefully read and considered the Chief Health Officer's advice provided to me on 10 December 2021 and 23 December 2021, the verbal advice provided on 14 December 2021, and the verbal advice provided to me by the Acting Chief Health Officer on 29 December 2021, 30 December 2021 and 4 2022.
2. In relation to the restrictions that will be imposed by this Order, the Chief Health Officer and Acting Chief Health Officer relevantly advised:
   1. Businesses are and will continue to be a primary area in which both workers and patrons interact. People from different parts of Victoria meet in these settings, and any infections that occur can be carried back to different parts of the community.[[67]](#footnote-68)
   2. Workplaces pose a transmission risk particularly where there are common areas, inadequate ventilation, and close contact between people. People from across Victoria meet in these settings, and any infections that occur can be carried back to different parts of the community.[[68]](#footnote-69)
   3. All workplaces require some level of obligations to help in both preventing transmission and reduce the risk of outbreaks if a confirmed case of COVID-19 enters a workplace, given the continued levels of transmission within Victoria. [[69]](#footnote-70)
   4. Evidence-based measures such as hand hygiene, physical distancing, use of personal protective equipment, restricted workplace access, contact tracing and isolation and quarantine have been recommended by WHO to mitigate these risks. [[70]](#footnote-71)
   5. Mitigation strategies including COVIDSafe Plans, QR check-in requirements and COVID Check-in Marshals, are required to minimise spreading COVID-19 into workplaces and sensitive settings, to protect vulnerable population groups and to ensure case numbers do not overwhelm our health system. [[71]](#footnote-72)
   6. A COVIDSafe plan demonstrates that an employer has considered the risk of COVID-19 incursion and transmission within their workplace, and strategies to reduce this risk. [[72]](#footnote-73)
   7. The requirement for workplaces to have a system which checks-in patrons or visitors is necessary to support our contact tracing efforts. In addition, COVID Check-in Marshals ensures patron compliance, to allow contract tracing efforts to be useful in the event of an outbreak and ensure vaccination requirements for entry are met. [[73]](#footnote-74)
   8. Requirements on employers and workers in response to suspected and confirmed cases of COVID-19, allow workers and students at risk to be notified of their exposure and allow them to take appropriate public health measures such as testing and quarantining. [[74]](#footnote-75)
   9. The use of RA testing as an asymptomatic screening tool in the context of high community prevalence is consistent with previous advice, but their use should be expanded now given the increased risk posed by the Omicron variant.[[75]](#footnote-76) Testing requirements need to shift away from PCR to RA tests to preserve and reduce pressure on the testing system.[[76]](#footnote-77)
   10. Some changes are necessary to the Workplace Order for consistency with the Quarantine, Isolation and Testing Order.[[77]](#footnote-78)
   11. Testing requirements need to shift away from PCR to RA tests to preserve and reduce pressure on the testing system.  In order to facilitate this shift, some changes need to be made to case definitions in the Orders.[[78]](#footnote-79) Repeated RA testing further improves accuracy as a screening modality.[[79]](#footnote-80)
3. I accepted that advice.

Countervailing possible impacts that the obligations imposed by the Order may have on individuals and the community

1. In making this decision, I have seriously considered the possible negative impacts of the Order on the individuals and the community.
2. In particular, as noted above, in the Human Rights Statement, I have considered how people’s human rights will be affected and limited by the Order.
3. However, I also recognised that the Order contains the following exceptions or qualifications to minimise the potential negative impacts on individuals and the community:
   1. The pandemic orders have differing requirements depending on the size and nature of a workplace. This acknowledges the differing associated risks and broad differences in the operations of businesses across Victoria.

Whether there are any less restrictive alternatives that are reasonably available to protect public health

1. In his advice, the Chief Health Officer sets out a range of measures, including measures which do not have a restrictive element (such as health promotion, education, epidemiology and monitoring).[[80]](#footnote-81)
2. The Chief Health Officer clearly states that such measures alone will not be sufficient to manage the serious risk to public health posed by COVID-19.[[81]](#footnote-82)
3. On the basis of the Chief Health Officer and Acting Chief Health Officer’s advice, I considered that that there were no other reasonably available means by which to manage the spread of COVID-19 in workplaces that would be less restrictive of freedoms. However, even if there were to be less restrictive measures, I have considered that the measures imposed by the Order are within the range of reasonably available alternatives to achieve the purpose.

Conclusion

1. Taking into account all of the above factors (including those contained in the Human Rights Statement), and weighing the public health benefits of the Order against the countervailing potential impacts on individuals and the community, I believed it was reasonably necessary to make the Order to protect public health.
2. For the same reasons, I formed the opinion that the limits placed on human rights by the Order are demonstrably justified for the purposes of the Charter.

**Schedule 3 – Reasons for Decision – Pandemic (Additional Industry Obligations) Order**

Summary of Order

1. This Order contains additional specific obligations on employers and workers in specific industries in relation to managing the risk associated with COVID-19.

*Purpose*

1. The purpose of the Order is to establish additional specific obligations on employers and workers in specific industries in relation to managing the risk associated with COVID-19 transmission in the work premises.

