Response.Lead

From: Virginia McCabe
Sent: Monday, 29 November 2021 5:25 PM
To: Lynne McKinlay; Dawn Schofield
Cc: Rachel Vowles; Kyle Fogarty; publichealthdirections; Response.Lead.Engagement; Response Lead - Policy
Subject: CHO PHD COVID-19 Vaccination Requirements for Workers in a high risk setting Direction
Attachments: CHO PHD COVID-19 Vaccination Requirements for Workers in a high risk setting Direction .docx

Hi Lynne and Dawn,

Please find attached for your consideration and comment the current version of the draft COVID-19 vaccination requirements for workers in a high risk setting Direction. Please note [redacted], and Education are to provide further clarification tomorrow morning on their operations that may be in scope, and further details may also be provided by [redacted] including in relation to [redacted].

The draft reflects consultation feedback received so far.

Kind regards,
Gina.

Gina McCabe
Public Health Directions COVID Governance Branch | Queensland Health

P [redacted]
E [redacted]@health.qld.gov.au
W health.qld.gov.au
A lvl 11, 33 Charlotte Street

Queensland Health acknowledges the Traditional Custodians of the land across Queensland, and pays respect to First Nations Elders past, present and future.

Direction from Chief Health Officer in accordance with emergency powers arising from the declared public health emergency

COVID-19 Vaccination Requirements for Workers in a high-risk setting Direction

Public Health Act 2005 (Qld)
Section 362B

On 29 January 2020, under the *Public Health Act 2005*, the Minister for Health and Minister for Ambulance Services made an order declaring a public health emergency in relation to coronavirus disease (COVID-19). The public health emergency area specified in the order is for 'all of Queensland'. Its duration has been extended by regulation to 26 December 2021 and may be further extended.

Further to this declaration, I, Dr Peter Aitken, Chief Health Officer, reasonably believe it is necessary to give the following directions pursuant to s362B of the *Public Health Act 2005* to assist in containing, or to respond to, the spread of COVID-19 within the community.

Guidance

This public health direction applies to workers who enter, work in, or provide services in a high-risk setting. The direction defines how a high-risk setting is identified by the Chief Health Officer and specifies the COVID-19 vaccination requirements and related obligations for workers and employers operating in a high-risk setting. The direction recognises that an employer may mandate vaccination for employees, where otherwise permitted at law, based on the requirements of a role.

Preamble

1. This Public Health Direction applies to workers in settings where there is a higher risk of transmission of the COVID-19 virus, the setting is accessed by a large number of vulnerable persons as service users, and/or a sudden reduction in available workforce due to COVID-19 impacts at the setting would significantly affect the continuity of critical services to the community with consequential public health risks.
2. This Public Health Direction supplements existing public health directions already made to contain or respond to the spread of COVID-19 by mandating vaccination of workers in healthcare settings, in quarantine facilities and in vulnerable facilities. Nothing in this public health direction reduces the requirements of those public health directions.
3. Separately from the requirements of Public Health Directions, under sections 362G and 362H of the *Public Health Act 2005*, an ***emergency officer (public health)*** can require a person to comply with additional directions if the emergency officer believes it is

reasonably necessary to assist in containing, or to respond to, the spread of COVID-19 in the community.

Citation

4. This Public Health Direction may be referred to as the *COVID-19 Vaccination Requirements for Workers in a High Risk Setting Direction.*

Commencement

5. This Public Health Direction applies from time of publication until the end of the declared public health emergency, unless it is revoked or replaced.

Application

6. This Public Health Direction applies to ***workers*** in a ***high-risk setting*****,** in the public, private and non-government sectors. This Public Health Direction does not apply to people who visit the high risk setting to access or use its services, either for themselves or as a support person for someone else.

PART 1 —WORKERS IN A HIGH-RISK SETTING

Worker

7. From 21 January 2022 - a ***worker*** must not enter, work in, or provide services in a ***high-risk setting,*** including a setting that is not the worker's primary place of work**,** unless the ***worker*** complies with the ***COVID-19 vaccination requirements***.

Examples: a contractor, union official, regulator, auditor, courier, perfomer, or sales representative may be a worker in a high risk setting even though they may only occasionally enter the setting as part of their work duties.

8. A patient, client or user of a service, or a parent, guardian or carer accompanying them to access the services, is not a ***worker*** at a high-risk setting.

High-risk setting

9. A ***high-risk setting*** is a type of service, business or activity declared to be a ***high-risk setting*** by the Chief Health Officer in ***Schedule 2***, having regard to the public health risk for the setting, including one or more of the following factors:

(a) higher risk of transmission of COVID-19 due to the nature of the setting and the way in which services are provided; or

(b) a high number of ***vulnerable persons*** use or access the setting; or

(c) the continuity of critical services to the community and consequential public health impacts if COVID-19 cases or quarantine unexpectedly reduced the available workforce of the setting.

Examples: an education setting where teachers and students work in close proximity has a higher risk of transmission; a youth justice detention centre has a high number of vulnerable persons who would be significantly and adversely affected by a COVID-19 outbreak at the centre.

PART 2 —COVID-19 VACCINATION REQUIREMENTS

10. The ***COVID-19 vaccination requirements*** are that:

    (a) by 17 December 2021, a ***worker*** in a ***high-risk setting*** has received the first dose of a ***COVID-19 vaccine***; and

    (b) by 11.59pm AEST on 23 January 2022, a ***worker*** in a ***high-risk setting*** has received the prescribed number of doses of a ***COVID-19 vaccine***; and

    (c) as soon as reasonably practicable after each dose of the ***COVID-19 vaccine***, the ***worker*** must show evidence of having received the ***COVID-19 vaccine*** dose to their ***employer***.

Note: evidence of meeting the COVID-19 vaccination requirements may include a person's COVID-19 vaccination certificate (digital or paper based), vaccination card, MyGov record or immunisation history statement from the Australian Immunisation Register. A person's immunisation history statement can be obtained from the Australian Government using myGov, the Medicare mobile app or by calling the Australian Immunisation Register and requesting a statement to be posted. Information is available at: https://www.servicesaustralia.gov.au/individuals/services/medicare/australian-immunisation-register/how-get-immunisation-history-statement.

Medical contraindication

11. Paragraph 8 does not apply to a ***worker*** who is unable to be vaccinated due to a ***medical contraindication*** where the ***responsible person*** for the ***high-risk setting***:

    (a) assesses the risk to other staff, clients and other persons at the ***high-risk setting***; and

    (b) the worker undertakes daily ***COVID-19 PCR testing*** before each work shift.

Note: results of the daily PCR testing may not be available before the worker's shift starts and can be provided to the employer or nominated person for the high-risk setting on a rolling basis as the results become available.

12. A ***worker*** in a ***high-risk setting*** to whom paragraph 12 applies must provide evidence of the ***medical contraindication***.

*Note: evidence of **medical contraindication** may be a digital or paper record from the person's Australian Immunisation Record, specifying the medical contraindication that makes the person unable to be vaccinated and the period of the **medical contraindication,** if it is temporary.*

13. Where the person has a temporary ***medical contraindication*** for being unable to receive the COVID-19 vaccination, paragraph 12 only applies for the period specified. If the ***medical contraindication*** continues beyond the specified period, the person must provide new evidence of a continuing ***medical contraindication*** or of their vaccination to comply with the ***COVID-19 vaccination requirements***.

Emergency entry to high risk settings

14. An unvaccinated person may enter a high risk setting to respond to an emergency and paragraph 8 does not apply.

    Example: a contractor, who is not vaccinated, enters a school during school hours to fix leaking pipes in the toilet block.

15. A ***worker*** must report the emergency entry to the ***high-risk setting*** to their employer as soon as is reasonably practicable.

Entry in personal or private capacity

16. Nothing in this Public Health Direction prevents a person who does not meet the ***COVID-19 vaccination requirements*** from using the services of the ***high-risk setting*** as a client, or visitor or accompanying a person who is using the services of the ***high-risk setting***.

    Example: an unvaccinated plumber who can only work on school premises in an emergency can continue to attend parent activities at the school their child attends. A relief teacher must meet the vaccination requirements to continue to work at the school their child attends, but may attend school activities, such as parent teacher interviews, award nights, as a parent, unvaccinated, with their child, and can attend the school to pick up a sick child.

PART 3 – RECORD KEEPING REQUIREMENTS FOR HIGH RISK SETTINGS

17. A ***worker,*** their ***employer*** and the ***responsible person*** must take all reasonable steps to ensure that the ***worker*** does not enter, work in, or provide services in a ***high-risk setting*** if the person does not meet the ***COVID-19 vaccination requirements*** and does not have a ***medical contraindication*** for all ***COVID-19 vaccines.***

18. The ***employer*** must keep a record, for each ***worker*** in the ***high-risk setting,*** of:

    (a) their vaccination status;

    (b) the type of evidence that was sighted to verify the workers' vaccination status; and

    (c) the timeframe for a temporary ***medical contraindication***; and

    (d) the type of evidence that was sighted to support a claimed ***medical contraindication***.

19. Where the ***responsible person*** in the ***high-risk setting*** is not the ***employer*** of the ***worker***, the **employer** is to keep the records in paragraph 19 and provide the information to the ***responsible person*** for the ***high-risk setting***.

    Example: an agency provides relief staff to the high-risk setting. The agency must maintain the records in relation to employee vaccination and provide summary information or a letter of assurance about employee vaccination status to the responsible person for the high-risk setting.

PART 4 —OTHER MATTERS

20. An ***employer*** of workers in a ***high-risk setting*** may identify a part of their service, business, or activity that is not a ***high-risk setting*** if:

(a) that part operates independently of the ***high-risk setting***, and the workforce is physically separated from the ***high-risk setting***, and

(b) there has arrangements in place to prevent transmission between the ***high-risk setting*** and other operations or services of the setting; and

(c) the separation of the work and workers does not adversely affect continuity of critical services for the community.

Example: an international school has administration offices at different premises for staff who co-ordinate logistics for the students, and who have no contact with the students or teaching staff. The employer determines that the administration office is not a high risk setting defined in Schedule 2.

21. Nothing in this public health direction prevents an employer from making a lawful direction requiring an employee to be vaccinated for COVID-19 where the employer has determined it is a requirement of the employee's role.

22. An ***emergency officer (public health)*** can require a ***responsible person,*** or a ***worker***, or their ***employer*** to comply with additional directions if the emergency officer believes the direction is reasonably necessary to assist in containing, or to respond to, the spread of COVID-19 within the community.

PART 5 — DEFINITIONS

23. Definitions used in this Direction are in Schedule 1.

PART 6 — PENALTIES

A person to whom the direction applies commits an offence if the person fails, without reasonable excuse, to comply with the direction.

Section 362D of the *Public Health Act 2005* provides:

Failure to comply with public health directions

A person to whom a public health direction applies must comply with the direction unless the person has a reasonable excuse.
Maximum penalty—100 penalty units or 6 months imprisonment.

Dr Peter Aitken
Chief Health Officer
XX November 2021
Published on the Queensland Health website at xx:xx am/pm

SCHEDULE 1 - Definitions

For the purposes of this Public Health Direction:

Authorised person is a person approved or permitted to access the information in accordance with licensing requirements, if any, the *Information Privacy Act 2009* and the *Public Records Act 2002* and related instruments of delegation.

COVID-19 PCR test means tested for COVID-19 with an oropharyngeal and deep nasal swab for polymerase chain reaction (PCR) testing, but does not include a self-test.

COVID-19 vaccination requirements see paragraph 11.

COVID-19 vaccine is a vaccine for COVID-19 that is approved for use in Australia or recognised by the Therapeutic Goods Administration.

Eligible health professionals means any of the following:

- fellows of the Royal Australian College of General Practitioners (as defined by the *Health Insurance Act 1973 Cth*); or
- fellows of the Australian College of Rural and Remote Medicine (as defined by the *Health Insurance Act 1973 Cth)*; or
- on Medicare's Vocation Register of General Practitioners (as defined by the *Health Insurance Act 1973 Cth)*; or
- practice registrar on an approved 3GA training placement; or
- paediatrician; or
- public health physician; or
- infectious diseases physician; or
- clinical immunologist.

Emergency officer (public health) means an emergency officer appointed under the *Public Health Act 2005*.
Note: Emergency officers appointed under the Public Health Act 2005 include ***public health officers*** *and police.*

Employer means a person, or other legal entity that employs or otherwise engages a ***worker***.

High-risk setting see Schedule 2.

Medical contraindication means a temporary or permanent contraindication that is notified to the Australian Immunisation Register (AIR) by a medical practitioner completing an ***Australian Immunisation Register (AIR) immunisation medical exemptions form*** in relation to a person and recorded on the person's Immunisation History Statement (IHS).

Note: *Evidence of a recognised medical contraindication means a* ***COVID-19 vaccination*** *medical exemption recorded by an* ***eligible health professional*** *on the Australian Immunisation Register for the person.*

Note: *a temporary vaccine exemption may apply until a specified date due to acute major illness, significant immunocompromise of short duration and recognised overseas vaccination.*

Responsible person for a ***high-risk setting*** means the person who is legally responsible for the setting, including in relation to compliance with regulatory and other requirements for the setting.

Example: the Principal of a school may be the responsible person; the Director General is the responsible person for a government department; a chief executive or Board Chair is the responsible person for a not for profit organisation. The responsible person may also be the employer but this will not always be the case.

Vulnerable person means a person who is ineligible or unable to be vaccinated for COVID-19 because of their age or a ***medical contraindication***, or a person with underlying medical conditions that place them at greater risk of adverse impacts from COVID-19 even if they are vaccinated.

Example: children under the eligible age limit for COVID-19 vaccination; children who are immunocompromised or undergoing treatment that affects the efficacy of the vaccine; residents in residential aged care facilities; people with disabilities; patients in hospitals.

Worker includes a person who:

(a) is employed at a ***high-risk setting***; or
(b) is a State government employee whose duties involve attendance at a ***high-risk setting***; or
(c) undertakes work, whether paid or unpaid, at the ***high-risk setting***; or
(d) is a contractor providing services to or at the ***high-risk setting***; or
(e) is attending the high-risk setting in the context of duties relating to the administration, regulation, governance, managerial oversight, or legal framework relating to the ***high-risk setting***; or
(f) is a performer, presenter or other specialist entering the ***high risk setting*** as part of delivering an activity, function or event; or
(g) is a volunteer delivering a service in the ***high-risk setting***, other than a parent assisting in a voluntary parental capacity while attending a school activity, function or event; or
(h) is undertaking a work placement related to an enrolled course of study

Note: A worker who visits a high-risk setting as an incidental part of their duties but is not providing services within the high-risk setting, such as a delivery driver, is not a worker at a high-risk setting.

SCHEDULE 2 – High Risk Settings

Setting
Education settings, including: Primary schools Secondary schools Outside school hours care and vacation care Kindergartens Early childhood education including kindergartens, registered and licensed early childhood settings including childcare centres and family daycare providers But not including: Universities and other higher educational institutions such as TAFEs and RTOs

Response.Lead.Engagement

From: Response.Lead.Engagement
Sent: Monday, 29 November 2021 12:52 PM
To: ALLEN, Craig
Cc: SCHIMMING, Sharon; 'Nick Seeley (DoE)'
Subject: URGENT: Mandatory vaccination high risk settings_Education settings

Importance: High

Hi Craig, Sharon,

Would you have an opportunity to discuss some policy considerations to mandatory vaccination for education settings sometime this afternoon?

We have been asked rapidly discuss with you in the event something is announced.

Do you have availability post 3pm this afternoon?

