Minister for Health

Statement of Reasons

# Pandemic Orders made 30 December 2021

On 30 December 2021, I Martin Foley, Minister for Health, made the following pandemic order under section 165AI of the *Public Health and Wellbeing Act 2008*:

|  |
| --- |
| Pandemic (Quarantine, Isolation and Testing) Order 2021 (No. 2)  |

In this document, I provide a statement of my reasons for the making of the above pandemic order.  My statement of reasons for making the pandemic order consists of the general reasons in [1]-[49] and the additional reasons set out in the applicable schedule for the order.

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# About the pandemic order

1. The pandemic order was made under section 165AI of the *Public Health and Wellbeing Act 2008* (**PHW Act**).

## Statutory power to make pandemic order

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 21 December 2021, I requested 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 written advice on 23 December 2021. That advice is supplemented by:
	1. the Chief Health Officer’s advice provided on 10 December 2021;
	2. verbal advice the Chief Health Officer provided on 14 December 2021;
	3. verbal advice the Acting Chief Health Officer provided on 29 December 2021; and
	4. verbal advice the Acting Chief Health Officer provided on 30 December 2021.
4. On 29 December 2021, I met with the Acting Chief Health Officer and asked him if the written advice that the Chief Health Officer provided on 23 December 2021 was still applicable in the current context, specifically in relation to testing, tracing, isolation and quarantine advice. During that meeting, the Acting Chief Health Officer confirmed that, considering the current context, the advice that the Chief Health Officer provided on 23 December 2021 was still applicable in the current context.
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 align to the nationally endorsed positions for self-isolation and quarantining periods in reflection of the changing nature of the COVID-19 pandemic.[[1]](#footnote-2)
6. The Acting Chief Health Officer advised me of the significant pressure being experienced by the testing system and the need to protect capacity for testing those in whom the value of testing is highest on both public health and clinical care grounds. In advising me, the Acting Chief Health Officer noted that any reduction in testing access, and any reductions in the effectiveness of contact tracing, isolation and quarantine, would contribute to increasing transmission of COVID-19 in Victoria, and attendant risk of public health consequences including pressure on the health care system. [[2]](#footnote-3)
7. Based on this risk, the Acting Chief Health Officer has recommended that I review the impact of the proposed changes in the near future, including consideration of reinforcing further testing and contact tracing measures beyond those agreed at National Cabinet on 30 December 2021. To support this review and consideration of additional measures, the Acting Chief Health Officer will provide me with further advice shortly based on further modelling of the impact of these changes on the projected trajectory of the COVID-19 pandemic in Victoria.[[3]](#footnote-4)
8. The Acting Chief Health Officer recommended to me, in line with the national settings announced by the AHPCC, that the self-isolation period for diagnosed persons should be reduced from 10 to 7 days from the date the person took a COVID-19 PCR test where they were diagnosed with COVID-19.[[4]](#footnote-5)
9. In line with national settings announced by APHCC and National Cabinet, the Acting Chief Health Officer reconfirmed his advice to me that the self-quarantine period should be 7 days for close contacts, irrespective of whether the close contact is vaccinated or unvaccinated.[[5]](#footnote-6)
10. In relation to exposed persons, the Acting Chief Health Officer recommended to me that people who have been advised they are an exposed person or a social contact must undertake a PCR test if symptomatic. Further, the Acting Chief Health Officer advised me that exposed persons and social contacts who are asymptomatic be strongly recommended to undertake five RATs each day for five days. I note his recommendation to me to consider making this mandatory when RAT supply is sufficient to meet demand, and will consider it at the appropriate time. The Acting Chief Health Officer also reconfirmed his previous advice to me that social contacts be required to notify their contacts when diagnosed.[[6]](#footnote-7)
11. In this meeting, the Acting Chief Health Officer also advised me that it is no longer reasonable that a person be required to self-isolate for 10 days should they not undertake a required PCR test, and that the current infringement system is appropriate for managing those individuals.[[7]](#footnote-8)
12. The Acting Chief Health Officer advised me that the existing provisions in Victoria should be retained to provide powers for the Chief Health Officer, Acting Chief Health Officer, Deputy Chief Health Officers and Local Public Health Units (LPHUs) to respond to and manage outbreaks in sensitive settings by directing individuals to isolate and test on a case-by-case basis. In advising me, the Acting Chief Health Officer noted that while the National Cabinet was silent on these existing arrangements, these powers are fundamental to the management of the COVID-19 pandemic in Victoria.[[8]](#footnote-9) I have accepted the advice of the Acting Chief Health Officer.
13. 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.
14. 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 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 evidence available in the circumstances that is relevant and reliable.[[9]](#footnote-10)
2. My decision to make the pandemic order 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. 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 PHW Act.[[10]](#footnote-11)