*Obligations*

1. The additional obligations on industries include requiring industries to conduct and keep records of surveillance testing unless the worker was a confirmed COVID-19 case in the last 90 days, requiring industries to ensure that workers wear the appropriate level of personal protective equipment or a face covering, requiring workers to provide a written declaration about additional workplaces if working in two or more, bubble workers, not allowing workers to attend work if exposed to a confirmed case in another workplace, and ceasing elective surgery unless it is urgent, including Category 1 and Category 2A admissions.The following industries must comply with the Order:
   1. poultry processing facilities;
   2. abattoirs and meat processing facilities;
   3. seafood processing facilities;
   4. supermarket work premises and perishable food work premises;
   5. warehousing and distribution centres;
   6. commercial cleaning services;
   7. care facilities;
   8. ports of entry servicing international arrivals;
   9. hotel quarantine;
   10. hospitals;
   11. construction sites.
2. An authorised officer or inspector may conduct an inspection of the work premises and audit the records of the employer.
3. An employer must consult with health and safety representatives, together with workers who are likely to be directly affected in relation to the implementation of the Additional Industry Obligations.
4. Elective surgery is restricted to Category 1 and 2A elective surgery procedures and non-urgent elective surgery is temporarilypostponed in private hospitals, day procedure centres and public hospitals in metropolitan Melbourne and regional Victoria.
5. Failure to comply with the Order may result in penalties.

*Changes from Pandemic (Additional Industry Obligations) Order 2021 (No. 1)*

1. Elective surgery is restricted to Category 1 and 2A elective surgery procedures and non-urgent elective surgery is temporarily postponed in private hospitals, day procedure centres and public hospitals in metropolitan Melbourne and regional Victoria.
2. Adding a narrow carve out from elective surgery restrictions for IVF procedures.

*Period*

1. The Order will commence at 11:59:00pm on 6 January 2021 and end at 11:59:00pm on 12 January 2022.

Relevant human rights

*Human rights that are limited*

1. For the purposes of section 165AP(2)(c), in my opinion, the obligations imposed by the order will limit the human rights specified in paragraph 118 of the Human Rights Statement.
2. My explanation for why those rights are limited by the order is set out in the Human Rights Statement.
3. The Human Rights Statement also sets out:
   1. my explanation of the nature of the human rights limited (as required by section 165AP(2)(i)); and
   2. my explanation of the nature and extent of the limitations (as required by section 165AP(2)(iii)).

*Human rights that are affected, but not limited*

1. Further, in my opinion, the obligations imposed by the order will affect, but not limit, the human rights specified in paragraph 119 of the Human Rights Statement.
2. My explanation for why those rights are affected, but not limited, by the Order is set out in the Human Rights Statement.