Please feel free to give me a call on [redacted]

Kind regards
Aimee

Queensland Government

Response Lead Engagement
COVID Response Division | Queensland Health

E [redacted]@health.qld.gov.au
W health.qld.gov.au
A 33 Charlotte Street, Brisbane QLD 4000

From: ALLEN, Craig [redacted]@qed.qld.gov.au>
Sent: Wednesday, 17 November 2021 12:05 PM
To: Response.Lead.Engagement [redacted]@health.qld.gov.au>
Cc: SCHIMMING, Sharon [redacted]@qed.qld.gov.au>
Subject: 20211115_Leadership Board Consultation_ Mandatory vaccination high risk settings_DM.docx

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Attached response from Department of Education

Regards
Craig Allen
A/Director-General

****

****

Mandatory vaccination requirements for workers in high-risk settings (public, private and non-Govt)

15 November 2021

DRAFT NOT GOVERNMENT POLICY

Definition of a high-risk setting:

- A setting where there may be:
  - higher risk of transmission of the virus (eg. people in close proximity); and/or
  - a high number of vulnerable persons as users of the service; and/or
  - a sudden reduction in the available workforce due to COVID-19 (as cases or close contacts required to quarantine) would impact the continuity of critical services to the community (e.g emergency, infrastructure or social services).

Scope

- Public service/sector (Departments, statutory bodies, government owned corporations)
- Local and Commonwealth Government
- Private sector
- Non-government sector
- Contractors, volunteers, union officials, regulators, auditors, and other persons that might enter a high risk setting even if it is not their primary place of work.

Approach

- A Chief Health Officer Public Health Direction specifying the high-risk settings in which workers must be vaccinated to continue to remain and work in the setting.
- The Direction would provide scope for employers to determine:
  - other settings where there may be a mandatory vaccination requirement due to the high risk or critical nature of the setting
  - staff that would be in-scope or out-of scope in the high-risk setting.

Principles

- Protecting our most vulnerable by ensuring their risk of transmission is as low as possible whilst accessing essential government services
- Users of essential government services will not be required to be vaccinated, but feel safe while doing so
- The ongoing delivery of critical services must be able to be maintained, and the setting must be able to continue operating if it lost workers due to the mandate
- Protecting persons who enter or work in particular settings is the best way to achieve the public health benefit and as such applies to a broad range of employment arrangements (e.g. contractors) and people entering settings (e.g. delivery drivers and visitors) but not users (e.g, prisoners, students).

Types of high-risk settings

- Below is a table of high-risk settings. Please provide your feedback on this list and insert any other settings you would like consideration given too, including the rationale, by 10am Wednesday 17 November 2021, to [redacted]@health.qld.gov.au

Relevant settings for CHO consideration

The below table covers a range of settings that **might** meet the definition of high risk. Please add any comments you would like the CHO to consider in these settings, for example, would a mandate likely lead to a significant reduction in the workforce such that it would disrupt essential services (e.g public transport, construction)

Relevant setting	Comments

Education settings
(early childhood, schools, TAFE, Universities, RTOs)
	• Preferable to specify all education settings including:
	  ○ Schools
	  ○ Early childhood settings, including registered family day-care
	  ○ Out of School Hours Care
	  ○ TAFE
	  ○ Higher educational institutions
	  ○ Registered training providers
	  ○ Outdoor education facilities
	  ○ Student hostels
	• Strong preference that 'education settings' extends to administration and office settings related to supporting the provision of education. For the Department of Education, this would mean central and regional offices. As such, the Direction would apply to ALL Department of Education employees (and all people entering any Department of Education premises).
	• Note that the first day of the school year is 24 January 2022. As such, if this is the 'deadline' for second dose, there is risk of a significant reduction in the school-based workforce which would disrupt an essential service (education).

Relevant setting	Comments

Response.Lead

From: Aimee Du Toit
Sent: Monday, 29 November 2021 4:58 PM
To: Response Lead - Policy; publichealthdirections; Rachel Vowles; Dawn Schofield
Cc: Kyle Fogarty; Response.Lead.Engagement; Lynne McKinlay
Subject: CONSULTATION OUTCOMES: Vaccination Requirements of Workers in High Risk Settings
Attachments: CHO PHD COVID-19 Vaccination Requirements for Workers in a high risk setting Direction_CONFIDENTIAL DRAFT.pdf; RE: FOR URGENT ADVICE: Vaccination Requirements for Workers in high risk settings ; CONFIDENTIAL: URGENT AND IMPORTANT PLEASE: consideration of mandatory vaccination for workers in high-risk settings

Dear all,

Please see a summary of the consultation which has been undertaken this afternoon on the Vaccination Requirements for Workers in High Risk Settings. Can I please seek clarity on the two queries in bold below at your earliest possibility.

Department of Education

- Met with Craig Allen (DG) and Sharon SCHIMMING (DDG)Education were aware of the planned announcement
- DoE will undertake the necessary communication with the Catholic and Independent sector as soon as announcement is made
- Education is clear that the Direction will capture all workers/volunteers which are 'delivering a service' in the setting
- This will include all volunteers, including tuckshops, reading groups, tennis coach, other extracurricular service which is contracted by the school for the school
- The Direction will capture 3200 regulated providers
- It will not capture people using the school in a private capacity outside of hours – ie. karate club
- Education will provide a list of examples that are in scope by 11am tomorrow.
- **Clarification needed on 'school camps'. School camps provide a service to the school, but it is not at the school. Noted the unintended consequence of this if confirmed to be included, for example, the bus driver taking children to a camp.**

If you have any questions, do not hesitate to call me.

Kind regards,
Aimee

Aimee Du Toit
Response Lead Engagement
COVID Response Division | Queensland Health
Available Monday - Thursday

P [redacted]
E [redacted]@health.qld.gov.au
W health.qld.gov.au
A Level 11, 33 Charlotte St

Response.Lead

From: Response.Lead.Engagement
Sent: Wednesday, 1 December 2021 3:04 PM
To: publichealthdirections
Subject: RE: early childhood settings for high risk

I have sent you a text
Aimee

Response Lead Engagement
COVID Response Division | Queensland Health

E [redacted]@health.qld.gov.au
W health.qld.gov.au
A 33 Charlotte Street, Brisbane QLD 4000

From: publichealthdirections [redacted]@health.qld.gov.au>
Sent: Wednesday, 1 December 2021 3:02 PM
To: Response.Lead.Engagement <Response.Lead.Engagement@health.qld.gov.au>
Subject: early childhood settings for high risk

Hi Aimee,

Do you mind forwarding me Dawn's text re: registered/licensed early childhood providers? There's been some questions around family day care comparative risk to other settings. If Dawn has indicated registered/licensed, I will confirm and include her text in the feedback table.

Thanks,
Gina.

Gina McCabe
Public Health Directions COVID Governance Branch | Queensland Health

P [redacted]
E [redacted]@health.qld.gov.au
W health.qld.gov.au
A lvl 11, 33 Charlotte Street

Queensland Health acknowledges the Traditional Custodians of the land across Queensland, and pays respect to First Nations Elders past, present and future.

Response.Lead

From: Response Lead - Policy
Sent: Thursday, 2 December 2021 2:31 PM
To: Response.Lead.Engagement
Cc: publichealthdirections; Rachel Vowles
Subject: RE: Summary of Engagement for High Risk Settings

Thank you very much, Aimee!

Katrin

From: Response.Lead.Engagement [redacted]@health.qld.gov.au>
Sent: Thursday, 2 December 2021 2:25 PM
To: Response Lead - Policy [redacted]@health.qld.gov.au>
Cc: publichealthdirections [redacted]@health.qld.gov.au>; Rachel Vowles [redacted]@health.qld.gov.au>; Response.Lead.Engagement [redacted]@health.qld.gov.au>
Subject: Summary of Engagement for High Risk Settings

Hi Katrin,

As requested, please see below a summary of the engagement which has been held in regards to vaccination requirements for high risk settings:

- Met with the Department of Education (Director-General and DDG) in advance of the announcement to ensure scope and rationale for 'Schools' was aligned with the Chief Health Officers intent. DoE undertook to engage with the broader private and independent sector

[redacted]

Overall, all were very supportive and the outcomes of the meetings were to ensure that the definitions were appropriate for the settings.

PHD may be able to add to this.

Kind regards,
Aimee

Response Lead Engagement
COVID Response Division | Queensland Health

E [redacted]@health.qld.gov.au
W health.qld.gov.au
A 33 Charlotte Street, Brisbane QLD 4000

Response.Lead

From: Response Lead - Policy
Sent: Friday, 3 December 2021 8:30 AM
To: publichealthdirections; Rachel Vowles
Cc: Response.Lead.Engagement; Response Lead - Policy
Subject: Mandatory vaccination for high risk settings | PR ad talking points
Attachments: Policy Rationale_Workers in high risk setting (COVID-19 vaccination requirements) Direction_DRAFT.docx; Talking points - mandatory vaccination workers in high risk settings.docx

Good morning

Please find attached Policy Rationale and talking points for mandatory vaccination of workers in high risk settings for inclusion in the package of materials for the Minister and CHO.

Warm regards

Katrin

Katrin Hausdorf
Manager
COVID-19 Response Lead - Policy
COVID-19 Response Division |
Queensland Health

P [redacted]
E [redacted]@health.qld.gov.au
W health.qld.gov.au

Queensland Health acknowledges the Traditional Owners of the land, and pays respect to Elders past, present and future.

COVID-19 Public Health Rationale
COVID-19 Vaccination Requirements for Workers in a high-risk setting Direction

3 DECEMBER 2021

DRAFT NOT GOVERNMENT POLICY

Overarching intent

The overarching intent of the *Workers in high-risk settings (COVID-19 Vaccination Requirements) Direction* (the Direction) is to protect the health of the community and workers in identified high-risk settings for COVID-19, reduce the risk of COVID-19 transmission and outbreaks and safeguard the provision of critical services in Queensland. The Direction sets out mandatory COVID-19 vaccination requirements for workers in high-risk settings, and extends to any other person who works as a volunteer, contractor, student, whether employed by the responsible person for the setting or performing the work under another arrangement. The Direction states that by 23 January 2022, workers must have received their second dose of a TGA approved COVID-19 vaccine to enter, work in, or provide services in a high-risk setting.

By mandating COVID-19 vaccination for workers in this way, the risk of COVID-19 transmission within high risk settings and into the Queensland community is reduced. This Direction builds on existing COVID-19 vaccine mandates for workers in healthcare and other related high-risk settings, like quarantine facilities.

In the current iteration of the Direction, the following settings are identified as high-risk:

- Schools and early education
- Correctional and detention facilities (including youth detention)
- Airports

A risk analysis for these settings is described in this rationale, and summarised in Table 2 at the end of this document. The Direction complements existing mandatory vaccination requirements in other Queensland Public Health Directions. The policy position aligns with mandates in place in nearly all Australian jurisdictions, as outlined in Table 1 at end of this document. This Direction is deliberately broad and will allow for additional high-risk settings to be declared going forward.

Where a worker at an identified setting is captured under an existing COVID-19 vaccine requirement (such as healthcare workers), this Direction does not extend the timeframes for these cohorts.

Agency and sector engagement for this Direction occurred with relevant areas within Government, including the Department of Education, Department of Communities, Youth Justice and Multicultural Affairs and Queensland Corrective Services. A range of external stakeholders were also engaged, including tourism and aviation representatives, including major airports and airlines. Feedback on the policy and approach was consistently supportive.

Broadening existing COVID-19 vaccination mandates to workers across a wider range of high-risk settings enhances protection against COVID-19 across Queensland and creates a uniform standard of protection for workers and the community.

Background and rationale at 3 December 2021

Queensland's response to the COVID-19 pandemic has been very successful to date. Large scale outbreaks in Queensland have been prevented with a rapid and decisive public health response. The emergence of the Delta variant early this year and its rapid spread around the globe changed the COVID-19 context and led to widespread outbreaks around the world. Nationally almost every State and Territory in Australia has faced local transmission of the Delta variant and New South Wales (NSW) and Victoria (VIC) experienced widespread and sustained outbreaks of COVID-19 from June 2021.

Effective vaccines for COVID-19 that prevent severe illness and reduce transmission for current variants are now widely available and endorsed by Australia's Therapeutic Goods Administration (TGA). Queensland Health is strongly encouraging and promoting COVID-19 vaccination state-wide. High vaccination coverage is essential to protect the community, the health system, and the economy.

Prior to COVID-19, immunisation programs have been able to successfully achieve 'herd immunity' for many deadly diseases, including measles and pertussis (whooping cough). True herd immunity means enough of the population is immunised that vulnerable groups who cannot be vaccinated are safe from disease. It has become apparent that herd immunity may not be possible with COVID-19, and particularly the Delta variant, because of its highly infectious nature, breakthrough infections among vaccinated people, and emerging evidence of waning vaccine derived immunity after as little as six months.

The protective potential of vaccination against COVID-19 at a population level is also affected by differential vaccine uptake rates among cohorts or in some communities. This is particularly problematic for settings where vulnerable people are present, or where there is an increased risk of rapid and widespread transmission.

In response and to maximise baseline protection, COVID-19 vaccine mandates for workers, and in some cases, visitors to a setting, are becoming more common both in Australia and globally. These mandates support uniform protective coverage in settings that are higher risk for workers and the community. Vaccine mandates are widely accepted and are a safe, low-impost and high impact way of reducing the risk of COVID-19 transmission, illness, and death.

Vaccination for workers has been mandated by a number of industries that are impacted by COVID-19 exposure, including airlines (like Qantas and Jetstar; cabin crew, pilots and airport workers by November 15 and all other employees by March 31 2022) and mining corporations like BHP (all workers and people entering BHP coal mines from January 2022). On 23 October 2021, Woolworths and Aldi announced that all staff across Australia will be required to be vaccinated for COVID-19 (applying from 31 March 2022 for Queensland).

As Queensland transitions to an environment where COVID-19 is endemic, it is inevitable that every Queenslander will eventually be exposed to COVID-19.

High vaccination coverage among workers in settings with the potential for exposure to COVID-19, particularly those serving vulnerable cohorts, will be a key determinant of health outcomes for Queenslanders and the impact of COVID-19 across the State.

With effective and safe vaccines, the public health response can begin to shift away from widespread restrictive social measures and limits on business (like density and gathering limits), and towards population vaccination coverage as a more enduring protection of public health.

Current vaccine mandates

Mandates in healthcare, quarantine and critical services

In Queensland, aligned with National Cabinet and AHPPC endorsed recommendations, vaccination against COVID-19 is currently a requirement for workers in the following high-risk settings:

- Hospitals and healthcare settings
- Queensland Health residential aged care facilities
- Hotel quarantine facilities

Vaccination against COVID-19 has also been mandated for all employees of the Queensland Police Service (QPS) by the Queensland Police Commissioner. This mandate was based on the rationale that COVID-19 challenges the ability of QPS to fulfil its policing role, and rapid transmission of COVID19 through the QPS would take police officers and staff members out of service while they undertake quarantine periods or recover from COVID-19. Reduced availability of police officers and staff members for deployment could threaten the ability of the QPS to serve the community.

All Australian jurisdictions have introduced mandatory vaccination requirements for healthcare workers across the public and private health sectors.

Mandates for public venues to support reopening borders

On 9 November 2021, the *Public Health and Social Measures linked to Vaccination Status: A Plan for 80% and Beyond* (PHSM Plan) was released. Once Queensland reaches 80 per cent double dose vaccination coverage, a requirement for COVID-19 vaccination will be introduced for workers at and visitors to pubs, clubs, cafés, cinemas, theatres, music festivals and a range of public-facing venues operated by the Queensland Government, including museums and galleries. The mandate will replace COVID-19 restrictions on density and gatherings at these venues.