### 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 PHW Act requires that a copy or written record of the Chief Health Officer's advice, a statement of reasons, and a human rights statement (Human Rights Statement) are published in the case of the making, variation or extension of an order.
4. All the reasons I have made this order 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 the PHW 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 order, I am required to be satisfied that the order is '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 order, I consulted with the Premier and my Coordinating Ministers Committee colleagues.
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 are 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 whether, and if so 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.
4. I note also that in providing his advice, the Chief Health Officer had regard to the Charter.[[11]](#footnote-12)

# Overview of public health advice

# Current context

1. Victoria is currently experiencing an outbreak of both the Delta strain and Omicron strain of severe acute respiratory syndrome coronavirus 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 (Variant of concern). When making this pandemic order, 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, including in relation to 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 29 December 2021, 3,767 new cases were locally acquired and no new cases from overseas have been reported to the Department of Health within the preceding 24 hours. The state seven-day local case growth rate to 29 December 2021 was 67 per cent.
2. As at 29 December 2021, there were 19,994 active cases in Victoria and 24,602 cases being managed as close contacts.
3. Five COVID-related deaths were reported in 24 hours preceding 29 December 2021, bringing the total number of COVID-19 related deaths in Victoria to 1,504.
4. From 29 December 2021, 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 40 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 the Christmas and New Year period, wastewater testing data is unavailable.

*Test results*

1. Victorians had been tested at a rate of 18,363 per 100,000 people over the 14 days to 29 December 2021 (from 15 December 2021 and 29 December 2021 inclusive).

*Vaccinations*

1. As at 29 December 2021:
	1. a total of 5,025,272 doses have been administered through the state’s vaccination program, contributing to a total of 11,247,566 doses administered in Victoria;
	2. 92.8 per cent of Victorians over the age of 12 have been fully vaccinated; and
	3. 94.5 per cent of Victorian over the age of 12 have been partially vaccinated.

*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); and
* 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); and
* 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); and
* 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 a pandemic order

## 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 the pandemic order, 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.[[12]](#footnote-13) 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 order I have made recognises that, although more than 92 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.[[13]](#footnote-14)
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 ‘booster’ vaccination; and how effective similar public health measures appear to be in containing COVID-19 in Northern Hemisphere countries as they enter winter. [[14]](#footnote-15)
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.[[15]](#footnote-16)
8. Having had regard to the advice of the Chief Health Officer, Acting Chief Health Officer and after having consulted with the Premier, my Coordinating Ministers Committee colleagues and others as set out in paragraph 30, it is my view that making this pandemic order 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. Requiring people who have been diagnosed with, or exposed to, COVID-19 to undertake testing, and self-isolate or self-quarantine as necessary to reduce the risk of further transmission.
9. The Chief Health Officer and/or Acting Chief Health Officer has 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. [[16]](#footnote-17)
	2. The significant pressure being experienced by the testing system and the need to protect capacity for testing those in whom the value of testing is highest on both public health and clinical care grounds.[[17]](#footnote-18)
	3. 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.[[18]](#footnote-19)
	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 rapid antigen (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.[[19]](#footnote-20)
	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.[[20]](#footnote-21)
	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.[[21]](#footnote-22)
	7. Depending on the availability of RA testing, aspects of the test, trace, isolate and quarantine approach (TTIQ) approach should be revised to better support the case, contact and outbreak management strategy from the likely impacts of Omicron on capacity and resourcing. Immediately foreseeable changes are:
		1. Testing requirements could transition from PCR testing to RA testing for contacts, in order to preserve PCR testing capacity for those with a higher pre-test probability, such as symptomatic individuals. Repeated RA testing further improves accuracy as a screening modality.[[22]](#footnote-23)
		2. Acknowledging a greater responsibility on individuals to test the infectiousness themselves, and potentially also having cases notify their contacts.[[23]](#footnote-24)
	8. Changing the quarantine duration and requirements for close contacts is likely to be appropriate. 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. [[24]](#footnote-25)
		1. 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.[[25]](#footnote-26)
	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 a rapid antigen test (RAT) on the sixth day of self-quarantine.[[26]](#footnote-27)
		1. 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.[[27]](#footnote-28)
		2. If a close contact returns a positive RA test, then the close contact should be required to undertake a PCR test.[[28]](#footnote-29)
		3. 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.[[29]](#footnote-30)
	10. 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.[[30]](#footnote-31)
	11. 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.[[31]](#footnote-32)
		1. Symptomatic exposed persons and social contacts should be required to undertake a PCR test. [[32]](#footnote-33)
		2. Asymptomatic exposed persons and social contacts should be strongly recommended to undertake five RATs each day for five days. The Minister should consider mandating this recommendation when RAT supply is sufficient to meet demand.[[33]](#footnote-34)
	12. 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.[[34]](#footnote-35)
	13. For an asymptomatic person who is not able to access RATs each day for five days, a lower number of RATs at a lesser frequency is better than not testing at all, and individuals should monitor for symptoms.[[35]](#footnote-36)
10. I accept the Chief Health Officer’s and Acting Chief Health Officer’s advice. In particular, the escalating case numbers and with the seven-day locally COVID-19 case average rising to 2,318 people per day, I now consider it necessary to implement further measures through a pandemic order.
11. I believe these measures are reasonably necessary and proportionate to the current risk of transmission in the community.