How the obligations imposed by the Order will protect public health

1. I have carefully read and considered the Chief Health Officer's advice provided to me on 10 December 2021 and 23 December 2021, the verbal advice provided on 14 December 2021, and the verbal advice provided to me by the Acting Chief Health Officer on 29 December 2021, 30 December 2021 and 4 2022.
2. In relation to the restrictions that will be imposed by this Order, the Chief Health Officer and Acting Chief Health Officer relevantly advised:
   1. COVID-19 case rates in Victoria remain elevated despite significant population coverage in Victoria of greater than 90 per cent full vaccination in those aged 12 years and above.[[82]](#footnote-83)
   2. The presence of the Omicron variant of concern has been confirmed in Victoria[[83]](#footnote-84) and Omicron cases appear to be increasing at a faster rate when compared to the Delta variant, which is consistent with a greater degree of infectivity.[[84]](#footnote-85)
   3. Victoria’s international airport and seaports (ports of entry) are the key work premises receiving international arrivals. International arrivals are potentially at elevated risk for COVID-19 due to exposure while in countries where COVID-19 cases are surging, or where novel variants of concern are emerging. International arrivals are also potentially at elevated risk by exposure to infected travellers during transit to Victoria. Workers at ports of entry are a key interfacing group that require ongoing protective measures in the context of a global pandemic. Additional PPE is a required measure to reduce the risk of exposure of and onward transmission from these workers into the community and to prevent incursion of new variants of concern. Additional surveillance testing for this workforce is also necessary and appropriate.[[85]](#footnote-86)
   4. Government-operated quarantine facilities remain of significance as part of the essential management of international arrivals including those who are subsequently confirmed to have COVID-19. Although the consequential risk of hotel quarantine workers acquiring infection from this setting has lessened relative to the current high rates of community transmission in Victoria, ongoing protective measures remain important in mitigating incursion risk, particularly given the recent emergence of the Omicron Variant of concern. These measures include mandatory vaccination requirements, use of appropriate PPE, COVIDSafe training and surveillance testing. Appropriate use of PPE is an evidence-based infection prevention control measure that is particularly important in settings such as hotel quarantine where novel threats may emerge, most notably with the emergence of the omicron variant of concern.[[86]](#footnote-87)
   5. Abattoirs, meat, poultry and seafood processing facilities are cold environments with high humidity, involving exertive work which increases aerosol production, and where physical distancing is often impractical. This can result in favourable conditions for COVID-19 transmission and a high risk of amplification and uncontained outbreaks. These outbreaks also have downstream consequences for essential food supply. Large uncontained outbreaks occurred in these settings in Victoria’s second wave, which spread into different parts of Victoria. These industries are essential to the food supply chain locally and nationally, which can be compromised when outbreaks occur. Retaining face coverings is a low impost protective public health measure which mitigates the risk of transmission amongst workers in this industry. Abattoirs, meat, poultry and seafood processing facilities were identified as being higher risk in the early stages of the pandemic and continue to be represented in outbreak data in Victoria, contributing to 1.5 per cent of outbreaks between August and December of 2021. [[87]](#footnote-88)
   6. Care facilities are sensitive settings that require additional public health measures to mitigate the risk to vulnerable residents and to protect the workforce. Residents within care facilities have several risk factors that increase their risk of severe illness, complications and death from COVID-19, warranting additional protective measures. This includes face masks for workers in resident facing roles when working indoors and staff declarations if working at more than one worksite. Incursion of COVID-19 into care facilities in the second wave in Victoria, resulted in large case numbers, many uncontained outbreaks, major workforce shortages and significant loss of life. Despite high vaccination coverage, this vulnerable population need additional protection, to avoid the severe consequences of transmission and in order to reduce the number of deaths in Victoria as far as practicable.[[88]](#footnote-89)
   7. Hospitals are also sensitive settings where patients are at increased risk of being exposed to and transmitting COVID-19. Furthermore, hospital patients may be particularly vulnerable to the negative impacts of COVID-19 infection including severe disease, further hospitalisation and death. Vulnerable patient cohorts include the elderly, the immunocompromised, and those affected with comorbidities which are known to be associated with adverse outcomes for COVID-19 including cancer, type 2 diabetes, respiratory disease, heart disease, chronic kidney disease, and hypertension[[89]](#footnote-90).
   8. Ceasing elective surgery will support the pressure on health systems cause by the Omicron surge and ensure there is capacity in the system to respond to COVID-19 demand. There are substantial pressures on the testing system and hospitalisations moved from 398 inpatients and falling, to 516 inpatients and going up. Twelve Victorian health services have indicated that they were already using extended-team workforce models to deliver care under specialist supervision, and some health services had indicated that they were no longer able to meet nurse to patient ratios. These workforce challenges would only increase as more healthcare workers became infected.[[90]](#footnote-91)
   9. Healthcare workers are more likely to be exposed to infectious cases while delivering care. Recommended obligations related to protecting this workforce include multisite worker restrictions and declarations, worker bubbles and compliance and consultation. It is critical to protect the workforce in order to minimise exposure of other workers to infection, mitigate the need for isolation of workers who become cases and reduce the impacts of furloughing workers who are close contacts, all of which have the potential to negatively impact worker health and wellbeing and the delivery of patient care. All obligations currently in place under the section 200 Directions should be retained, in addition to healthcare worker mandatory vaccination obligations, as Victoria continues to have a large volume of active cases, including a high number who are hospitalised.[[91]](#footnote-92)
   10. Surveillance testing of high-risk industries involves the implementation of testing requirements and recommendations for workers, in order to detect cases early. Surveillance testing helps identify asymptomatic but potentially infectious workers, and therefore minimises the impacts of outbreaks on essential industries. Early diagnosis of cases ensures that the infected worker can isolate and take additional measures to reduce the risk of transmission to others. Surveillance testing complements other workplace specific protective measures such as worker vaccine mandates and COVIDSafe plans.[[92]](#footnote-93)
3. I accepted that advice.
4. Given the emerging risk of the Omicron Variant of concern , global uncertainty regarding its impact and the speed at which it is spreading,[[93]](#footnote-94) the increasing trend in COVID-19 case load may continue for the duration of this initial declaration period and this has also been a factor of consideration in my decision to make this pandemic order.

Countervailing possible impacts that the obligations imposed by the Order may have on individuals and the community

1. In making this decision, I have seriously considered the possible negative impacts of the Order on the individuals and the community.
2. In particular, as noted above, in the Human Rights Statement, I have considered how people’s human rights will be affected and limited by the Order.
3. In addition, I have also considered the following additional potential negative impacts:
   1. “Freedom of movement of persons in Victoria is limited if diagnosed with COVID-19, living with a diagnosed person, or having been in close contact with a diagnosed person.”[[94]](#footnote-95)
   2. Workers in certain additional obligation industries are required to wear the appropriate level of personal protective equipment or a face covering. If this “interferes with a person’s choice to exercise cultural, religious, or linguistic practices in the workplace, this would constitute an incursion into that person’s cultural, religious, racial, or linguistic rights to the extent that those rights are not already limited by attending work with occupational safety or uniform requirements.”[[95]](#footnote-96)
   3. The Order limits a worker’s protection from medical treatment without full, free and informed consent “because persons may be directed by their employer pursuant to the Order to undertake a COVID-19 test”,[[96]](#footnote-97) assuming that taking a COVID-19 test constitutes medical treatment.
   4. Workers are required to comply with surveillance testing requirements and declare any additional workplaces if they are working in more than one workplace. “This information would constitute personal and health information and its provision to gain access to the care facility would therefore be an interference with privacy”.[[97]](#footnote-98) However, this may not have a significant negative impact as “only the details required to establish risk and contact trace are sought.”[[98]](#footnote-99)
   5. “The Order creates an impost on business owners seeking to enjoy their property rights so they can operate their businesses without interference. Sending a worker home to self-quarantine is likely to cause meaningful detriment to a business.”[[99]](#footnote-100) Furthermore, “the Order might in the short term reduce or affect the capacity of certain businesses to generate income from their real and personal property.”[[100]](#footnote-101)
   6. The requirements for workers to self-isolate under the Order “place significant restrictions on the ability of people to move freely”,[[101]](#footnote-102) although exposed workers are only required to self-isolate “for the time the medical evidence suggests is appropriate to make sure that a person is not at risk of transmitting COVID-19.”[[102]](#footnote-103)
   7. Elective surgery procedures are restricted to urgent procedures only, including Category 1 and Category 2A at private hospitals, day procedure centres and public hospitals across Victoria. Without restrictions, there is a high risk that the system will not have sufficient capacity, including ICU capacity. Further, fatigue and workload pressures on staff will be exacerbated, affecting the capacity of the system to respond to COVID-19 and provide critical care.
4. In making this pandemic order, I have included limited exceptions to the additional obligations for specified industries to ensure they are less onerous in specific circumstances, including:
   1. Workers in an abattoir, meat processing facility, poultry processing facility or seafood processing facility are required to wear the appropriate level of PPE to carry out the functions of their role. However, this requirement does not apply where it may not be reasonably practicable to wear a face mask in the work premises, or if the nature of a worker’s work may mean that wearing a face mask creates a risk to their health and safety. Workers may also be exempted from complying with this requirement where they are subject to an exception to the face covering requirement under the Movement and Gathering Order.
   2. Care facility workers may be subject to a written exemption from the Chief Health Officer in relation to the additional obligations imposed on care facilities where an exemption is necessary to ensure that care facility residents are provided with a reasonable standard of care. Care facility workers may also remove their face covering whilst communicating with a resident where visibility of the mouth is essential to communicate with the resident.
   3. Certain requirements are only applicable to the extent that they are reasonably practicable. This includes making arrangements for high-risk hospital work premises workers to work consistently with the same group of workers where reasonably practicable. Ensuring this is only where reasonably practicable is less onerous than mandating this requirement in all circumstances.
   4. Public hospitals in regional Victoria which are not currently operating COVID streaming sites can choose to reduce elective surgery, if deemed necessary due to local challenges associated with the COVID-19 pandemic.