The requirement is deliberately broad and focused on settings with high public attendance— focusing on recreational venues that are higher risk due to the nature of the setting (e.g. alcohol consumption, density, dancing), and those that attract a number of geographically and demographically diverse people, where COVID-19 exposure and transmission could lead to a widespread outbreak.

Achieving uniform vaccination coverage across workers and visitors at these locations provides a baseline level of protection against community transmission. It is intended to be preventive and are intended to mitigate risk to the community with an expected increase in cases and spread going forward. It is also likely that a meaningful proportion of patrons will be children under the age of 16 years, for whom a COVID-19 vaccine is currently not available. Ensuring uniform vaccination coverage among the adults in the identified settings will protect children and protect against more widespread outbreaks.

Unvaccinated visitors will not be able to enter vulnerable settings such as hospitals, residential aged care, disability care accommodation, and correctional facilities to further support a baseline level of protection. This requirement is distinct from accessing facilities to receive care, where vaccination will not be required. This requirement will introduce a baseline level of protection against COVID-19 ingress in these vulnerable facilities going forward, when it is expected that COVID-19 will be circulating more widely in the community, and reduces the likelihood of needing to introduce further restrictions at these facilities.

Identifying additional high-risk settings

Queensland borders are reopening, bringing an increased likelihood of COVID-19 ingress and outbreaks throughout the State, including in vulnerable communities and regions. It is critical that the potential for significant outbreaks is controlled to the maximum extent possible, particularly in light of emerging variants of concern (see section on Omicron below).

There is an immediate urgency for additional protections in settings with a high potential to seed an outbreak, affect vulnerable members of the community, and where an outbreak could directly impact on

the delivery of critical services. Employers and workers in these settings also have a responsibility to ensure the safety of visitors, clients, patients, and people in their care.

There are discrete factors that affect the risk profile of any given setting for the transmission and wider potential impact of COVID-19.

From a public health perspective, COVID-19 transmission risk is directly affected by the ability to physically distance, air flow (i.e. whether the environment is enclosed or outdoors), and the use of infection prevention and control measures (i.e. non-pharmaceutical interventions - masks and hand hygiene). The impact of COVID-19 is amplified by the presence of people vulnerable to the effects of COVID-19 (like unvaccinated people, the elderly, immunocompromised, those with comorbidities, and people with a disability), or where people from a wide geographic spread are exposed and COVID-19 can be transmitted to multiple regions, including vulnerable or remote communities.

More broadly, from a 'systems impact' perspective, in some cases a COVID-19 outbreak in a workplace can have substantial impacts beyond those immediately affected and their families—where an outbreak occurs among workers who provide services critical to the public, like a health care or emergency services setting, the impact on the available workforce and service provision can be even more widespread and long-lasting.

While vaccination coverage continues to increase at a whole-of-population level, as noted above the protective potential of vaccination against COVID-19 is also affected by differential vaccine uptake. COVID-19 has demonstrated extraordinary efficiency in seeking out unvaccinated and vulnerable people within communities, workplaces and industries. This has been evident in the nature and setting of major outbreaks of the Delta variant in NSW and VIC—including aged care facilities, schools and prisons—and repeated waves of infection overseas.

With the above risk factors taken into account, this Direction provides a framework for additional vaccine mandates in Queensland.

In the current iteration, priority high-risk settings are identified in the education, corrections, and aviation sectors. These are settings that, despite individual uptake of vaccines and prioritisation in the vaccine rollout, are more susceptible to COVID-19 transmission, and where an outbreak will have a potentially significant impact on the community. Table 1 at the end of this document describes the risk profile and evidence for COVID-19 transmission at these settings, and Table 2 provides a jurisdictional comparison for these and other currently mandated settings.

Schools and early education

The Queensland Government takes the position that schools are an essential service and should remain open wherever possible. This is consistent with the view of the Australian Health Protection Principals Committee (AHPPC). With border closures and sustained public health measures since the national stay at home orders (including school closures) in March 2020, extended or widespread school closures in Queensland have so far been largely avoided.

The COVID-19 vaccine has recently been made available to children aged 12-15 years in Australia. As at 2 December 2021, 76.3 per cent of Australian children aged 12 to 15 years have received at least one dose of the vaccine and 66.7 per cent of children are fully immunised.

Children under the age of 11 years comprise 15.3 per cent of Queensland's population. In the absence of an approved vaccine for children under the age of 12 years, young children are the single largest unvaccinated cohort in Australia. As COVID-19 begins to circulate more widely in Australia, young children will become the new front line of the COVID-19 pandemic.

Schools are environments where physical distancing is difficult to maintain, where groups of people spend extended periods of time together in an enclosed environment, and where other public health measures

such as physical distancing and mask wearing can be impractical, particularly in early childhood settings with very young children.

In Victoria (VIC) and New South Wales (NSW), numerous outbreaks were seeded in school and early childhood settings following easing of lockdown conditions. COVID-19 outbreaks reportedly closed more than 270 schools (two thirds of which were primary schools) and 300 childcare centres across NSW during October 2021, and in VIC dozens of schools have been linked to COVID-19 outbreaks.

A recent example of COVID-19 risk at the school setting for Queensland is the Indooroopilly Cluster earlier this year (August 2021). This outbreak—the biggest in Queensland to date—was seeded across four schools and over subsequent weeks resulted in 147 cases and 17,000 close and secondary household contacts in home quarantine.

At the beginning of the outbreak, although a large number of exposure venues were identified, with the exception of the index case and family, all community cases were detected in association with a limited number of exposure venues, namely the affected Brisbane schools, and a karate class. Transmission had occurred not only within but across schools, with a high degree of crossover including siblings at different schools.

During this outbreak, affected contacts were rapidly identified and placed into home quarantine. Because of this, the flow-on effects of the outbreak could be observed by day five of the outbreak, where 80 per cent of new daily cases were known household contacts of cases. By day eight 100 per cent of new daily cases were being detected among known close contacts. The transmission rate of the Delta variant in households, and arguably any enclosed environment where people spend lengthy periods of time in close contact, has been estimated at between 70 to 100 per cent.

Fortunately, acute infection with SARS-CoV-2 is generally associated with mild disease in children. Compared to adults, children are 25 times less likely to develop severe disease.

However, the effect of an outbreak among and on-transmission from this cohort has the potential to be much more widespread, in terms of the impact within schools and on households, including inter-generational exposure, as well as student and staff absences and disruptions to schools with closures during outbreaks.

As at 30 November 2021, according to Queensland Health reporting of vaccines administered by Hospital and Health Services, 39,059 school and early childhood staff have received their second dose of the COVID-19 vaccine. This does not include doses administered by primary care providers (including General Practice), or other Commonwealth facilities, and the true figure is likely to be higher.

The total number of school and early childhood education workers in Queensland is not known. To illustrate the potential scale and impact of exposure to COVID-19 among workers in education, a 2020 report by the Queensland College of Teachers, the peak regulatory body for the teaching profession in Queensland, reports over 110,000 approved teachers, with over 68 per cent of these employed in permanent or long-term temporary teaching positions. According to the report, half of all teachers–51.3 per cent—are over 45 years of age and 16.5 per cent are 60 years or older.

The severity of COVID-19 increases with age. People in their 30s who are not vaccinated are at four times the risk of a teenager of becoming sufficiently unwell from COVID-19. For people in their 50s, the risk is 40 times higher than that of a teenager of becoming very unwell, being hospitalised, or dying. The death rate for COVID-19 starts to increase for those over 50 years of age. Those under 50 years of age who are infected have a death rate of 0.2–0.4 per cent of those infected, while for those 50–59 years it rises to 1.3 per cent of those infected, then 3.6 per cent for 60–69 years and higher again into the older years.

This means that as well as being at increased risk of exposure to COVID-19 at the setting, over half of the employed teaching cohort in Queensland is at increased risk of moderate to severe illness, or death, from COVID-19. The rates of severe illness or death are even higher for people who have underlying conditions like diabetes, hypertension, or asthma.

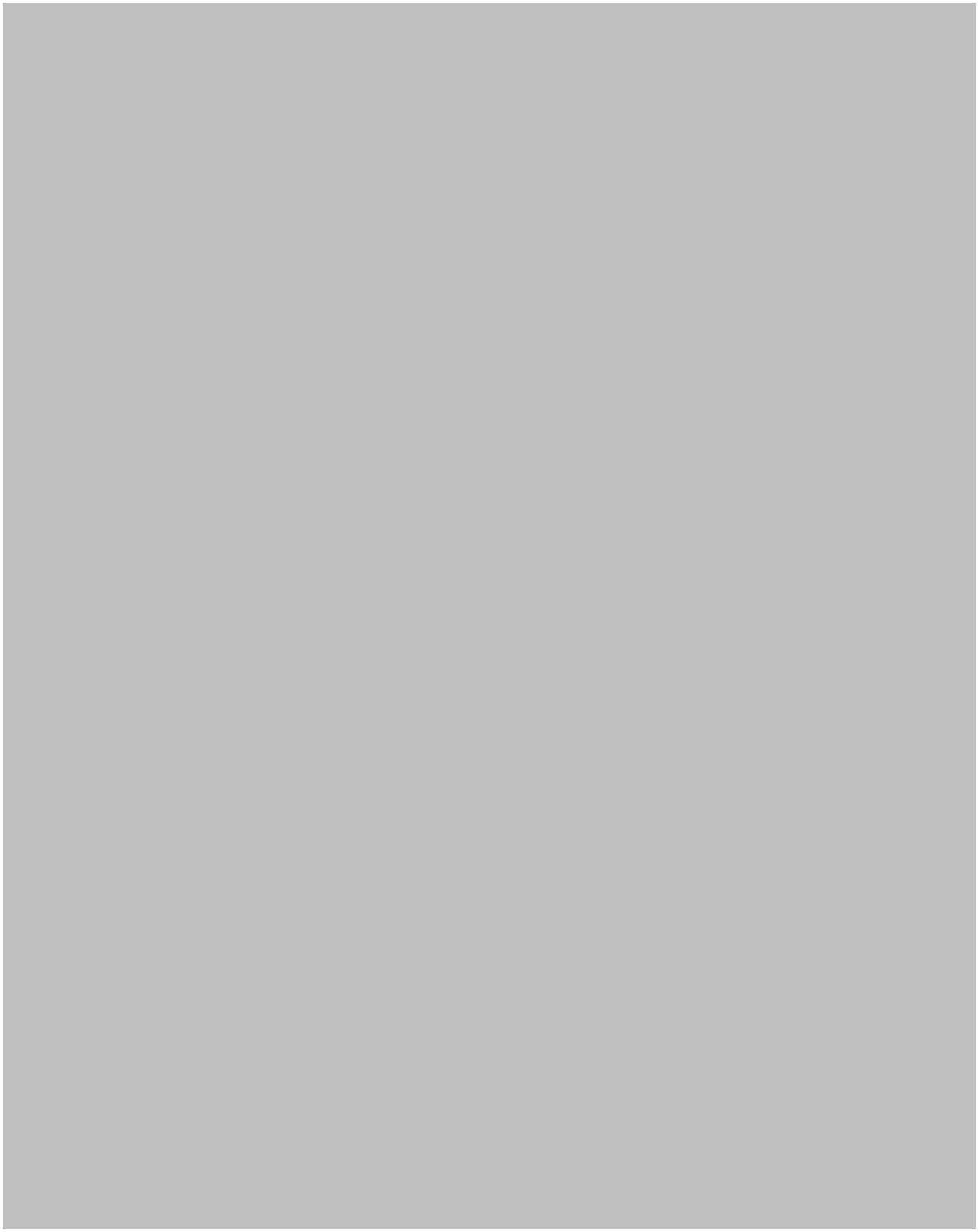
The AHPPC's *Statement on COVID-19, Schools and Reopening Australia* states that a primary goal for schools is to reduce transmission for the entire school community, protect the un-immunised population of students at school and maintain the ability of schools to remain open. Using actions from the hierarchy of controls, AHPPC notes that three specific principles apply to minimise disease in schools. These are (a) reducing opportunities for introduction of the virus, (b) reducing transmission of the virus if it is introduced, and (c) early use of containment measures if spread occurs.

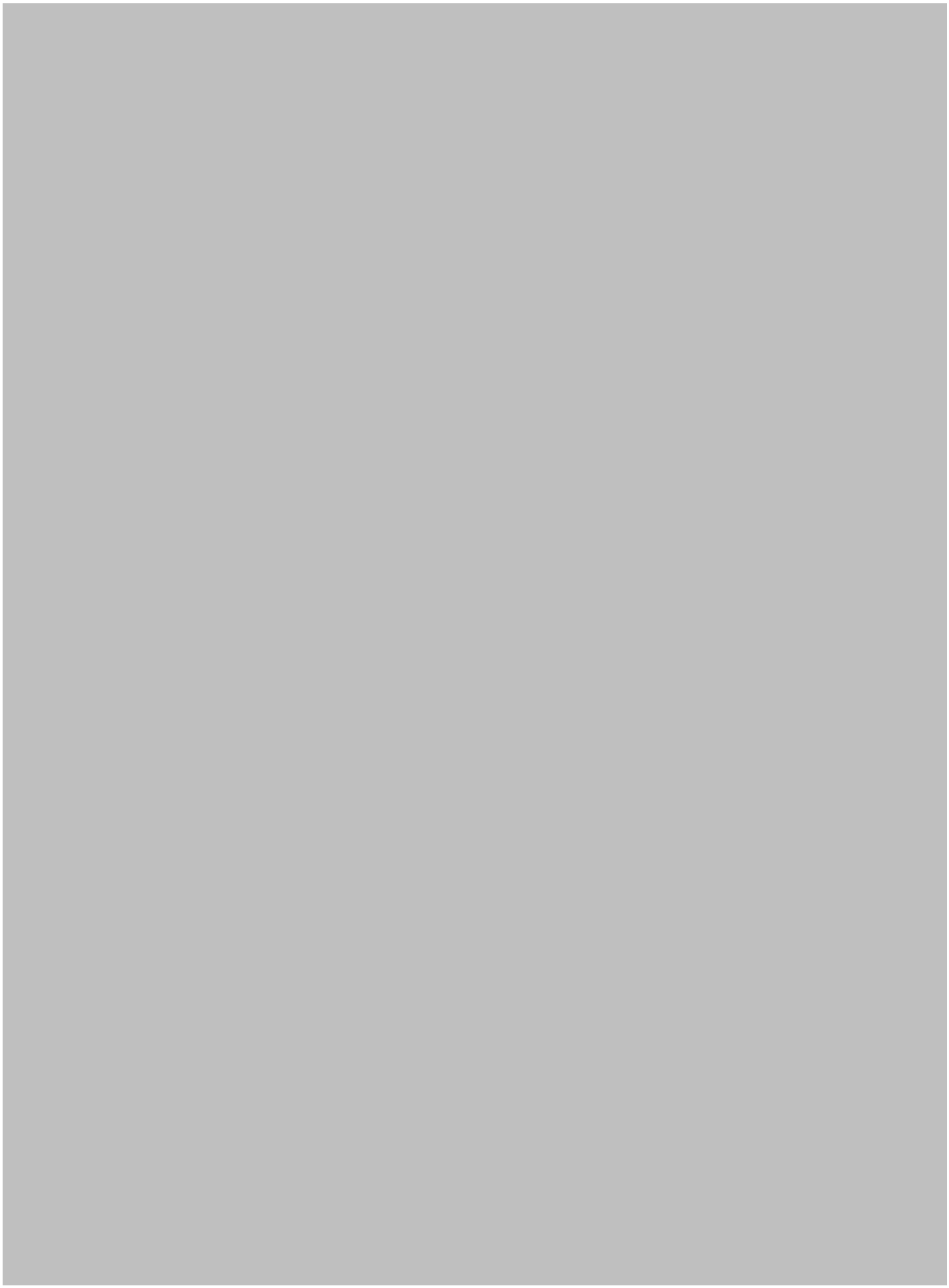
Vaccination offers a high level of individual protection for workers in schools and early childhood settings. Uniform vaccination among workers at school and early education, including childcare settings would contribute meaningfully to principles (a) and (b) described above.