## Risks of no action taken

1. 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:

“*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*.”[[36]](#footnote-37)

## Schedules

1. The specific Reasons for Decision for the Pandemic Order is set out in Schedule 1.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The Hon. Martin Foley**

Minister for Health

30 December 2021

# Schedule 1 – 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.

### 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 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 an indoor space during their infectious period of their COVID-19 diagnosis and infectious period.
2. A person is a close contact of a diagnosed person if an officer or nominated representative of the Department determines that they are a close contact of a diagnosed person, 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 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, the person must self-quarantine for 7 days from when the diagnosed person undertook their PCR test that confirmed they were a diagnosed person; or
		2. If the close contact does not self-quarantine with a diagnosed person, must self-quarantine for 7 days from when they last had contact with a diagnosed person.
	2. 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.
3. An exposed person is an individual who is not a close contact in a workplace or education facility and has had: at least 15 minutes face to face contact, or greater than 2 hours within the same indoor space with a confirmed case of COVID-19 during their infectious period.
	1. An exposed person 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.
4. 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 during their infectious period, or spent more than 2 hours in an indoor space with a diagnosed during their infectious period.
	1. A person who is a social contact is required to obtain COVID test/s as set out in the 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. The Order requires 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. The operator must record the COVID- test results of each exposed person before permitting the exposed person to return to the premises.

### Changes from Pandemic (Quarantine, Isolation and Testing) Order 2021 (No. 1)

1. A diagnosed person must also take reasonable steps to notify the following persons of their COVID-19 diagnosis and infectious period:
	1. the diagnosed person’s close contacts;
	2. the diagnosed person’s social contacts.
2. A person is a close contact of a diagnosed person if an officer or nominated representative of the Department determines that they are a close contact of a diagnosed person, 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 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, the person must self-quarantine for 7 days from when the diagnosed person undertook their PCR test that confirmed they were a diagnosed person; or
		2. If the close contact does not self-quarantine with a diagnosed person, must self-quarantine for 7 days from when they last had contact with a diagnosed person.
	2. 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. This includes that:
		1. all symptomatic close contacts must undertake a PCR test on the first day of their self-quarantine. If the result is negative, they must undertake a rapid antigen test (RAT) on the sixth day of self-quarantine;
		2. asymptomatic close contacts, undertake RATs on the first day after they are informed that they are a close contact, and on the sixth day of their self-quarantining period
3. An exposed person is an individual who is not a close contact in a workplace or education facility and has had at least 15 minutes face to face contact, or greater than 2 hours within the same indoor space with a confirmed case of COVID-19 during their infectious period.
	1. An exposed person 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. This includes that:
		1. people who have been advised they are an exposed person must undertake a PCR test if symptomatic, or if they develop symptoms of COVID-19;
		2. exposed persons who are asymptomatic be strongly recommended to undertake five RATs each day for five days;
4. 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 during their infectious period, or spent more than 2 hours in an indoor space with a diagnosed during their infectious period.
	1. A person who is a social contact is required to obtain COVID test/s as set out in the Testing Requirements for Contacts and Exposed Persons” as amended from time to time, and follow the “COVID-19 rapid antigen test procedure” where applicable.
		1. people who have been advised they are a social contact must undertake a PCR test if symptomatic, or if they develop symptoms of COVID-19;
		2. social contacts who are asymptomatic be strongly recommended to undertake five RATs each day for five days;