Whether there are any less restrictive alternatives that are reasonably available to protect public health

1. In his advice, the Chief Health Officer sets out a range of measures, including measures which do not have a restrictive element (such as health promotion, education, epidemiology and monitoring).[[103]](#footnote-104)
2. The Chief Health Officer clearly states that such measures alone will not be sufficient to manage the serious risk to public health posed by COVID-19.[[104]](#footnote-105)
3. On the basis of the Chief Health Officer and Acting Chief Health Officer’s advice, I considered there to be no other reasonably available means by which to manage the spread of COVID-19 in workplaces that would be less restrictive of freedoms. However, even if there were less restrictive measures, I consider that the restrictions imposed by the Order are in the range of reasonably available options to achieve the purpose.

Conclusion

1. Taking into account all of the above factors (including those contained in the Human Rights Statement) and weighing the public health benefits of the Order against the countervailing potential impacts on individuals and the community, I believed it was reasonably necessary to make the Order to protect public health.
2. For the same reasons, I formed the opinion that the limits placed on human rights by the Order are demonstrably justified for the purposes of the Charter.

**Schedule 4 – Reasons for Decision – Pandemic (Quarantine, Isolation and Testing) Order**

Summary of Order

1. This Order requires persons who are diagnosed with COVID-19 to self-isolate. It also requires persons who are living with a diagnosed person, their close contacts, social contacts, or exposed persons to self-quarantine and undertake testing.
2. There are different requirements of self-quarantine depending on the level of exposure to someone diagnosed with COVID-19.

*Purpose*

1. The objective of this Order is to limit the movement of people who are diagnosed with COVID-19, those persons who live with them, their close contacts, and exposed persons to limit the spread of COVID-19.

*Obligations*

1. The Order requires diagnosed persons to
   1. self-isolate at a suitable premises until 7 days after the date on which they took a COVID-19 PCR test or COVID-19 rapid antigen test that returned a positive result;
   2. notify the Department of the premises chosen to self-isolate and the contact details of any other residents at the premises; and
   3. notify any close contacts, social contacts, work premises where the diagnosed person usually works, and any education facility where the person attended during the infectious period of their COVID-19 diagnosis.
2. A probable case is someone who has received a positive result on a COVID-19 rapid antigen test.
3. The Order requires probable cases to:
   1. self-isolate at a suitable premises until 7 days after the date on which they took COVID-19 rapid antigen test that returned a positive result, or until they receive a negative result on a PCR test, whichever is earlier;
   2. notify the Department using the COVID-19 Positive Rapid Antigen Test Self-Reporting Form or via the call centre.
   3. notify any close contacts, social contacts, work premises where the diagnosed or a probable case person usually works, and any education facility where the person attended during the infectious period of their COVID-19 diagnosis.
4. A person is a close contact of a diagnosed person or a probable case if an officer or nominated representative of the Department determines that they are a close contact of a diagnosed person or a probable case, including in the event of an outbreak, and has given that person a notice of that determination; or the person has spent more than four hours in an indoor space at a private residence, accommodation premises or care facility with a diagnosed person or probable case during their infectious period.
   1. A close contact must self-quarantine for a period of 7 days. The date that a person must self-quarantine from is as follows:
      1. If the close contact self-quarantines with a diagnosed person or a probable case, the person must self-quarantine for 7 days from when the diagnosed person or probable case undertook their PCR or RA test that confirmed they were a diagnosed person or a probable case; or
      2. If the close contact does not self-quarantine with a diagnosed person or probable case, must self-quarantine for 7 days from when they last had contact with a diagnosed person or probable case.
   2. The self-quarantine period of a close contact of a probable case can end before 7 days where the probable case receives a negative PCR test result.
   3. All close contacts must undertake testing as set out in the document “Testing Requirements for Contacts and Exposed Persons” (as amended from time to time) and follow the “COVID-19 rapid antigen test procedure” where applicable.
5. An exposed person is an individual who is not a close contact and has had at least 15 minutes face to face contact, or greater than 2 hours within the same indoor space in a workplace or education facility with a diagnosed person or probable case during their infectious period.
   1. An exposed person must undertake testing if symptomatic as set out in the document “Testing Requirements for Contacts and Exposed Persons” as amended from time to time, and follow the “COVID-19 rapid antigen test procedure” where applicable.
6. A person is a social contact if they are not a close contact or exposed person and they have had more than 15 minutes of face-to-face contact with a diagnosed person or probable case during their infectious period, or spent more than 2 hours in an indoor space with a diagnosed person or probable case during their infectious period.
   1. A person who is a social contact is required to obtain COVID test/s if symptomatic as set out in the document “Testing Requirements for Contacts and Exposed Persons” as amended from time to time, and follow the “COVID-19 rapid antigen test procedure” where applicable.
7. The Order requires that the operator of a work premises or education facility who is informed of a positive diagnosis by a diagnosed person must notify exposed persons of their potential exposure, and of their testing, reporting and self-quarantine obligations. If the exposed person is symptomatic and is required to undertake COVID-19 testing, the operator must record evidence of a negative test result before permitting the exposed person to return to the premises.
8. A symptomatic person in the community is a person experiencing one or more any COVID-19 symptoms unless those symptoms are caused by an underlying health condition or medication.
   1. A symptomatic person in the community is required to obtain COVID testing as set out in the document “Testing Requirements for Contacts and Exposed Persons” as amended from time to time, and follow the “COVID-19 rapid antigen test procedure” where applicable.