While children under 12, and those over 12 who are unvaccinated, remain susceptible to COVID-19, their opportunities to acquire infection are reduced if the adults around them are vaccinated. This is a process called cocooning that is also used for other infectious diseases in infants. Notably, high vaccination rates amongst school family units are also a key protective factor.

All other Australian jurisdictions except for Queensland and Tasmania (TAS) have already introduced mandatory COVID-19 vaccination for workers in schools and early childhood settings (see Table 1 for a jurisdictional comparison at the end of this document).

In Queensland, for Department of Education employees, a range of vaccinations are strongly recommended depending on risk and exposure, but this would be the first mandatory vaccination for this cohort. Ensuring workers in schools and early education settings are uniformly vaccinated against COVID-19 will support AHPPC recommendations for schools, directly reduce risk to the workforce, help to protect against severe outbreaks and repeated school closures, sustain workforce capacity and reduce the risk of COVID-19 exposure to vulnerable people.





[redacted]

Engagement with the sector

Department of Education (DoE; Director-General and DDG) - conveyed the scope and rationale for the inclusion of 'Schools'. DoE undertook to engage with the broader private and independent sector to convey the policy intent.

[redacted]

It is expected that any staff who enter a high-risk setting for the purposes of work, even if not their primary workplace would be in-scope for the vaccination requirement. This would include but not be limited to union officials, regulators, and contractors like maintenance staff.

To be clear the intent is not to mandate vaccination of the worker but to mandate that in certain higher-risk settings, only vaccinated persons may work.

It is recognised that in rare circumstances, a worker may be genuinely unable to be vaccinated due to a medical contraindication. Accordingly, and provided the contraindication is certified, the worker may continue to work in a high-risk setting where their work cannot be performed outside the setting. For their own and others' protection when at the setting, they will need to comply with PPE requirements consistent with requirements as set by the responsible person for the setting. They must also undertake daily COVID-19 PCR testing before commencing each work shift. A permanent vaccine exemption can only be granted on the grounds of previous anaphylaxis or severe adverse event attributed to the COVID-19 vaccine or vaccine component across all vaccines available for use in Australia, and it is not expected that many people will fall into this category. Staff with a temporary contraindication will be expected to complete their vaccination following the exclusion period.

From time to time there may be exceptional circumstances that result in a critical workforce shortage, such as illness, high demand or another emergent event, and there may be an occasion where there is a shortage of vaccinated workers. In this event, and to allow for the continued and safe delivery of services, the Direction provides that an unvaccinated worker may be permitted to enter, work in or provide services in the setting, for a short period until vaccinated workers can be recruited. This is subject to strict standards, including a risk assessment by the person responsible for the healthcare setting, PPE use and daily COVID-19 PCR testing by the worker. It is expected that this option only be exercised in extreme and sustained circumstances, where the shortage means a direct impact on patient or client care or the effective operation of the setting. An example is a shortage of more than 10 per cent of staff for a sustained period of 7 days or more among a small staff cohort, with the remaining skills mix and rostering unable to compensate for the shortage. Similarly, in an emergency where it is absolutely necessary, other unvaccinated workers, including contractors, may enter a high-risk setting to respond to an emergency, but must comply with PPE requirements.

The Direction is not intended to restrict visitors to the settings, or for users of the service to gain access – for example, students or parents at a school, or a person accessing an airport as a traveller. It should be noted that visitors to corrections facilities are required to be vaccinated under the PHSM Plan, with corrections considered a vulnerable facility in the same way as hospitals, aged care and disability accommodation facilities.

Further, the Direction is not intended to mandate COVID-19 vaccination for support people who are directly providing legal, advocacy, social welfare, mental health and wellbeing supports for vulnerable clients or users of a service, and is subject to PPE use as required by the responsible person and modified PCR surveillance testing. An example is an unvaccinated mental health support worker regularly provides support to a person detained at a corrective services facility who relies on continuity of face to face contact for their mental health and wellbeing and their health outcomes would be adversely impacted by a change in support arrangements. This arrangement is considered an exception and is at the discretion of the responsible person. The exception is provided for as in these circumstances, the risk to the individual is considered to outweigh the public health benefit of the policy.

Uniform vaccination coverage will protect staff and safeguard the community by minimising the risk of COVID-19 transmission within the workforce as well as to and from vulnerable cohorts (for schools and correctional facilities) and travellers (for airports) as COVID-19 becomes more widespread. Limiting transmission within these workplaces will also reduce the likelihood of workplace outbreaks and staff shortages that can impact on the delivery of these essential services.

Future implementation

As Queensland transitions to a 'living with COVID-19' future, COVID-19 will begin to be managed more like other vaccine-preventable diseases—public health restrictions are expected to reduce, and regulatory requirements will become more targeted. During the transition to endemic COVID-19, and particularly during the early stages, it will remain critically important to limit the transmission and spread of COVID-19, protect the health of Queenslanders, and sustain health system and contact tracing capacity.

Mandating uniform vaccination coverage for workers in identified high risk settings ensures that the spread of the virus among vulnerable cohorts and in higher-risk settings is slowed. This will safeguard against broader impacts on the community, industry, and the health system.

It is likely that high-risk settings will continue to be identified as the virus moves through the population. As noted above, without available vaccines, children are becoming new front line of the pandemic and schools and early childhood settings are increasingly recognised as key high-risk settings. The impact of waning immunity has not yet been tested in Queensland, and this may have unpredictable consequences across a range of settings and workplaces where vaccination may have been prioritised or seen rapid uptake early in the vaccine rollout.

Omicron variant

On November 26, the World Health Organization (WHO) classified a new variant, the Omicron or B.1.1.529 variant as a variant of concern. The first known confirmed infection was from a specimen collected on 9 November 2021 and the variant was first reported to the WHO from South Africa on 24 November 2021.

In recent weeks in South Africa infections have risen steeply, coinciding with the detection of this variant. It appears to be taking over dominance in some South African regions in less than two weeks.

The variant has a large number of mutations – 32 on the spike protein alone, compared to only 9 on the Delta variant, and preliminary evidence is suggesting that this variant may produce an increased risk of reinfection among people who have had COVID-19 previously. The transmissibility of the variant is currently unknown, although some early indications are that it is highly transmissible. The severity of disease is also unknown, although on balance it is considered unlikely that it causes more severe disease than other known variants. The effectiveness of vaccine against the variant is still under investigation, although current vaccines appear to remain effective against severe disease and death. Pfizer have indicated they expect to know within two weeks whether the variant is vaccine resistant. An advantage is that should another vaccine be required it is likely that a new mRNA vaccine could be produced and made available within months.

Public health considerations – 2 December 2021

Epidemiological situation

Queensland

- Queensland reported three (3) new COVID-19 cases in the previous 24 hours:
  - one case (fully vaccinated) detected on the Gold Coast with no known contact with another case.
  - two cases detected on day five of hotel quarantine, both with recent interstate travel (New South Wales and Victoria respectively).
- The total number of cases in Queensland stands at 2,133.
- Queensland is managing a total of 18 active cases, with 14 in the hospital (nil in ICU) and four awaiting transfer. There are currently no active First Nations cases in Queensland.
- There has been a significant increase in the number of people entering home quarantine, now permitted for many domestic arrivals under the Vaccine Plan after Queensland achieved 70 per cent vaccination coverage on 14 November.
- There are currently 10,721 people in quarantine: 7,354 people in home quarantine, 3,256 people in government hotel quarantine and 111 in alternate quarantine.
- As at 30 November 2021, a total of 3,158,650 Queenslanders aged 16 and over have been vaccinated with two doses of a COVID-19 vaccine, which amounts to 76.80 per cent of this cohort; 3,565,779 people – 86.65 per cent – have had at least one dose.

Emergence of Omicron variant

- On 26 November, the World Health Organization (WHO) classified a new variant, Omicron (or B.1.1.529) as a variant of concern. The first known confirmed infection was from a specimen collected on 9 November 2021.
- The variant was first reported to the WHO from South Africa on 24 November 2021.
- The variant has a large number of mutations (including 26-32 on the spike protein, which is considerably more than the Delta variant), and preliminary evidence is suggesting this variant may produce an increased risk of reinfection among people who have had COVID-19 previously.
- Omicron is being urgently investigated by researchers globally, with the WHO announcing it could take weeks for sufficient data and analysis to draw preliminary conclusions.
- There is currently insufficient information available to make conclusions on the transmissibility and disease severity of the variant. The effectiveness of available vaccines against the Omicron variant is also under investigation.

National

- As at 1 December, in the 24 hours prior jurisdictions have reported 1,440 newly confirmed cases.
- Australia has reported 87.4 per cent of the eligible population aged 16 years and over as fully vaccinated; 92.6 per cent have had at least one dose.
- NSW and Victoria, with sustained and widespread outbreaks of the Delta variant since June-July, are seeing a reduction in daily new cases in recent weeks with fluctuating, but generally downward trajectory. Noting wide-ranging lifting of restrictions and lockdown conditions, Queensland is monitoring case numbers in these jurisdictions as well as in the Australian Capital Territory (ACT) where daily positive cases have also been gradually falling since the start of the latest outbreak.
- A total of seven cases of Omicron variant have been recorded in Australia, with six in NSW and one in the Northern Territory (NT).
- Quarantine requirements for Australians returning from overseas to NSW, Victoria, ACT and South Australia were had started to ease in November. However, following the emergence of the Omicron variant, these jurisdictions have re-introduced restrictions for arrivals from countries of concern.

New South Wales

- NSW reported 251 new locally acquired COVID-19 cases and no new deaths in the past 24 hours; there have been 75,975 locally acquired cases and 574 deaths reported since 16 June.
- NSW is currently managing 160 cases in hospital, with 26 people in ICU (11 requiring ventilation).
- NSW has reported that 92.5 per cent of the eligible population aged 16 years and over is fully vaccinated and 94.6 per cent has received at least one dose.
- NSW has a range of movement and gathering restrictions in place for unvaccinated people, which will remain in effect until 15 December.

Victoria

- Victoria has reported 1,179 new locally acquired cases and six deaths in the last 24 hours; there now have been 102,131 locally acquired cases and 523 deaths reported since 16 June.
- Victoria is managing 299 cases in hospital, including 43 in intensive care (18 requiring ventilation).
- As at 1 December, 91 per cent of eligible Victorians aged 16 years and over are fully vaccinated of a COVID-19 vaccine and 93.4 per cent has received at least one dose.
- There are currently no restrictions in place for Victorians who are fully vaccinated.

Australian Capital Territory

- ACT has reported four new locally acquired cases and nil deaths in the last 24 hours; there have been 2,010 locally acquired cases and 11 deaths reported since 12 August.
- ACT is managing eight cases in hospital, with three people in intensive care, two of whom requiring ventilation.
- Over 95 per cent of eligible population in ACT aged 16 years and over are fully vaccinated.
- The vaccination rate of the population over 12 years old is 97.8 per cent fully vaccinated.

Northern Territory

- One new community case reported in past 24 hours. The Katherine and Robinson River outbreak now totals 59 cases (since 15 November 2021).
- As at 1 December, 77.9 per cent of eligible population in NT aged 16 years and over are fully vaccinated of a COVID-19 vaccine and 87.7 per cent has received at least one dose.
- The lockdown for Katherine has moved to a lockout from 27 November. During the lockout period, people inside the designated area are not permitted to leave and people outside are not able to enter, except for essential workers. This is due to lift on 7 December.

Global

- As at 1 December, more than 8,036 billion doses of COVID-19 vaccine have been administered globally (John Hopkins University).
- The cumulative number of confirmed cases reported globally is now over 263 million and the cumulative number of deaths is over 5.2 million (John Hopkins University).
- Globally, weekly case incidence plateaued during the week of 22-28 November 2021, with nearly 3.8 million confirmed new cases reported, similar to the previous week's figures. However, new weekly deaths decreased by 10 per cent in the past seven days as compared to the previous week, with over 47,500 new deaths reported.
- The African, Western Pacific and European Regions reported increases in new weekly cases of 93 per cent, 24 per cent and 7 per cent, respectively, while the Regions of the Americas and South-East Asia reported decreases of 24 per cent and 11 per cent, respectively. (Note: the increase in the African Region was largely due to batch reporting of antigen tests by South Africa last week, therefore the trends should be interpreted with caution.) New weekly deaths decreased by 36 per cent and 8 per cent in the Regions of the Americas and the Eastern Mediterranean, respectively, and increased by 26 per cent and 7 per cent in the South-East Asia and African Regions, respectively. (WHO).

Living with COVID-19

- The Queensland Government has launched a state-wide campaign to encourage Queenslanders to get vaccinated. There is a particular focus on encouraging increased uptake in regional and remote areas. Many of these areas currently have lower vaccination coverage than the State average.
- Booster COVID-19 vaccination doses for people who received their second dose at least six months ago have been available Designated COVID-19 Hospitals in Queensland from 1 November 2021.
- On 18 October 2021, Queensland released the COVID-19 Vaccine Plan to Unite Families. Under this plan, changes to border restrictions and quarantine requirements at increasing levels of state-wide vaccination coverage are described.
- At 70 per cent of Queensland's eligible population fully vaccinated (achieved on 15 November), anyone who has been in a declared domestic hotspot in the previous 14 days can travel into Queensland provided they are fully vaccinated; arrive by air; have a negative COVID-19 test in the previous 72 hours can undertake home quarantine for 14 days (subject to meeting conditions).
- At 80 per cent of Queensland's eligible population fully vaccinated (expected in early December) travellers from an interstate hotspot can arrive by road or air, with no quarantine required but must be fully vaccinated and have a negative COVID-19 test in the previous 72 hours. Direct international arrivals can undertake home quarantine subject to conditions set by Queensland Health, provided they are fully vaccinated and have a negative COVID-19 test in previous 72 hours.
- At 90 per cent of Queensland's eligible population fully vaccinated, it is expected there will be no entry restrictions or quarantine for vaccinated arrivals from interstate or overseas. Unvaccinated travellers will need to apply for a border pass, or enter within the international arrivals cap, and undertake quarantine.
- On 9 November 2021, the Queensland Government released its *Public Health and Social Measures linked to Vaccination Status: A Plan for 80% and Beyond*, which sets out measures variously applying to vaccinated and unvaccinated people aged 16 years and over.
- Under the Plan, once Queensland reaches 80 per cent double dose vaccination coverage there will be no COVID-19 density restrictions on pubs, clubs, cafés, cinemas, theatres, music festivals where all staff and attendees are fully vaccinated.

Public Health System capacity

- Currently, Queensland Public Health Units are working to ensure the Queensland community is complying with public health controls. Another key focus for Queensland's Public Health Units is to ensure that those directed to undertake quarantine, including home quarantine, comply with all requirements, including the testing regime.
- Additional restrictions are imposed and lifted in response to evidence of community outbreaks to ensure the safety of Queenslanders, and more specifically our most vulnerable people in residential aged care facilities, hospitals, and disability accommodation services.
- Cases of COVID-19 in the Queensland community have been managed well to date and it remains important to mitigate against widespread outbreaks. It is particularly important to quickly bring clusters under control with effective contact tracing and other protective measures to maintain the integrity of the health system to respond to non-COVID-19 related care.