*Period*

1. This Order will commence at 11:59:00pm on 30 December 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 identified in paragraph 67 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 and Acting Chief Health Officer’s advice to me which includes, verbal advice provided to me by the Acting Chief Health Officer on 30 December 2021 and 29 December 2021, the written advice provided to me by the Chief Health Officer on 23 December 2021 which supplements the written advice he provided on 10 December 2021 and his verbal advice provided on 14 December 2021.
2. In relation to the restrictions that will be imposed by this Order, the Chief Health Officer and Acting Chief Health Officer has 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. [[37]](#footnote-38)
	2. Diagnosed persons with confirmed COVID-19 should continue to have specific requirements to ensure their risk of onward transmission is minimised.[[38]](#footnote-39) 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.[[39]](#footnote-40)
	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.[[40]](#footnote-41)
	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 rapid antigen (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.[[41]](#footnote-42)
	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.[[42]](#footnote-43)
	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.[[43]](#footnote-44)
	7. 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.[[44]](#footnote-45) Immediately foreseeable changes are:
		1. Testing requirements could transition from PCR testing to RA testing for contacts, in order to preserve PCR testing capacity for those with a higher pre-test probability, such as symptomatic individuals. Repeated RA testing further improves accuracy as a screening modality.[[45]](#footnote-46)
		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.[[46]](#footnote-47)
	8. 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.[[47]](#footnote-48)
	9. 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.[[48]](#footnote-49)
	10. 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.[[49]](#footnote-50)
		1. 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.[[50]](#footnote-51)
	11. 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 a rapid antigen test on the sixth day of self-quarantine.[[51]](#footnote-52)
		1. 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.[[52]](#footnote-53)
		2. If a close contact returns a positive RA test, then the close contact should be required to undertake a PCR test.[[53]](#footnote-54)
		3. 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.[[54]](#footnote-55)
	12. Requirements should be made for exposed persons, who have been exposed to a diagnosed person but do not meet the criteria for being a close contact. This is done with the aim of ensuring onward transmission and amplification is minimised. 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.[[55]](#footnote-56)
	13. 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.[[56]](#footnote-57)
	14. 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.[[57]](#footnote-58)
		1. Symptomatic exposed persons and social contacts should be required to undertake a PCR test. [[58]](#footnote-59)
		2. Asymptomatic exposed persons and social contacts should be strongly recommended to undertake five RATs each day for five days. The Minister should consider mandating this recommendation when RAT supply is sufficient to meet demand.[[59]](#footnote-60)
	15. 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.[[60]](#footnote-61)
	16. For an asymptomatic person who is not able to access RATs each day for five days, a lower number of RATs at a lesser frequency is better than not testing at all, and individuals should monitor for symptoms. The recommendation to undertake the RAT tests each day is based on the understanding that increasing the number of tests improves the sensitivity of the testing.[[61]](#footnote-62)
3. 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.
4. In the making of this pandemic order, I also had 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. 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.
	2. 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.
	3. 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.
	4. 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 and Acting 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’s 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, 30 December 2021. [↑](#footnote-ref-3)
3. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-4)
4. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-5)
5. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-6)
6. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-7)
7. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-8)
8. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-9)
9. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021), p. 5 at [13]-[15]. [↑](#footnote-ref-10)
10. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021), p. 14 at [50]. [↑](#footnote-ref-11)
11. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021), p. 14 at [51]; see also p. 4 at [7];Department of Health, *Chief Health Officer Advice to Minister for Health* (23 December 2021), p.4 at [12]. [↑](#footnote-ref-12)
12. See *Public Health and Wellbeing Act 2008* (Vic) section 3(1) for the definition of ‘serious risk to public health’. [↑](#footnote-ref-13)
13. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021),p. 4 at [5]. [↑](#footnote-ref-14)
14. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021), p. 4 at [6]. [↑](#footnote-ref-15)
15. Department of Health, *Chief Health Officer Advice to Premier – Advice Relating to the Making of a Pandemic Declaration* (8 December 2021), p. 13 at [47]. [↑](#footnote-ref-16)
16. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021), p. 24 at [108]. [↑](#footnote-ref-17)
17. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-18)
18. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-19)
19. Department of Health, *Chief Health Officer Advice to Minister for Health* (23 December 2021), p. 12 at [54].  [↑](#footnote-ref-20)
20. Department of Health, *Chief Health Officer Advice to Minister for Health* (23 December 2021), p. 12 at [55]. [↑](#footnote-ref-21)
21. Department of Health, *Chief Health Officer Advice to Minister for Health* (23 December 2021), p. 13 at [58]. [↑](#footnote-ref-22)
22. Department of Health, *Chief Health Officer Advice to Minister for Health* (23 December 2021), p. 20 at [108(i)]. [↑](#footnote-ref-23)
23. Department of Health, *Chief Health Officer Advice to Minister for Health* (23 December 2021). p. 20 at [108(ii)]. [↑](#footnote-ref-24)
24. Department of Health, *Chief Health Officer Advice to Minister for Health* (23 December 2021), p. 20 at [109]. [↑](#footnote-ref-25)
25. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-26)
26. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-27)
27. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-28)
28. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-29)
29. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-30)
30. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021), p. 25 at [116]. [↑](#footnote-ref-31)
31. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021) p. 24 [107].  [↑](#footnote-ref-32)
32. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-33)
33. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-34)
34. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-35)
35. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-36)
36. Department of Health, *Chief Health Officer Advice to Premier – Advice Relating to the Making of a Pandemic Declaration* (8 December 2021), p. 13 at [48]. [↑](#footnote-ref-37)
37. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021), p. 24 at [108]. [↑](#footnote-ref-38)
38. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021), p. 24 at [109]. [↑](#footnote-ref-39)
39. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-40)
40. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021), pp. 25-26 at [117]. [↑](#footnote-ref-41)
41. Department of Health, *Chief Health Officer Advice to Minister for Health* (23 December 2021), p. 12 at [54].  [↑](#footnote-ref-42)
42. Department of Health, *Chief Health Officer Advice to Minister for Health* (23 December 2021), p. 12 at [55]. [↑](#footnote-ref-43)
43. Department of Health, *Chief Health Officer Advice to Minister for Health* (23 December 2021), p. 13 at [58]. [↑](#footnote-ref-44)
44. Department of Health, *Chief Health Officer Advice to Minister for Health* (23 December 2021), p. 20 at [108]. [↑](#footnote-ref-45)
45. Department of Health, *Chief Health Officer Advice to Minister for Health* (23 December 2021), p. 20 at [108(i)]. [↑](#footnote-ref-46)
46. Department of Health, *Chief Health Officer Advice to Minister for Health* (23 December 2021), p. 20 [108(ii)]. [↑](#footnote-ref-47)
47. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021), p. 24 at [110]. [↑](#footnote-ref-48)
48. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021), pp. 24-25 at [111]. [↑](#footnote-ref-49)
49. Department of Health, *Chief Health Officer Advice to Minister for Health* (23 December 2021), p. 20 at [109]. [↑](#footnote-ref-50)
50. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-51)
51. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-52)
52. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-53)
53. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-54)
54. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-55)
55. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021), p. 25 at [113]-[115]. [↑](#footnote-ref-56)
56. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021) p. 25 [116]. [↑](#footnote-ref-57)
57. Department of Health, *Chief Health Officer Advice to Minister for Health* (10 December 2021) p. 24 [107].  [↑](#footnote-ref-58)
58. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-59)
59. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-60)
60. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-61)
61. Text reflects verbal advice provided by the Acting Chief Health Officer to the Minister for Health, 30 December 2021. [↑](#footnote-ref-62)