*Changes from Pandemic (Quarantine, Isolation and Testing) Order 2021 (No. 2)*

1. A probable case is someone who has received a positive result on a COVID-19 RA test;
2. The Order requires probable cases to:
   1. self-isolate at a suitable premises until 7 days after the date on which they took a COVID-19 RA test that returned a positive result, or until they receive a negative result on a PCR test, whichever is earlier;
   2. notify the Department using the COVID-19 Positive Rapid Antigen Test Self-Reporting Form or via the call centre.
   3. notify any close contacts, social contacts, work premises where the diagnosed person usually works, and any education facility where the person attended during the infectious period of their COVID-19 diagnosis.
3. Definitions and requirements of close contact, exposed person and social contact updated to treat probable cases like diagnosed persons, with limited differences.
4. The self-quarantine period of a close contact of a probable case can end before 7 days where the probable case receives a negative PCR test result.
5. A symptomatic person in the community is a person experiencing one or more any COVID-19 symptoms unless those symptoms are caused by an underlying health condition or medication.
   1. A symptomatic person in the community is recommended to obtain COVID testing as set out in the document “Testing Requirements for Contacts and Exposed Persons” as amended from time to time, and follow the “COVID-19 rapid antigen test procedure” where applicable.

*Period*

This Order will commence at 11:59:00pm on 6 January 2022 and end at 11:59:00pm on 12 January 2022.

Relevant human rights

*Human rights that are limited*

1. For the purposes of section 165AP(2)(c), in my opinion, the obligations imposed by the order will limit the human rights identified in paragraph 95 of the Human Rights Statement.
2. My explanation for why those rights are limited by the order is set out in the Human Rights Statement.
3. The Human Rights Statement also sets out:
   1. my explanation of the nature of the human rights limited (as required by section 165AP(2)(i)); and
   2. my explanation of the nature and extent of the limitations (as required by section 165AP(2)(iii)).

*Human rights that are affected, but not limited*

1. Further, in my opinion, the obligations imposed by the order will affect, but not limit, the human rights identified in paragraph 96 of the Human Rights Statement.
2. My explanation for why those rights are affected, but not limited, by the Order is set out in the Human Rights Statement.