Health Care System capacity

- Queensland will soon transition to the next phase of the COVID-19 response, which will involve wider circulation of COVID-19 in the Queensland community. Queensland Health has considered a range of epidemiological modelling, including scenario-based impacts to hospital capacity and workforce. This modelling, and lessons from the recent NSW and Victorian outbreaks, have identified that a flexible and high capacity health system delivery model is critical. It is expected that with increased vaccine

protection, the number of people requiring hospitalisation and intensive care in the event of an outbreak are likely to remain within hospital and health system capacity.

- As Queensland's response to COVID-19 has evolved, expert advisory groups, particularly the COVID-19 Response Group have further developed and refined Queensland Health's response plans. Particular consideration has been given to the impacts of the Delta variant and an increasing likelihood of a surge in cases as Queensland transitions to living with COVID-19.
- Queensland Health is operating a tiered health system response to activate additional capacity when triggers associated with increasing case numbers are met. This response includes expanding to hospitals and settings (such as homes) beyond the Designated COVID-19 Hospital Network, postponing elective surgeries, and leveraging private hospital capacity as required.
- The established Designated COVID Hospital Network can accommodate a moderate surge in cases, across both inpatient and at home care through Hospital in the Home (HITH) placements.
- Strategies are in place with private providers to minimise the interruption to urgent elective services should a wider community outbreak across Queensland impact on hospital and health service delivery. Strong partnerships with major private providers will assist public hospital systems to respond to a COVID-19 surge.

Community acceptance and adherence

- Queensland's public health measures have been generally well-received and met with compliance. The community have so far been largely supportive of public health measures.
- There are ongoing concerns of 'pandemic fatigue', particularly in vulnerable sections of the community, and associated non-compliance with public health measures nationally. However, the need for lockdowns or widespread restrictions is expected to reduce dramatically with increased vaccination coverage. Queensland, like other jurisdictions, is preparing to move into a new 'living with endemic COVID-19'.
- Emerging key issues relate to vaccine mandates imposed by state and territories in various settings, and the complexities of differing freedoms for vaccinated and unvaccinated people. State and territory mandates can vary considerably with local context, with vaccine mandates in some jurisdictions applying to the majority of the population.

Wastewater monitoring

- To strengthen surveillance capabilities and increase confidence that transmission is not occurring, Queensland conducts a surveillance program to detect traces of coronavirus in wastewater in 19 communities across the state.
- Wastewater monitoring systems detect viral fragments and can help experts determine where in the state there might be people with a current or recent COVID-19 infection. The system has significant value in its potential to serve as an early warning system for potentially undetected cases. It cannot pinpoint the exact source of the viral fragments.
- COVID-19 fragments were detected in wastewater samples collected from the Coombabah and Elanora wastewater treatment plants on 29 November.

Table 1. Jurisdictional comparison of COVID-19 vaccine mandates for workers in key high-risk settings (26 November 2021)

Cohort	Jurisdictional comparison [Note: date of second vaccination provided, unless otherwise specified]								
	National position	QLD	NSW	ACT	VIC	SA	TAS	WA	NT
Education and childcare workers	Vaccination of staff encouraged by AHPPC	–	✓ 8 Nov	✓ 29 Nov	✓ 29 Nov	Booked 2nd dose by 11 Dec	–	✓ 31 Jan	✓ 24 Dec

Table 2 - Risk factors and evidence of COVID-19 transmission at critical settings serving the Queensland population

SETTING	Risk factors within setting				Likelihood~	Consequence		EVIDENCE
	Worker mobility	Close proximity	Indoor environment	Other infection control measures*		Individuals	Community (outbreak)	

SETTING	Risk factors within setting				Likelihood~	Consequence		EVIDENCE
	Worker mobility	Close proximity	Indoor environment	Other infection control measures*		Individuals	Community (outbreak)	
Schools and early education *Essential service*	*Moderate educator movement across setting; often cohorted*	*Cohorted groups in classrooms, spread within cohorts likely, gyms, canteens, assemblies*	*Enclosed spaces, classrooms may have improved airflow, outdoor learning*	*Can be impractical in early childhood settings; difficult to enforce*	*Multiple household contacts, widely connected community, children more likely asymptomatic*	*Unvaccinated children; impacts for older unvaccinated teaching staff higher*	*Household transmission, high crossover, family impact*	**QLD** - High transmission between students, staff and families in the Indooroopilly Cluster. - Qld's largest COVID-19 outbreak of 147 cases. In this cluster, 60 cases (40%) were students and 80 cases (54%) were household contacts. **NSW** - More than 270 schools and 300 childcare centres closed due to COVID-19 cases during October 2021; two thirds were primary schools. **National Centre for Immunisation Research and Surveillance (NCIRS) report (September 2021)[x]** - During the recent NSW outbreak (to end July 2021) there was a 5-fold higher rate of transmission (secondary attack rate 4.7%) than in 2020 (secondary attack rate 0.9%) in educational settings—reflective of increased transmissibility of Delta variant. - ECEC services experienced the highest rate of transmission (6.4%), as they remained fully open with high attendance rates. Transmission was highest between ECEC staff members (16.9%) and from an ECEC staff member to a child (8.1%). - High population-level rates of COVID-19 vaccination, including vaccination of school/ECEC staff, are critical. **United States** - The opening of schools contributed to a growth of COVID-19 cases by 5 percentage points—vaccines and mask-wearing in this setting identified as critical[xi] - CDC recommends that all teachers, staff and eligible students be vaccinated as soon as possible[xii]

*PPE, Mask wearing, hand hygiene
~Mobility of cohort and extent of community acces

[i] Australian Health Protection Principal Committee (AHPPC) statement on mandatory vaccination of all workers in health care settings | Australian Government Department of Health
[ii] Hospital-acquired SARS-CoV-2 infection in the UK's first COVID-19 pandemic wave - The Lancet
[iii] Australian Health Protection Principal Committee (AHPPC) statement on mandatory vaccination of aged care in-home and community aged care workers | Australian Government Department of Health
[iv] Australian Health Protection Principal Committee (AHPPC) statement on mandating vaccination for disability support workers | Australian Government Department of Health
[v] COVID-19 Vaccines for People with Disabilities | CDC
[vi] People with Certain Medical Conditions | CDC
[vii] Deaths involving COVID-19 by self-reported disability status during the first two waves of the COVID-19 pandemic in England: a retrospective, population-based cohort study - The Lancet Public Health
[viii] https://www.publicdefenders.nsw.gov.au/Documents/updated-report-impact-of-covid-19-on-nsw-prisoners-september-2021.pdf
[ix] https://jamanetwork.com/journals/jama/fullarticle/2768249
[x] https://www.ncirs.org.au/sites/default/files/2021-09/NCIRS%20NSW%20Schools%20COVID_Summary_8%20September%2021_Final.pdf
[xi] The association of opening K–12 schools with the spread of COVID-19 in the United States: County-level panel data analysis | PNAS
[xii] Guidance for COVID-19 Prevention in K-12 Schools | CDC

TALKING POINTS

3 December 2021

Mandatory vaccination for workers in high-risk settings

1. We are quickly moving towards reopened borders and a time where public health restrictions will ease—a 'living with COVID-19' future where vaccination will be our primary protection against COVID-19.

2. Vaccination is our best defense against COVID-19 – whether this be against known variants like Delta, or new variants like Omicron.

3. Our borders will soon be reopening to vaccinated travellers from parts of the country that have COVID-19 circulating in the community.

4. With more cross-border movements, there will be an increased chance of COVID-19 seeding in Queensland and a higher likelihood that we will see outbreaks around the State.

5. Now is the time to turn our attention to ensuring there are protections in place for additional high-risk settings and critical workers.

6. Uniform vaccination coverage in higher risk settings protects workers, workplaces, and the community, as well as safeguarding critical and essential business continuity during the ongoing pandemic.

7. We have already mandated vaccination for workers across all health care settings—covering aged care, public and private hospitals, general practitioners, in-home care provision and not-for profit health organisations.

8. COVID-19 vaccine requirements will now be introduced for workers at schools and in early childhood education, at correctional and detention facilities and at airports across the State.

9. These are settings that perform an essential service for our community, where people are in close proximity and where an outbreak can have significant consequences.

10. We have already seen numerous outbreaks in schools and early childhood settings in Victoria and New South Wales. Outbreaks in schools have been seen around the world as the virus seeks out the unvaccinated and the vulnerable. While they remain unvaccinated, children are becoming the new front line of the pandemic.

11. The risk of COVID-19 transmission is higher at schools. Schools and childcare are environments where physical distancing is difficult to maintain and other measures such as mask wearing can be impractical, particularly in early childhood settings with very young children.

12. Vaccination will ensure a high level of protection for workers in schools and early childhood settings.

13. There will be no requirement for vaccination for students, or for parents who are attending schools in a private capacity, for example, to collect their children.

[redacted]

15. The mandate will apply to any person who enters these settings for work.

[redacted]

21. Vaccination of workers in these settings protects against outbreaks, sustains critical workforce capacity and minimises the risk of COVID-19 exposure to vulnerable people.

22. As time goes on, further consideration will be given to other high-risk settings.

23. Protecting Queensland from COVID-19 remains our priority and vaccination is the best thing we can do to protect ourselves and the most vulnerable members of our community.

Response.Lead

From: Response.Lead.Engagement
Sent: Friday, 3 December 2021 2:13 PM
To: SCHIMMING, Sharon; Craig.ALLEN [redacted] Rynell.HASTIE-BURROUGHS [redacted] Tom.JUMPERTZ [redacted]
Cc: Rachel Vowles; Dawn Schofield; Response.Lead.Engagement
Subject: CONFIDENTIAL for URGENT review please: Draft public health direction
Attachments: CHO PHD COVID-19 Vaccination Requirements for Workers in a high risk setting Direction_v3.docx

Good afternoon Department of Education colleagues

As discussed with Rachel and Dawn, please find attached in confidence the current version of the draft COVID-19 Vaccination Requirements for Workers in a High Risk Setting public health direction for your urgent review.

Also as discussed, we will need your feedback as soon as possible this afternoon please as the draft is due to progress to Minister D'Ath this afternoon.

Kind regards,
Louise

Louise Norman
Response Lead Engagement
COVID-19 Response Division | Queensland Health
E: Response.Lead.Engagement@health.qld.gov.au

P [redacted]
E [redacted]@health.qld.gov.au
W health.qld.gov.au
A 33 Charlotte Street, Brisbane QLD 4000

Direction from Chief Health Officer in accordance with emergency powers arising from the declared public health emergency

COVID-19 Vaccination Requirements for Workers in a high-risk setting Direction

Public Health Act 2005 (Qld)
Section 362B

On 29 January 2020, under the *Public Health Act 2005*, the Minister for Health and Minister for Ambulance Services made an order declaring a public health emergency in relation to coronavirus disease (COVID-19). The public health emergency area specified in the order is for 'all of Queensland'. Its duration has been extended by regulation to 26 December 2021 and may be further extended.

Further to this declaration, I, Dr Peter Aitken, Chief Health Officer, reasonably believe it is necessary to give the following directions pursuant to s362B of the *Public Health Act 2005* to assist in containing, or to respond to, the spread of COVID-19 within the community.

Guidance

This public health direction applies to workers who enter, work in, or provide services in a high-risk setting. The direction defines how a high-risk setting is identified by the Chief Health Officer and specifies the COVID-19 vaccination requirements and related obligations for workers and employers operating in a high-risk setting. The direction recognises that an employer may mandate vaccination for employees, where otherwise permitted at law, based on the requirements of a role.

Preamble

1. This Public Health Direction applies to ***workers*** in settings where there is a higher risk of transmission of the COVID-19 virus, the setting is accessed by a large number of vulnerable persons as service users, and/or a sudden reduction in available workforce due to COVID-19 impacts at the setting would significantly affect the continuity of critical services to the community with consequential public health and safety risks.
2. This Public Health Direction supplements existing public health directions already made to contain or respond to the spread of COVID-19 by mandating vaccination of workers in healthcare settings, in quarantine facilities and in vulnerable facilities. Nothing in this public health direction reduces the requirements of those public health directions.
3. Separately from the requirements of Public Health Directions, under sections 362G and 362H of the *Public Health Act 2005*, an ***emergency officer (public health)*** can require a person to comply with additional directions if the emergency officer believes it is

reasonably necessary to assist in containing, or to respond to, the spread of COVID-19 in the community.

Citation

4. This Public Health Direction may be referred to as the *COVID-19 Vaccination Requirements for Workers in a High-Risk Setting Direction.*

Commencement

5. This Public Health Direction applies from time of publication until the end of the declared public health emergency, unless it is revoked or replaced.

Application

6. This Public Health Direction applies to ***workers*** in a ***high-risk setting*****,** in the public, private and non-government sectors, and identifies the COVID-19 vaccination and related requirements for ***workers***, ***employers*** and ***responsible persons*** in ***high risk settings***.
7. This Public Health Direction does not apply to people who visit the ***high-risk setting*** to access or use its services, either for themselves or as a support person for someone else.
8. The requirements of this public health direction prevail where a ***worker*** is required to be vaccinated under this direction, and another public health direction also applies to the ***worker*** but does not require the worker to be vaccinated. The ***worker*** must comply with the ***COVID-19 vaccination requirements*** for ***workers*** in a ***high-risk setting***.

PART 1 —WORKERS IN A HIGH-RISK SETTING

Worker

9. A ***worker*** must not enter and remain in, work in, or provide services in a ***high-risk setting,*** including a setting that is not the worker's primary place of work**,** unless the ***worker*** complies with the ***COVID-19 vaccination requirements*** in paragraph 11.

   Note: A patient, client or user of a service, or a parent, guardian or carer accompanying a patient to access the services, is not a ***worker*** *at a high-risk setting.*

   Examples: a contractor, union official, regulator, auditor, courier, performer, or sales representative must comply with the COVID-19 vaccination requirements to work in a ***high-risk setting*** *even though they may only occasionally enter the setting as part of their work duties.*

High-risk setting

10. A ***high-risk setting*** is a type of service, business or activity declared to be a ***high-risk setting*** by the Chief Health Officer in ***Schedule 2***, having regard to the public health risk for the setting, including one or more of the following factors:

(a) higher risk of transmission of COVID-19 due to the nature of the setting and the way in which services are provided; or

(b) a high number of ***vulnerable persons*** use or access the setting; or

(c) the continuity of critical services to the community and consequential public health and safety impacts if COVID-19 cases or quarantine unexpectedly reduced the available workforce of the setting.

Examples: an education setting where teachers and students work in close proximity has a higher risk of transmission; a youth justice detention centre has a high number of vulnerable persons who would be significantly and adversely affected by a COVID-19 outbreak at the centre. An outbreak in these settings might impact the ability to provide a critical service.

PART 2 —COVID-19 VACCINATION REQUIREMENTS

11. The ***COVID-19 vaccination requirements*** are that:

(a) by 17 December 2021, a ***worker*** in a ***high-risk setting*** has received the first dose of a ***COVID-19 vaccine***; and

(b) by 11.59pm AEST on 23 January 2022, a ***worker*** in a ***high-risk setting*** has received the prescribed number of doses of a ***COVID-19 vaccine***; and

(c) as soon as reasonably practicable after each dose of the ***COVID-19 vaccine***, the ***worker*** must show evidence of having received the ***COVID-19 vaccine*** dose to their ***employer***.

PART 3 —EXCEPTIONS

Medical contraindication and clinical trials

12. Paragraph 9 does not apply to a ***worker*** who is unable to be vaccinated due to a ***medical contraindication*** where the ***responsible person*** for the ***high-risk setting***:

(a) assesses the risk to other staff, clients and other persons at the ***high-risk setting***; and

(b) the ***worker*** undertakes daily ***COVID-19 PCR testing*** before a work shift; and

(c) the ***worker*** uses personal protective equipment as required by the ***responsible person*** for the ***high-risk setting***.

Note: results of the daily PCR testing may not be available before the worker's shift starts and can be provided to the employer or nominated person for the high-risk setting on a rolling basis as the results become available.

13. A ***worker*** in a ***high-risk setting*** to whom paragraph 12 applies must provide evidence of the ***medical contraindication***.

*Note: evidence of **medical contraindication** may be a digital or paper record from the person's Australian Immunisation Record, specifying the medical contraindication that makes the person unable to be vaccinated and the period of the **medical contraindication,** if it is temporary.*

14. Where the person has a temporary ***medical contraindication*** for being unable to receive the COVID-19 vaccination, paragraph 12 only applies for the period specified. If the ***medical contraindication*** continues beyond the specified period, the person must provide new evidence of a continuing ***medical contraindication*** or of their ***COVID-19 vaccination*** to comply with the ***COVID-19 vaccination requirements***.

15. Paragraph 9 does not apply to a ***worker*** who is ***unvaccinated*** and provides their ***employer*** a medical certificate or letter from a legally qualified medical practitioner certifying that the person is currently taking part in a ***COVID-19 vaccine*** trial and receipt of a Therapeutic Goods Administration approved vaccine would impact the validity of the trial.

Responding to Critical Workforce Shortages

16. The ***responsible person*** for a ***high-risk setting*** may permit a ***worker*** in a ***high-risk setting*** who has not complied with the ***COVID-19 vaccination requirements*** to enter, work in, or provide services in the ***high-risk*** setting, for a maximum period of 1 month until the critical workforce issue can be resolved, if:

(a) the responsible person has assessed the risk to other persons accessing the ***high-risk*** setting; and

(b) the ***responsible person*** reasonably believes it is necessary to respond to a ***critical workforce shortage*****;** and

(c) personal protective equipment is used by the ***worker*** in the ***high-risk setting*** as required by the ***responsible person*** or the ***employer***; and

(d) a ***COVID-19 PCR test*** is undertaken by the ***unvaccinated worker*** in the ***high risk setting*** before starting work each day, and the test results provided to the ***employer*** as soon as reasonably practicable after the ***worker*** receives the test result.

*Note: the use of PPE and daily PCR surveillance testing for COVID-19 is required for a limited period of one month when an **unvaccinated** worker in a **high-risk setting** may enter, work, or provide services in a **high-risk setting** to respond to a **critical workforce shortage** while **fully vaccinated** workers are recruited or alternative arrangements are made to respond to the **critical workforce shortage**.*

Responding to Critical Support Needs

17. The ***responsible person*** for ***a high-risk setting*** may permit a ***worker*** in a ***high-risk setting*** who has not complied with the ***COVID-19 vaccination requirements*** to enter, work in, or provide services in the ***high-risk setting***, to provide support to a client or user of the ***high-risk setting***, for mental health or well-being and for legal or advocacy services, if:

(a) the ***responsible person*** has assessed the risk to other persons in the ***high-risk setting***; and

(b) the ***responsible person*** reasonably believes it is necessary to provide health, wellbeing, legal or advocacy support to a ***vulnerable person*** at the ***high-risk setting*****;** and

(c) personal protective equipment is used by the ***worker*** in the ***high-risk setting*** as required by the ***responsible person*** or the ***employer***; and

(d) where the ***worker*** enters the ***high-risk setting*** for a single visit, a ***COVID-19 PCR test*** is undertaken by the ***unvaccinated worker*** within 24 hours of entry, and

(e) where the ***worker*** enters the ***high-risk setting*** on multiple consecutive days, a ***COVID-19 PCR test*** is undertaken by the ***unvaccinated worker*** before entering the ***high-risk setting*** each day, and the test results provided to the ***responsible person*** for the ***high-risk setting*** as soon as reasonably practicable when received.

*Note: the use of PPE and PCR surveillance testing for COVID-19 is required when an **unvaccinated** worker is permitted to enter a **high-risk setting** to provide support to a vulnerable client on multiple consecutive days.*

Example: *an unvaccinated mental health support worker regularly provides support to an inmate of a corrective services facility . The inmate relies on continuity of face to face contact for their mental health and wellbeing and their health outcomes would be adversely impacted by a change in support arrangements.*

Emergency entry to high risk settings

18. An unvaccinated person may enter a high risk setting to respond to an emergency and paragraph 9 does not apply.

    Example: a contractor, who is not vaccinated, enters a school during school hours to fix flooding in the toilet block.

19. A ***worker*** must report the emergency entry to the ***high-risk setting*** to their ***employer*** or ***responsible person*** for the ***high-risk setting*** as soon as is reasonably practicable.

PART 4 – RECORD KEEPING REQUIREMENTS FOR HIGH RISK SETTINGS

20. A ***worker*** and their ***employer*** must take all reasonable steps to ensure that the ***worker*** does not enter, work in, or provide services in a ***high-risk setting*** if the person does not meet the ***COVID-19 vaccination requirements*** and does not have a ***medical contraindication*** for all ***COVID-19 vaccines.***

21. The ***employer*** must keep a record, for each ***worker*** in the ***high-risk setting,*** of:

    (a) their COVID-19 vaccination status;

    (b) the type of evidence that was sighted to verify the worker's COVID-19 vaccination status; and

    (c) the timeframe for a temporary ***medical contraindication***; and

    (d) the type of evidence that was sighted to support a claimed ***medical contraindication***.

22. Where the ***responsible person*** in the ***high-risk setting*** is not the ***employer*** of the ***worker***, the **employer** is to keep the records in paragraph 21 and provide confirmation of its workforce complying with the ***COVID-19 vaccination requirements*** to the ***responsible person*** for the ***high-risk setting***.

    Example: an agency provides relief staff to the high-risk setting. The agency must maintain the records in relation to employee vaccination and provide a letter confirming employee vaccination compliance to the responsible person for the high-risk setting.

23. The ***responsible person*** must take reasonable steps to notify ***employers*** of ***workers*** in the ***high-risk setting*** of the ***COVID-19 vaccination requirements*** and to maintain a record of the compliance confirmation provided by the ***employer*** in relation to its workforce***.***

PART 5 —OTHER MATTERS

24. Nothing in this public health direction prevents an employer from making a lawful direction requiring an employee to be vaccinated for COVID-19 where the employer has determined it is a requirement of the employee's role.

25. Nothing in this Public Health Direction prevents a ***worker*** who does not meet the ***COVID-19 vaccination requirements*** from using the services of the ***high-risk setting*** as a client, or visitor or accompanying a person who is using the services of the ***high-risk setting***.

    Example: an unvaccinated plumber who can only work on school premises in an emergency can continue to attend parent activities at the school their child attends. A relief teacher must meet the vaccination requirements to continue to work at the school their child attends, but may attend school activities, such as parent teacher interviews, as a parent, even though they are unvaccinated, with their child, and can attend the school to pick up a sick child, drop off forgotten items and for other parental responsibilities.

26. An ***emergency officer (public health)*** can require a ***responsible person,*** or a ***worker***, or their ***employer*** to comply with additional directions if the emergency officer believes the direction is reasonably necessary to assist in containing, or to respond to, the spread of COVID-19 within the community.

PART 6 — DEFINITIONS

27. Definitions used in this Direction are in Schedule 1.

PART 7 — PENALTIES

A person to whom the direction applies, including a ***worker***, ***employer*** or ***responsible person*** for a ***high-risk setting***, commits an offence if the person fails, without reasonable excuse, to comply with the direction.

Section 362D of the *Public Health Act 2005* provides:

Failure to comply with public health directions

> A person to whom a public health direction applies must comply with the direction unless the person has a reasonable excuse.
> Maximum penalty—100 penalty units or 6 months imprisonment.

Dr Peter Aitken
Chief Health Officer
XX December 2021
Published on the Queensland Health website at xx:xx am/pm

SCHEDULE 1 - Definitions

For the purposes of this Public Health Direction:

Authorised person is a person approved or permitted to access the information in accordance with licensing requirements, if any, the *Information Privacy Act 2009* and the *Public Records Act 2002* and related instruments of delegation.

Co-located means located on the same premises, using shared facilities and staff and users of the high-risk setting move freely between the co-located functions or settings.

Example: a regional high school and a TAFE are co-located in a regional town. TAFE educators attend the high school to deliver some classes and high school students attend the TAFE facilities for some of their training. The educational settings share workshops and common areas. Workers in the TAFE that is co-located with the high school must comply with the COVID-19 vaccination requirements.

Example: part of a school's grounds are fenced off while construction of a gym is undertaken. While the construction work progresses, school staff and students are excluded from the construction site and the construction company has control of the site. The construction site is not co-located with the school and is not subject to the COVID-19 vaccination requirements that apply to the ***high-risk setting****.*

Corrective services facilities visitor means any visitor to a corrective services facility other than a personal visitor as defined In the *Corrective Services Act 2006*

COVID-19 PCR test means tested for COVID-19 with an oropharyngeal and deep nasal swab for polymerase chain reaction (PCR) testing, but does not include a self-test.

COVID-19 vaccination requirements see paragraph 11.

Evidence of ***COVID-19 vaccination*** (printed or electronic) includes:

(a) written confirmation of COVID-19 vaccination provided to the person as part of the vaccination process, such as a record of vaccine card; or

(b) vaccination information displayed on the ***Check in Qld app;*** *or*

(c) a ***COVID-19 digital certificate*** or printed vaccination certificate from the Australian Immunisation Register; or

(d) an online or printed ***immunisation history statement*** for COVID-19 vaccination, including confirmation of a medical contraindication; or

Note: A visitor's immunisation history statement can be obtained from the Australian Government using myGov, the Medicare mobile app or by calling the Australian Immunisation Register and requesting a statement to be posted.

Note: If a person is unable to receive a ***COVID-19 vaccination*** *because of a medical contraindication, they must provide* evidence of a ***medical contraindication.***

(e) an ***International COVID-19 Vaccination Certificate***:

(i) in a printed or electronic form from the Department of Home Affairs that confirms completion of an Australia Travel Declaration and vaccination against COVID-19 overseas; or

(ii) through Medicare online account through myGov or the Medicare mobile app; or

(iii) an official record of vaccination provided to the person when vaccinated against COVID-19 overseas.

COVID-19 vaccine is a vaccine for COVID-19 that is approved for use in Australia or recognised by the Therapeutic Goods Administration.

Critical workforce shortage means a sustained workforce shortage in a ***high-risk setting*** that the ***responsible person*** for the ***high-risk setting*** considers may directly and significantly compromise the health or safety of other persons within the ***high-risk setting*** or the delivery of essential services to users of the ***high-risk setting***.

*Example: A critical workforce shortage may be a shortage of more than 10 per cent of staff for a sustained period of 7 days or more, however this will depend on the size of the **high-risk setting,** baseline staffing levels (including rostering arrangements and relief pool arrangements), and will depend on the nature and extent of the operational impacts on a vulnerable cohort.*

Eligible health professionals means any of the following:

- fellows of the Royal Australian College of General Practitioners (as defined by the *Health Insurance Act 1973 Cth*); or
- fellows of the Australian College of Rural and Remote Medicine (as defined by the *Health Insurance Act 1973 Cth)*; or
- on Medicare's Vocation Register of General Practitioners (as defined by the *Health Insurance Act 1973 Cth)*; or
- practice registrar on an approved 3GA training placement; or
- paediatrician; or
- public health physician; or
- infectious diseases physician; or
- clinical immunologist.

Emergency officer (public health) means an emergency officer appointed under the *Public Health Act 2005*.
*Note: Emergency officers appointed under the Public Health Act 2005 include **public health officers** and police.*

Employer means a person, or other legal entity that employs or otherwise engages a ***worker***.

High-risk setting is a type of service, business or activity declared to be a ***high-risk setting*** by the Chief Health Officer in ***Schedule 2***, having regard to the public health risk for the setting, including one or more of the factors listed in paragraph 8.

Medical contraindication means a temporary or permanent contraindication that is notified to the Australian Immunisation Register (AIR) by an ***eligible health professional*** completing an ***Australian Immunisation Register (AIR) immunisation medical exemptions form*** in relation to a person and recorded on the person's Immunisation History Statement (IHS).

Note: *Evidence of a recognised medical contraindication means a **COVID-19 vaccination** medical exemption recorded by an **eligible health professional** on the Australian Immunisation Register for the person.*

Note: *a temporary vaccine exemption may apply until a specified date due to acute major illness, significant immunocompromise of short duration and recognised overseas vaccination.*

Responsible person for a ***high-risk setting*** means the person who is legally responsible for the setting, including in relation to compliance with regulatory and other requirements for the setting.

Example: the Principal of a school may be the responsible person; the Director General is the responsible person for a government department; a chief executive or Board Chair is the responsible person for a not for profit organisation. The responsible person may also be the employer but this will not always be the case.

Visitor means any person who enters a high-risk setting other than a ***worker*** and does not include a ***corrective services facility visitor.***

Vulnerable person means a person who is ineligible or unable to be vaccinated for COVID-19 because of their age or a ***medical contraindication***, or a person with underlying medical conditions that place them at greater risk of adverse impacts from COVID-19 even if they are vaccinated.

Example: children under the eligible age limit for COVID-19 vaccination; children who are immunocompromised or undergoing treatment that affects the efficacy of the vaccine; residents in residential aged care facilities; people with disabilities; patients in hospitals.

Worker includes a person who:

(a) is employed at a ***high-risk setting***; or
(b) is a government employee whose duties involve attendance at a ***high-risk setting***; or
(c) undertakes work, whether paid or unpaid, at the ***high-risk setting***; or
(d) is a contractor providing services to or at the ***high-risk setting***; or
(e) a ***corrective services facility visitor***; or
(f) is attending the high-risk setting in the context of duties relating to the administration, regulation, governance, managerial oversight, or legal framework relating to the ***high-risk setting***; or
(g) is a performer, presenter or other specialist entering the ***high risk setting*** as part of delivering an activity, function or event; or
(h) is a volunteer delivering a service in the ***high-risk setting***; or
(i) is undertaking a work placement related to an enrolled course of study

Examples: a contractor, union official, regulator, auditor, courier, performer, lollipop school crossing person, or sales representative must comply with the COVID-19 vaccination requirements to work in a high risk setting even though they may only occasionally enter the setting as part of their work duties.

Note: A worker who visits a high-risk setting as an incidental part of their duties but is not providing services within the high-risk setting, such as a delivery driver or taxi driver is not a worker at a high-risk setting.