How the obligations imposed by the Order will protect public health

1. I carefully read and considered the Chief Health Officer's advice provided to me on 23 December 2021, 10 December 2021, and the verbal advice provided on 14 December 2021, the verbal advice provided to me by the Acting Chief Health Officer on 29 December 2021 referred to above at paragraph , and the verbal advice provided to me by the Acting Chief Health Officer on 30 December 2021 and 4 January 2022.
2. In relation to the restrictions that will be imposed by this Order, the Chief Health Officer and the Acting Chief Health Officer relevantly advised:
   1. Mandatory requirements to isolate or quarantine remain a proportionate measure to ensure persons who are or may be infected with COVID-19 do not transmit the infection to others once they have been diagnosed as a case or determined to be a close contact, meaning onward transmission can be prevented and outbreaks controlled more rapidly.[[105]](#footnote-106)
   2. Diagnosed persons with confirmed COVID-19 should continue to have specific requirements to ensure their risk of onward transmission is minimised.[[106]](#footnote-107) In line with the national settings announced by the APHCC and National Cabinet, the self-isolation period for diagnosed persons should be 7 days from the date the person took a COVID-19 PCR test where they were diagnosed with COVID-19.[[107]](#footnote-108)
   3. Diagnosed persons should continue to have specific requirements to notify their work or education premises if they attended during their infectious period. Under this model, increased accountability is placed on persons with a confirmed COVID-19 diagnosis to inform workplaces and education settings they have attended during their infectious period so that these setting can more promptly instigate public health responses. This measure is also intended for organisations in the community to grow more proficient at appropriately responding to exposures and to become more aware of their responsibilities and capabilities during this evolving stage of the pandemic. Diagnosed persons should also continue to be required to notify the department of their place of self-isolation as well as any persons at this location that they have tested positive to COVID-19, to ensure these persons can take precautions to minimise risk of infection.[[108]](#footnote-109)
   4. In the context of ongoing community transmission of the Delta variant, and the likely increase in transmission of Omicron, it is advisable that the role of RA testing be urgently expanded in Victoria. RA tests show moderate sensitivity and high specificity for the detection of SARS-CoV-2 and are an appropriate asymptomatic screening tool in the setting of high community prevalence.[[109]](#footnote-110)
   5. Better access to and awareness of RA testing will arm Victorians with a more proactive preventative tool, particularly for those who may experience asymptomatic infection and unwittingly pass this on to their friends and family.[[110]](#footnote-111)
   6. The use of RA testing as an asymptomatic screening tool in the context of high community prevalence is consistent with previous advice, but their use should be expanded now given the increased risk posed by the Omicron variant.[[111]](#footnote-112)
   7. The measures recommended by the Chief Health Officer on 23 December for isolation and testing are still applicable.[[112]](#footnote-113) Testing requirements need to shift away from PCR to RA tests to preserve and reduce pressure on the testing system.  In order to facilitate this shift, some changes need to be made to case definitions in the Orders.[[113]](#footnote-114) Repeated RA testing further improves accuracy as a screening modality.[[114]](#footnote-115)
3. Depending on the availability of RA testing, aspects of the test, trace, isolate and quarantine approach should be revised to better support the case, contact and outbreak management strategy from the likely impacts of Omicron on capacity and resourcing.[[115]](#footnote-116)
4. As advised by the Acting Chief Health Officer, I am recommending the following positions:
   1. Testing requirements need to shift away from PCR to RA tests to preserve and reduce pressure on the testing system.  In order to facilitate this shift, some changes need to be made to case definitions in the Orders.[[116]](#footnote-117) Repeated RA testing further improves accuracy as a screening modality.[[117]](#footnote-118)
   2. Acknowledging a greater responsibility on individuals to test the infectiousness themselves, and potentially also having cases notify their contacts. This approach may become increasingly important once Response teams reach capacity, resulting in delays in contact tracing or implementation of appropriate public health measures, and may be considered low impost as these individuals are oftentimes best placed to directly liaise with their contacts given established relations or known contact details. Similarly, a requirement for operators and employers to notify the Department once outbreak thresholds have been reached help instigate public health measures while normalising the actions that individuals can take to help protect their contacts or settings, and hence the community.[[118]](#footnote-119)
   3. A close contact as determined by the Department of Health is intended to identify individuals with the greatest risk of developing COVID-19 following exposure to an infectious case.[[119]](#footnote-120)
   4. Interactions that occur in private residences or residential facilities represent a high transmission risk due to the intimate nature of interactions that occur in a prolonged or repeated manner in enclosed spaces. Similarly, outbreaks are high risk settings with established coronavirus transmission representing a heightened risk of infection. Requiring close contacts to quarantine minimises the chance of a person being infectious in the community. Close contacts should also continue to have specific COVID-19 testing requirements during their quarantine period to ensure any conversion to COVID-19 infection is promptly identified.[[120]](#footnote-121)
   5. Vaccine effectiveness for infection and symptomatic infection for two doses against Omicron is likely reduced. Therefore, there is likely minimal differential benefit in applying requirements based on the vaccination status.[[121]](#footnote-122)
   6. In line with APHCC and National Cabinet, the self-quarantine period should be 7 days for close contacts, irrespective of whether the close contact is vaccinated or unvaccinated.[[122]](#footnote-123)
   7. The measures recommended by the Chief Health Officer on 23 December for isolation and testing are still applicable.[[123]](#footnote-124)
   8. The use of RA testing as an asymptomatic screening tool in the context of high community prevalence is consistent with previous advice, but their use should be expanded now given the increased risk posed by the Omicron variant.[[124]](#footnote-125)
   9. Symptomatic close contacts should be required to undertake a PCR test on the first day of their self-quarantine. If the result is negative, they should be required to undertake an RA test on the sixth day of self-quarantine.[[125]](#footnote-126)
   10. Asymptomatic close contacts should be required to undertake RA testing on the first day after they are informed that they are a close contact, and on the sixth day of their self-quarantining period.[[126]](#footnote-127)
   11. If a close contact returns a positive RA test, then the close contact should be required to undertake a PCR test.[[127]](#footnote-128)
   12. Close contacts that cannot access an RA test should be required to undertake a PCR test on the sixth day of self-quarantine and remain in self-quarantine until they receive a negative result.[[128]](#footnote-129)
   13. Individuals who have been potentially exposed to an infectious case at a workplace or education facility can be designated as an exposed person by the employer or provider of these settings. This measure is important to maintain occupational safety in the context of a return to social and economic activities in the midst of an ongoing pandemic. This also places a level of responsibility on diagnosed persons and employers/providers to act in a manner that helps protect the health of their workers and enrolled persons, and thus the overall Victorian community. Requirements for exposed persons are less than those for close contacts, as there is a lower risk of infection. However, controls are still necessary to ensure potential chains of transmission are halted where possible.[[129]](#footnote-130)
   14. Potential transmission can occur from interactions between infectious cases and other members of the community who do not fulfill the criteria of being a close contact or exposed person. It is important for such persons (termed social contacts) to be made aware of their potential risks and be recommended to seek testing as a precautionary measure to halt potential chains of transmission once notified by the case. This also places a level of responsibility on diagnosed persons to act in a manner that helps protect the health of their close circle of contacts, and thus the overall Victorian community.[[130]](#footnote-131)
   15. Testing requirements for persons identified as being at increased risk of developing COVID-19 following known exposure is necessary to identify potential cases and inform appropriate public health responses.[[131]](#footnote-132)
   16. Symptomatic exposed persons and social contacts should be required to undertake a PCR test. [[132]](#footnote-133)
   17. Asymptomatic exposed persons and social contacts should be strongly recommended to undertake five RA tests each day for five days. The Minister should consider mandating this recommendation when RA test supply is sufficient to meet demand.[[133]](#footnote-134)
   18. It is no longer reasonable that a person be required to self-isolate for 10 days should they not undertake a required PCR test. The current infringement system is appropriate for managing those individuals.[[134]](#footnote-135)
   19. For an asymptomatic person who is not able to access RA tests each day for five days, a lower number of RA tests at a lesser frequency is better than not testing at all, and individuals should monitor for symptoms. The recommendation to undertake the RA tests each day is based on the understanding that increasing the number of tests improves the sensitivity of the testing.[[135]](#footnote-136)
   20. There is significant pressure being experienced by the testing system and there is a need to protect capacity for testing those in whom the value of testing is highest on both public health and clinical care grounds. However, any reduction in testing access, and any reductions in the effectiveness of contact tracing, isolation and quarantine, will contribute to increasing transmission of COVID-19 in Victoria, and attendant risk of public health consequences including pressure on the health care system. Therefore, in the near future, it is recommended that review of the impact of the proposed changes, including consideration of reinforcing further testing and contact tracing measures beyond those agreed at National Cabinet on 30 December 2021, be strongly considered.[[136]](#footnote-137)
5. I accept this advice. I believe that self-isolation, self-quarantine and testing obligations remain an important safeguard for early detection of diagnosed persons to prevent large scale outbreaks.
6. In the making of this pandemic order, I also took due consideration of:
   1. The necessity of a suite of measures, including testing and isolation for people who are the ‘known sources’ of potential transmission, to suppress outbreaks and reduce the risk of community transmission rather than address heightened numbers of cases from failures in prevention;
   2. The effect of not taking these public health measures may threaten the viability of the Victorian healthcare system. The risk being avoided is that the health system will be overwhelmed, which would mean that people could lose their lives (due to both COVID and non-COVID related causes) whereas they would normally be successfully treated to recovery in our healthcare system.
   3. High population vaccination coverage rates provide significant protection against severe disease and death and decrease the rates of onward transmission of COVID-19. However, high population vaccination coverage rates do not negate all risk to the community and additional protective measures and safeguards should remain in place, particularly when the Omicron variant of concern is known to be within the Victorian community while its risk profile is not yet well understood.