SCHEDULE 2 – High-risk settings

High-risk settings
The following education settings: • schools and outdoor education facilities • other education facilities, including TAFE, that are ***co-located*** with a school • outside school hours care and vacation care • early childhood education including kindergartens, registered and licensed early childhood settings

Response.Lead

From: Dawn Schofield
Sent: Sunday, 5 December 2021 9:52 PM
To: publichealthdirections; Kyle Fogarty
Cc: Response.Lead.Engagement; Response Lead - Policy
Subject: RE: CHO PHD - Public Health and Social Measures linked to vaccination status Direction and COVID-19 Vaccination Requirements for Workers in a High Risk Setting Direction
Attachments: CHO PHD Public Health and Social Measures linked to vaccination v4_DS.docx; Policy Rationale_Workers in high risk setting (COVID-19 vaccination requirements) Direction_DRAFT_DS.docx; CHO PHD COVID-19 Vaccination Requirements for Workers in a high risk setting Direction_v3_DS.docx

Follow Up Flag: Follow up
Flag Status: Flagged

Thanks all,

I've made a few comments on the attached based on conversations with other agencies.

[redacted]

Thanks
Dawn

Dawn Schofield
Executive Director
Office of the Director-General and System Strategy Division

Mobile: [redacted]
Email: [redacted]@health.qld.gov.au

From: publichealthdirections <publichealthdirections@health.qld.gov.au>
Sent: Friday, 3 December 2021 4:57 PM
To: Dawn Schofield <Dawn.Schofield@health.qld.gov.au>; Kyle Fogarty <Kyle.Fogarty@health.qld.gov.au>
Cc: publichealthdirections <publichealthdirections@health.qld.gov.au>; Response.Lead.Engagement <Response.Lead.Engagement@health.qld.gov.au>; Response Lead - Policy <response.lead.policy@health.qld.gov.au>
Subject: FW: CHO PHD - Public Health and Social Measures linked to vaccination status Direction and COVID-19 Vaccination Requirements for Workers in a High Risk Setting Direction

Afternoon Dawn and Kyle

Please find attached an updated Border Restrictions Direction to the one sent you this morning.

[redacted]

Kind regards,

Prue

Prue Peart
Legal Policy Unit
Office of the Director-General | Queensland Health

P [redacted]
E [redacted]@health.qld.gov.au
W health.qld.gov.au
A Lvl 9, 33 Charlotte Street, Brisbane

Queensland Health acknowledges the Traditional Custodians of the land across Queensland, and pays respect to First Nations Elders past, present and future.

From: publichealthdirections
Sent: Friday, 3 December 2021 9:38 AM
To: Rachel Vowles [redacted]@health.qld.gov.au>
Cc: publichealthdirections [redacted]@health.qld.gov.au>; Kyle Fogarty [redacted]@health.qld.gov.au>; Response.Lead.Engagement [redacted]@health.qld.gov.au>; Response Lead - Policy [redacted]@health.qld.gov.au>
Subject: CHO PHD - Public Health and Social Measures linked to vaccination status Direction and COVID-19 Vaccination Requirements for Workers in a High Risk Setting Direction

Good morning,

Attached are the current drafts of the public health directions and policy rationales relating to the package of directions required for public health measures to respond to the risk of transmission of COVID-19 and which align with Queensland's COVID-19 Vaccine Plan to Unite Families at the point when 80% of eligible Queenslanders (aged 16 years and over) are fully vaccinated.

The package comprises:

- *Public Health and Social Measures linked to vaccination status Direction*
- *COVID-19 Vaccination Requirements for Workers in a High Risk Setting Direction*
- *Border Restrictions Direction (No.56)*
- *Policy rationales for each directions*
- *Talking points in relation to each directions*

Border Restrictions Direction (No.56) will:

- Allow fully vaccinated people to enter Queensland if they have undertaken a PCR test within 3 days of the persons arrival
- Introduces the term hotspot traveller to describe fully vaccinated people who have undertaken a PCR test within 3 days. This term will be used in the Border Declaration Pass
- Allow fully vaccinated border zone residents from the non-restricted border zone to enter for any purpose

- Streamline the purposes for which people can enter Qld from the border zone and provides greater consistency
- Make the purposes for which restricted border zone residents can enter Qld to be consistent with those for Qld residents re-entering from the restricted border zone
- Allow domestic travellers and others who are home quarantining to leave home quarantine when the direction commences and certain conditions are met

Public Health and Social Measures Linked to Vaccination Status:

- Identifies businesses, activities and undertakings where both workers and visitors (patrons, guests and other persons) will need to be vaccinated either to enter and remain at the premises, or to require reduced occupant density limits to respond to the risk of transmission of COVID-19.
- Requires visitors and workers entering those businesses to provide evidence of vaccination or medical contraindication, and contact information for contact tracing purposes. Digital and paper based options are available for evidence of vaccination and contact information, although use of the Check In Qld App is preferred.
- Government employees who enter places of business in the performance of their duties will need to provide evidence of vaccination, unless they are entering in a law enforcement capacity. The scope of law enforcement has not been specifically defined but would be expected to include WH&S inspectors and food safety inspectors. A departmental employee checking in with an apprentice would need to be vaccinated to enter and remain in a restricted business.
- Roadhouses and service stations are included as an essential business, activity or undertaking and treated similarly to a food court unless there is a standalone restaurant at the roadhouse.
- In house cafes and catering services will only be considered a restaurant or café when they open to the public. For example, the Kedron Ambulance Service has a café that is predominantly for workers but is open to the public and would need to meet the same requirements as any other café or restaurant even though seating is within the Ambulance Services precinct.
- Ferry services previously within the category of tourism experiences will be categorised as transport providers where operating as such. A bar or café on board the ferry will need to comply with the relevant restrictions for a bar or café.
- Clinical trials have been included as a new category akin to medical contraindication.

COVID-19 Vaccination Requirements for Workers in a High Risk Setting Direction

- Provides for the CHO to identify high risk settings by reference to public health risk factors
- Requires workers in an identified high risk setting to be fully vaccinated by 23 January 2022
- Includes co-located settings within high risk settings, where there would otherwise be no vaccination requirement for those workers. E.g. TAFE co-located with a high school.
- Workers includes staff employed by someone other than the high risk setting, and volunteers e.g. lollipop people at school crossings, contractors, performers, parent and other volunteers at schools
- Provides an exception for unvaccinated support workers, with approval of the responsible person, to provide continuity of care and support for vulnerable people, to allow continued access to mental health and wellbeing, legal and advocacy supports such as Murri Watch. Surveillance testing and PPE are required.

The Human Rights Assessments for the PHSM and Vaccination in High Risk Settings are with Crown Law to settle, and advice on enforceability has been requested and is expected later today.

Kind regards,
Gina.

Gina McCabe
Public Health Directions COVID Governance Branch | Queensland Health

P [redacted]
E [redacted]@health.qld.gov.au
W health.qld.gov.au
A lvl 11, 33 Charlotte Street

Queensland Health acknowledges the Traditional Custodians of the land across Queensland, and pays respect to First Nations Elders past, present and future.

Direction from Chief Health Officer in accordance with emergency powers arising from the declared public health emergency

COVID-19 Vaccination Requirements for Workers in a high-risk setting Direction

Public Health Act 2005 (Qld)
Section 362B

On 29 January 2020, under the *Public Health Act 2005*, the Minister for Health and Minister for Ambulance Services made an order declaring a public health emergency in relation to coronavirus disease (COVID-19). The public health emergency area specified in the order is for 'all of Queensland'. Its duration has been extended by regulation to 26 December 2021 and may be further extended.

Further to this declaration, I, Dr Peter Aitken, Chief Health Officer, reasonably believe it is necessary to give the following directions pursuant to s362B of the *Public Health Act 2005* to assist in containing, or to respond to, the spread of COVID-19 within the community.

Guidance

This public health direction applies to workers who enter, work in, or provide services in a high-risk setting. The direction defines how a high-risk setting is identified by the Chief Health Officer and specifies the COVID-19 vaccination requirements and related obligations for workers and employers operating in a high-risk setting. The direction recognises that an employer may mandate vaccination for employees, where otherwise permitted at law, based on the requirements of a role.

Preamble

1. This Public Health Direction applies to ***workers*** in settings where there is a higher risk of transmission of the COVID-19 virus, the setting is accessed by a large number of vulnerable persons as service users, and/or a sudden reduction in available workforce due to COVID-19 impacts at the setting would significantly affect the continuity of critical services to the community with consequential public health and safety risks.
2. This Public Health Direction supplements existing public health directions already made to contain or respond to the spread of COVID-19 by mandating vaccination of workers in healthcare settings, in quarantine facilities and in vulnerable facilities. Nothing in this public health direction reduces the requirements of those public health directions.
3. Separately from the requirements of Public Health Directions, under sections 362G and 362H of the *Public Health Act 2005*, an ***emergency officer (public health)*** can require a person to comply with additional directions if the emergency officer believes it is

reasonably necessary to assist in containing, or to respond to, the spread of COVID-19 in the community.

Citation

4. This Public Health Direction may be referred to as the *COVID-19 Vaccination Requirements for Workers in a High-Risk Setting Direction.*

Commencement

5. This Public Health Direction applies from time of publication until the end of the declared public health emergency, unless it is revoked or replaced.

Application

6. This Public Health Direction applies to ***workers*** in a ***high-risk setting*****,** in the public, private and non-government sectors, and identifies the COVID-19 vaccination and related requirements for ***workers***, ***employers*** and ***responsible persons*** in ***high risk settings***.
7. This Public Health Direction does not apply to people who visit the ***high-risk setting*** to access or use its services, either for themselves or as a support person for someone else.
8. The requirements of this public health direction prevail where a ***worker*** is required to be vaccinated under this direction, and another public health direction also applies to the ***worker*** but does not require the worker to be vaccinated. The ***worker*** must comply with the ***COVID-19 vaccination requirements*** for ***workers*** in a ***high-risk setting***.

PART 1 —WORKERS IN A HIGH-RISK SETTING

Worker

9. A ***worker*** must not enter and remain in, work in, or provide services in a ***high-risk setting,*** including a setting that is not the worker's primary place of work**,** unless the ***worker*** complies with the ***COVID-19 vaccination requirements*** in paragraph 11.

   Note: A ~~patient, client or~~ user of a service, or a parent, guardian or carer accompanying a ~~patient~~ user of a service to access the services, is not a ***worker*** *at a high-risk setting.*

   Examples: a contractor, union official, regulator, auditor, courier, performer, or sales representative must comply with the COVID-19 vaccination requirements to work in a ***high-risk setting*** *even though they may only occasionally enter the setting as part of their work duties.*

High-risk setting

10. A ***high-risk setting*** is a type of service, business or activity declared to be a ***high-risk setting*** by the Chief Health Officer in ***Schedule 2***, having regard to the public health risk for the setting, including one or more of the following factors:

(a) higher risk of transmission of COVID-19 due to the nature of the setting and the way in which services are provided; or

(b) a high number of ***vulnerable persons*** use or access the setting; or

(c) the continuity of critical services to the community and consequential public health and safety impacts if COVID-19 cases or quarantine unexpectedly reduced the available workforce of the setting.

Examples: an education setting where teachers and students work in close proximity has a higher risk of transmission; a youth justice detention centre has a high number of vulnerable persons who would be significantly and adversely affected by a COVID-19 outbreak at the centre. An outbreak in these settings might impact the ability to provide a critical service.

PART 2 —COVID-19 VACCINATION REQUIREMENTS

11. The ***COVID-19 vaccination requirements*** are that:

(a) by 17 December 2021, a ***worker*** in a ***high-risk setting*** has received the first dose of a ***COVID-19 vaccine***; and

(b) by 11.59pm AEST on 23 January 2022, a ***worker*** in a ***high-risk setting*** has received the prescribed number of doses of a ***COVID-19 vaccine***; and

(c) as soon as reasonably practicable after each dose of the ***COVID-19 vaccine***, the ***worker*** must show evidence of having received the ***COVID-19 vaccine*** dose to their ***employer***.

PART 3 —EXCEPTIONS

Medical contraindication and clinical trials

12. Paragraph 9 does not apply to a ***worker*** who is unable to be vaccinated due to a ***medical contraindication*** where the ***responsible person*** for the ***high-risk setting***:

(a) assesses the risk to other staff, clients and other persons at the ***high-risk setting***; and

(b) the ***worker*** undertakes daily ***COVID-19 PCR testing*** before a work shift; and

(c) the ***worker*** uses personal protective equipment as required by the ***responsible person*** for the ***high-risk setting***.

Note: results of the daily PCR testing may not be available before the worker's shift starts and can be provided to the employer or nominated person for the high-risk setting on a rolling basis as the results become available.

13. A ***worker*** in a ***high-risk setting*** to whom paragraph 12 applies must provide evidence of the ***medical contraindication***.

*Note: evidence of **medical contraindication** may be a digital or paper record from the person's Australian Immunisation Record, specifying the medical contraindication that makes the person unable to be vaccinated and the period of the **medical contraindication,** if it is temporary.*

14. Where the person has a temporary ***medical contraindication*** for being unable to receive the COVID-19 vaccination, paragraph 12 only applies for the period specified. If the ***medical contraindication*** continues beyond the specified period, the person must provide new evidence of a continuing ***medical contraindication*** or of their ***COVID-19 vaccination*** to comply with the ***COVID-19 vaccination requirements***.

15. Paragraph 9 does not apply to a ***worker*** who is ***unvaccinated*** and provides their ***employer*** a medical certificate or letter from a legally qualified medical practitioner certifying that the person is currently taking part in a ***COVID-19 vaccine*** trial and receipt of a Therapeutic Goods Administration approved vaccine would impact the validity of the trial.

Responding to Critical Workforce Shortages

16. The ***responsible person*** for a ***high-risk setting*** may permit a ***worker*** in a ***high-risk setting*** who has not complied with the ***COVID-19 vaccination requirements*** to enter, work in, or provide services in the ***high-risk*** setting, for a maximum period of 1 month until the critical workforce issue can be resolved, if:

(a) the responsible person has assessed the risk to other persons accessing the ***high-risk*** setting; and

(b) the ***responsible person*** reasonably believes it is necessary to respond to a ***critical workforce shortage;*** and

(c) personal protective equipment is used by the ***worker*** in the ***high-risk setting*** as required by the ***responsible person*** or the ***employer***; and

(d) a ***COVID-19 PCR test*** is undertaken by the ***unvaccinated worker*** in the ***high risk setting*** before starting work each day, and the test results provided to the ***employer*** as soon as reasonably practicable after the ***worker*** receives the test result.

*Note: the use of PPE and daily PCR surveillance testing for COVID-19 is required for a limited period of one month when an **unvaccinated** worker in a **high-risk setting** may enter, work, or provide services in a **high-risk setting** to respond to a **critical workforce shortage** while **fully vaccinated** workers are recruited or alternative arrangements are made to respond to the **critical workforce shortage**.*

Responding to Critical Support Needs

17. The ***responsible person*** for ***a high-risk setting*** may permit a ***worker*** in a ***high-risk setting*** who has not complied with the ***COVID-19 vaccination requirements*** to enter, work in, or provide services in the ***high-risk setting***, to provide support to a client or user of the ***high-risk setting***, for mental health or well-being and for legal or advocacy services, if:

(a) the ***responsible person*** has assessed the risk to other persons in the ***high-risk setting***; and

(b) the ***responsible person*** reasonably believes it is necessary to provide health, wellbeing, legal or advocacy support to a ***vulnerable person*** at the ***high-risk setting;*** and

(c) personal protective equipment is used by the ***worker*** in the ***high-risk setting*** as required by the ***responsible person*** or the ***employer***; and

(d) where the ***worker*** enters the ***high-risk setting*** for a single visit, a ***COVID-19 PCR test*** is undertaken by the ***unvaccinated worker*** within 24 hours of entry, and

(e) where the ***worker*** enters the ***high-risk setting*** on multiple consecutive days, a ***COVID-19 PCR test*** is undertaken by the ***unvaccinated worker*** before entering the ***high-risk setting*** each day, and the test results provided to the ***responsible person*** for the ***high-risk setting*** as soon as reasonably practicable when received.