Countervailing possible impacts that the obligations imposed by the Order may have on individuals and the community

1. In making this decision, I considered the possible negative impacts of the Order on the individuals and the community.
2. In particular, as noted above, in the Human Rights Statement, I have considered how people’s human rights will be affected and limited by the Order.
3. In addition, I also considered the following additional potential negative impacts:
   1. “Persons who are required to self-isolate or self-quarantine are permitted to leave the premises at which they are isolating/quarantining for limited purposes. They are therefore not able to move freely.”[[137]](#footnote-138)
   2. “Given that children under 12 years remain ineligible for vaccination, many people required to self-isolate or self-quarantine have been young children and their families. Even where children are older or a family is constituted only of adults, many people choose to self-isolate or self-quarantine away from their family. This can cause disruptions in relationships, economic difficulties, isolation from culture and traditions, and uncertainty and anxiety.”[[138]](#footnote-139)
   3. “Self-isolation or self-quarantine measures can also constitute an incursion into the rights of people of different cultural, religious, racial or linguistic backgrounds to practice their culture, religion, or language to the extent that the short period prevents them from doing so. While there are many ways of enjoying one’s culture, religion, or language at home or online, there may be activities which can only be done face-to-face or in a certain location outside the home.”[[139]](#footnote-140)
   4. A person who is diagnosed with COVID-19 required to self-isolate may impact on their social relationships and everyday life, such as going to work or going shopping. Furthermore, some persons may not reside with other diagnosed persons or close contacts who are quarantining, resulting in limited support if they experience mild symptoms.
   5. A person who is a close contact or an exposed person of a diagnosed person is required to self-quarantine which also impacts on their social relationships and everyday life. As such, some persons may not be residing with close contacts who are self-quarantining will have limited support if they experience mild symptoms.
   6. A person who is self-quarantining will also need to undertake COVID-19 testing and wear a face covering, unless an exception applies, when going to get a test. These additional requirements will further affect a person’s everyday life.
   7. A person may choose to self-isolate or self-quarantine at a premise of their choice, which may not be their ordinary place of residence, to protect other household members. However, this option may not be viable for some people experiencing financial hardship or persons with limited social connections.
4. However, I also recognised that the Order contains the following exceptions or qualifications to minimise the potential negative impacts on individuals and the community:
   1. People who are self-isolating or self-quarantining may go about their day at their place of self-isolation or self-quarantine, largely undisturbed, and are permitted to receive deliveries of the things they need. They can leave self-isolation or self-quarantine in specified circumstances, including to obtain medical care.
   2. This Order does not physically force anyone to undergo medical treatment.
   3. The exemption and exception powers allow Department officers to consider special cases where self-isolation or self-quarantine conditions are especially difficult. Diagnosed persons may choose a place to self-isolate.

Whether there are any less restrictive alternatives that are reasonably available to protect public health

1. The Chief Health Officer’s Advice includes reasons why COVID-19 constitutes a serious risk to public health, and recommends measures that are necessary or appropriate to be put in place in the pandemic orders in order to reduce or eliminate the threat. Requirements to test, quarantine and isolate are fundamental to the containment of COVID-19 and I believe that the measures imposed are appropriate to reduce or eliminate the public health risk.
2. On the basis of the Chief Health Officer and Acting Chief Health Officer’s advice, I consider there to be no other reasonably available means by which to limit the spread of COVID-19 that would be less restrictive of this particular right than in the quarantine, isolation and testing measures contained in this Order. However, even if there were less restrictive means, I considered that the limitation imposed by this Order is in the range of reasonably available options to reduce the spread of COVID-19.

Conclusion

1. Taking into account all of the above factors (including those contained in the Human Rights Statement) and weighing the public health benefits of the Order against the countervailing potential impacts on individuals and the community, I believed it was reasonably necessary to make the Order to protect public health.
2. For the same reasons, in my opinion, I formed the opinion that the limits placed on human rights by the Order are demonstrably justified for the purposes of the Charter.

1. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-2)
2. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 4 January 2022. [↑](#footnote-ref-3)
3. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 4 January 2022. [↑](#footnote-ref-4)
4. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021) p. 5 [13]-[15]. [↑](#footnote-ref-5)
5. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021) p. 14 [50]. [↑](#footnote-ref-6)
6. See *Public Health and Wellbeing Act 2008* (Vic) section 3(1) for the definition of ‘serious risk to public health’. [↑](#footnote-ref-7)
7. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021)p. 4 [5]. [↑](#footnote-ref-8)
8. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021) p. 4 [6]. [↑](#footnote-ref-9)
9. Department of Health, *Chief Health Officer Advice to Premier – Advice Relating to the Making of a Pandemic Declaration* (8 December 2021) p. 13 [47]. [↑](#footnote-ref-10)
10. Department of Health, *Chief Health Officer Advice to Minister for Health* (23 December 2021) p. 12 [54].  [↑](#footnote-ref-11)
11. Department of Health, *Chief Health Officer Advice to Minister for Health* (23 December 2021) p. 12 [55]. [↑](#footnote-ref-12)
12. Department of Health, *Chief Health Officer Advice to Minister for Health* (23 December 2021) p. 13 [58]. [↑](#footnote-ref-13)
13. Department of Health, Chief Health Officer Advice to Minister for Health, (23 December 2021) p. 19 at [103]. [↑](#footnote-ref-14)
14. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 4 January 2022. [↑](#footnote-ref-15)
15. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 4 January 2022. [↑](#footnote-ref-16)
16. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 4 January 2022. [↑](#footnote-ref-17)
17. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 4 January 2022. [↑](#footnote-ref-18)
18. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 4 January 2022. [↑](#footnote-ref-19)
19. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 4 January 2022. [↑](#footnote-ref-20)
20. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 4 January 2022. [↑](#footnote-ref-21)
21. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 4 January 2022. [↑](#footnote-ref-22)
22. [↑](#footnote-ref-23)
23. Department of Health, *Chief Health Officer Advice to Minister for Health* (23 December 2021) p. 16 [80]-[81]. [↑](#footnote-ref-24)
24. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 4 January 2022. [↑](#footnote-ref-25)
25. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 4 January 2022. [↑](#footnote-ref-26)
26. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 4 January 2022. [↑](#footnote-ref-27)
27. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 4 January 2022. [↑](#footnote-ref-28)
28. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 4 January 2022. [↑](#footnote-ref-29)
29. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 4 January 2022. [↑](#footnote-ref-30)
30. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 4 January 2022 [↑](#footnote-ref-31)
31. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 4 January 2022. [↑](#footnote-ref-32)
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33. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021)p. 18 [77]. [↑](#footnote-ref-34)
34. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021)p. 28 [149]. [↑](#footnote-ref-35)
35. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021)p. 32 [156]. [↑](#footnote-ref-36)
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39. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 4 January 2022. [↑](#footnote-ref-40)
40. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021) p. 31 [152]-[154]. [↑](#footnote-ref-41)
41. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021)p. 31 [152]. [↑](#footnote-ref-42)
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45. Department of Health, *Human Rights Statement: Pandemic (Open Premises) Order* (15 December 2021) [166.2]. [↑](#footnote-ref-46)
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53. Text reflects verbal advice provided by the Chief Health Officer to the Minister for Health, 14 December 2021 [↑](#footnote-ref-54)
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59. Text reflects verbal advice provided by the Chief Health Officer to the Minister for Health, 14 December 2021. [↑](#footnote-ref-60)
60. Text reflects verbal advice provided by the Chief Health Officer to the Minister for Health, 14 December 2021. [↑](#footnote-ref-61)
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72. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021) p. 19 [80]. [↑](#footnote-ref-73)
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