*Note: the use of PPE and PCR surveillance testing for COVID-19 is required when an **unvaccinated** worker is permitted to enter a **high-risk setting** to provide support to a vulnerable client on multiple consecutive days.*

Example: an unvaccinated mental health support worker regularly provides support to an inmate of a corrective services facility . The inmate relies on continuity of face to face contact for their mental health and wellbeing and their health outcomes would be adversely impacted by a change in support arrangements.

Emergency entry to high risk settings

18. An unvaccinated person may enter a high risk setting to respond to an emergency and paragraph 9 does not apply.

    Example: a contractor, who is not vaccinated, enters a school during school hours to fix flooding in the toilet block.

19. A ***worker*** must report the emergency entry to the ***high-risk setting*** to their ***employer*** or ***responsible person*** for the ***high-risk setting*** as soon as is reasonably practicable.

PART 4 – RECORD KEEPING REQUIREMENTS FOR HIGH RISK SETTINGS

20. A ***worker*** and their ***employer*** must take all reasonable steps to ensure that the ***worker*** does not enter, work in, or provide services in a ***high-risk setting*** if the person does not meet the ***COVID-19 vaccination requirements*** and does not have a ***medical contraindication*** for all ***COVID-19 vaccines.***

21. The ***employer*** must keep a record, for each ***worker*** in the ***high-risk setting,*** of:

    (a) their COVID-19 vaccination status;

    (b) the type of evidence that was sighted to verify the worker's COVID-19 vaccination status; and

    (c) the timeframe for a temporary ***medical contraindication***; and

    (d) the type of evidence that was sighted to support a claimed ***medical contraindication***.

22. Where the ***responsible person*** in the ***high-risk setting*** is not the ***employer*** of the ***worker***, the **employer** is to keep the records in paragraph 21 and provide confirmation of its workforce complying with the ***COVID-19 vaccination requirements*** to the ***responsible person*** for the ***high-risk setting***.

    Example: an agency provides relief staff to the high-risk setting. The agency must maintain the records in relation to employee vaccination and provide a letter confirming employee vaccination compliance to the responsible person for the high-risk setting.

23. The ***responsible person*** must take reasonable steps to notify ***employers*** of ***workers*** in the ***high-risk setting*** of the ***COVID-19 vaccination requirements*** and to maintain a record of the compliance confirmation provided by the ***employer*** in relation to its workforce***.***

PART 5 —OTHER MATTERS

24. Nothing in this public health direction prevents an employer from making a lawful direction requiring an employee to be vaccinated for COVID-19 where the employer has determined it is a requirement of the employee's role.

25. Nothing in this Public Health Direction prevents a ***worker*** who does not meet the ***COVID-19 vaccination requirements*** from using the services of the ***high-risk setting*** as a client, or visitor or accompanying a person who is using the services of the ***high-risk setting***.

    Example: an unvaccinated plumber who can only work on school premises in an emergency can continue to attend parent activities at the school their child attends. ~~*A relief teacher must meet the vaccination requirements to continue to work at the school their child attends, but may attend school activities, such as parent teacher interviews, as a parent, even though they are unvaccinated, with their child, and can attend the school to pick up a sick child, drop off forgotten items and for other parental responsibilities.*~~

Commented [DS1]: I think education wanted to have this removed.

26. An ***emergency officer (public health)*** can require a ***responsible person,*** or a ***worker***, or their ***employer*** to comply with additional directions if the emergency officer believes the direction is reasonably necessary to assist in containing, or to respond to, the spread of COVID-19 within the community.

PART 6 — DEFINITIONS

27. Definitions used in this Direction are in Schedule 1.

PART 7 — PENALTIES

A person to whom the direction applies, including a ***worker***, ***employer*** or ***responsible person*** for a ***high-risk setting***, commits an offence if the person fails, without reasonable excuse, to comply with the direction.

Section 362D of the *Public Health Act 2005* provides:

Failure to comply with public health directions

> A person to whom a public health direction applies must comply with the direction unless the person has a reasonable excuse.
> Maximum penalty—100 penalty units or 6 months imprisonment.

Dr Peter Aitken
Chief Health Officer
XX December 2021
Published on the Queensland Health website at xx:xx am/pm

SCHEDULE 1 - Definitions

For the purposes of this Public Health Direction:

Authorised person is a person approved or permitted to access the information in accordance with licensing requirements, if any, the *Information Privacy Act 2009* and the *Public Records Act 2002* and related instruments of delegation.

Co-located means located on the same premises, using shared facilities and staff and users of the high-risk setting move freely between the co-located functions or settings.

Example of co-located: a regional high school and a TAFE are co-located ~~in a regional town~~on the same campus. ~~TAFE educators attend the high school to deliver some classes and high school students attend the TAFE facilities for some of their training.~~ The educational settings share ~~workshops and~~ common areas and facilities such as classrooms, workshops, gym or canteen. Workers in the TAFE that is co-located with the high school must comply with the COVID-19 vaccination requirements.

Commented [DS2]: Just don't want to get confused with the situation where students at a high school may be bussed or independently get to a separate (not collocated) TAFE campus or TAFE teachers that may be visitors to a school for the purpose of teaching

*Example of not co-located: part of a school's grounds are fenced off while construction of a gym is undertaken. While the construction work progresses, school staff and students are excluded from the construction site and the construction company has control of the site. The construction site is not co-located with the school and is not subject to the COVID-19 vaccination requirements that apply to the **high-risk setting**.*

Corrective services facilities visitor means any visitor to a corrective services facility other than a personal visitor as defined In the *Corrective Services Act 2006*

COVID-19 PCR test means tested for COVID-19 with an oropharyngeal and deep nasal swab for polymerase chain reaction (PCR) testing, but does not include a self-test.

COVID-19 vaccination requirements see paragraph 11.

Evidence of ***COVID-19 vaccination*** (printed or electronic) includes:

(a) written confirmation of COVID-19 vaccination provided to the person as part of the vaccination process, such as a record of vaccine card; or

(b) vaccination information displayed on the ***Check in Qld app;*** *or*

(c) a ***COVID-19 digital certificate*** or printed vaccination certificate from the Australian Immunisation Register; or

(d) an online or printed ***immunisation history statement*** for COVID-19 vaccination, including confirmation of a medical contraindication; or

Note: A visitor's immunisation history statement can be obtained from the Australian Government using myGov, the Medicare mobile app or by calling the Australian Immunisation Register and requesting a statement to be posted.

*Note: If a person is unable to receive a **COVID-19 vaccination** because of a medical contraindication, they must provide* evidence of a ***medical contraindication.***

(e) an ***International COVID-19 Vaccination Certificate***:

(i) in a printed or electronic form from the Department of Home Affairs that confirms completion of an Australia Travel Declaration and vaccination against COVID-19 overseas; or

(ii) through Medicare online account through myGov or the Medicare mobile app; or

(iii) an official record of vaccination provided to the person when vaccinated against COVID-19 overseas.

COVID-19 vaccine is a vaccine for COVID-19 that is approved for use in Australia or recognised by the Therapeutic Goods Administration.

Critical workforce shortage means a sustained workforce shortage in a ***high-risk setting*** that the ***responsible person*** for the ***high-risk setting*** considers may directly and significantly compromise the health or safety of other persons within the ***high-risk setting*** or the delivery of essential services to users of the ***high-risk setting***.

*Example: A critical workforce shortage may be a shortage of more than 10 per cent of staff for a sustained period of 7 days or more, however this will depend on the size of the **high-risk setting,** baseline staffing levels (including rostering arrangements and relief pool arrangements), and will depend on the nature and extent of the operational impacts on a vulnerable cohort.*

Eligible health professionals means any of the following:

- fellows of the Royal Australian College of General Practitioners (as defined by the *Health Insurance Act 1973 Cth*); or
- fellows of the Australian College of Rural and Remote Medicine (as defined by the *Health Insurance Act 1973 Cth)*; or
- on Medicare's Vocation Register of General Practitioners (as defined by the *Health Insurance Act 1973 Cth)*; or
- practice registrar on an approved 3GA training placement; or
- paediatrician; or
- public health physician; or
- infectious diseases physician; or
- clinical immunologist.

Emergency officer (public health) means an emergency officer appointed under the *Public Health Act 2005*.
*Note: Emergency officers appointed under the Public Health Act 2005 include **public health officers** and police.*

Employer means a person, or other legal entity that employs or otherwise engages a ***worker***.

High-risk setting is a type of service, business or activity declared to be a ***high-risk setting*** by the Chief Health Officer in ***Schedule 2***, having regard to the public health risk for the setting, including one or more of the factors listed in paragraph 8.

Medical contraindication means a temporary or permanent contraindication that is notified to the Australian Immunisation Register (AIR) by an ***eligible health professional*** completing an ***Australian Immunisation Register (AIR) immunisation medical exemptions form*** in relation to a person and recorded on the person's Immunisation History Statement (IHS).

Note: *Evidence of a recognised medical contraindication means a **COVID-19 vaccination** medical exemption recorded by an **eligible health professional** on the Australian Immunisation Register for the person.*

Note: *a temporary vaccine exemption may apply until a specified date due to acute major illness, significant immunocompromise of short duration and recognised overseas vaccination.*

Responsible person for a ***high-risk setting*** means the person who is legally responsible for the setting, including in relation to compliance with regulatory and other requirements for the setting.

Example: the Principal of a school may be the responsible person; the Director General is the responsible person for a government department; a chief executive or Board Chair is the responsible person for a not for profit organisation. The responsible person may also be the employer but this will not always be the case.

Visitor means any person who enters a high-risk setting other than a ***worker*** and does not include a ***corrective services facility visitor.***

Vulnerable person means a person who is ineligible or unable to be vaccinated for COVID-19 because of their age or a ***medical contraindication***, or a person with underlying medical conditions that place them at greater risk of adverse impacts from COVID-19 even if they are vaccinated.

Example: children under the eligible age limit for COVID-19 vaccination; children who are immunocompromised or undergoing treatment that affects the efficacy of the vaccine; residents in residential aged care facilities; people with disabilities; patients in hospitals.

Worker includes a person who:

(a) is employed at a ***high-risk setting***; or
(b) is a government employee whose duties involve attendance at a ***high-risk setting***; or
(c) undertakes work, whether paid or unpaid, at the ***high-risk setting***; or
(d) is a contractor providing services to or at the ***high-risk setting***; or
(e) a ***corrective services facility visitor***; or
(f) is attending the high-risk setting in the context of duties relating to the administration, regulation, governance, managerial oversight, or legal framework relating to the ***high-risk setting***; or
(g) is a performer, presenter or other specialist entering the ***high risk setting*** as part of delivering an activity, function or event; or
(h) is a volunteer delivering a service in the ***high-risk setting***; or
(i) is undertaking a work placement related to an enrolled course of study

Examples: a contractor, union official, regulator, auditor, courier, performer, lollipop school crossing person, or sales representative must comply with the COVID-19 vaccination requirements to work in a high risk setting even though they may only occasionally enter the setting as part of their work duties.

Note: A worker who visits a high-risk setting as an incidental part of their duties but is not providing services within the high-risk setting, such as a delivery driver or taxi driver is not a worker at a high-risk setting.

SCHEDULE 2 – High-risk settings

High-risk settings
The following education settings: • schools and outdoor education facilities • other education facilities, including TAFE, that are ***co-located*** with a school • outside school hours care and vacation care • early childhood education including kindergartens, registered and licensed early childhood settings

COVID-19 Public Health Rationale
COVID-19 Vaccination Requirements for Workers in a high-risk setting Direction

3 DECEMBER 2021

DRAFT NOT GOVERNMENT POLICY

Overarching intent

The overarching intent of the *Workers in high-risk settings (COVID-19 Vaccination Requirements) Direction* (the Direction) is to protect the community and workers in identified high-risk settings from the health impacts of COVID-19, reduce the risk of COVID-19 transmission and outbreaks, and safeguard the provision of critical services in Queensland. The Direction sets out mandatory COVID-19 vaccination requirements for workers in high-risk settings, and extends to any other person who works as a volunteer, contractor, student, whether employed by the responsible person for the setting or performing the work under another arrangement. The Direction states that by 23 January 2022, workers must have received their second dose of a TGA approved COVID-19 vaccine to enter, work in, or provide services in a high-risk setting.

By mandating COVID-19 vaccination for workers in this way, the risk of COVID-19 transmission within high risk settings and into the Queensland community is reduced. This Direction builds on existing COVID-19 vaccine mandates for workers in healthcare and other related high-risk settings, like quarantine facilities.

In the current iteration of the Direction, the following settings are identified as high-risk:

- Schools and early education
- Correctional and detention facilities (including youth detention)
- Airports

A risk analysis for these settings is described in this rationale, and summarised in Table 2 at the end of this document. The Direction complements existing mandatory vaccination requirements in other Queensland Public Health Directions. The policy position aligns with mandates in place in nearly all Australian jurisdictions, as outlined in Table 1 at end of this document. This Direction is deliberately broad and will allow for additional high-risk settings to be declared going forward.

Where a worker at an identified setting is captured under an existing COVID-19 vaccine requirement (such as healthcare workers), this Direction does not extend the timeframes for these cohorts.

Agency and sector engagement for this Direction occurred with relevant areas within Government, including the Department of Education, Department of Communities, Youth Justice and Multicultural Affairs and Queensland Corrective Services. A range of external stakeholders were also engaged, including tourism and aviation representatives, including major airports and airlines. Feedback on the policy and approach was consistently supportive.

Broadening existing COVID-19 vaccination mandates to workers across a wider range of high-risk settings enhances protection against COVID-19 across Queensland and creates a uniform standard of protection for workers and the community.

Background and rationale at 3 December 2021

Queensland's response to the COVID-19 pandemic has been very successful to date. Large scale outbreaks in Queensland have been prevented with a rapid and decisive public health response. The emergence of the Delta variant early this year and its rapid spread around the globe changed the COVID-19 context and led to widespread outbreaks around the world. Nationally almost every State and Territory in Australia has faced local transmission of the Delta variant and New South Wales (NSW) and Victoria (VIC) experienced widespread and sustained outbreaks of COVID-19 from June 2021.

Effective vaccines for COVID-19 that prevent severe illness and reduce transmission for current variants are now widely available and endorsed by Australia's Therapeutic Goods Administration (TGA). Queensland Health is strongly encouraging and promoting COVID-19 vaccination state-wide. High vaccination coverage is essential to protect the community, the health system, and the economy.

Prior to COVID-19, immunisation programs have been able to successfully achieve 'herd immunity' for many deadly diseases, including measles and pertussis (whooping cough). True herd immunity means enough of the population is immunised that vulnerable groups who cannot be vaccinated are safe from disease. It has become apparent that herd immunity may not be possible with COVID-19, and particularly the Delta variant, because of its highly infectious nature, breakthrough infections among vaccinated people, and emerging evidence of waning vaccine derived immunity after as little as six months.

The protective potential of vaccination against COVID-19 at a population level is also affected by differential vaccine uptake rates among cohorts or in some communities. This is particularly problematic for settings where vulnerable people are present, or where there is an increased risk of rapid and widespread transmission.

In response and to maximise baseline protection, COVID-19 vaccine mandates for workers, and in some cases, visitors to a setting, are becoming more common both in Australia and globally. These mandates support uniform protective coverage in settings that are higher risk for workers and the community. Vaccine mandates are widely accepted and are a safe, low-impost and high impact way of reducing the risk of COVID-19 transmission, illness, and death.

Vaccination for workers has been mandated by a number of industries that are impacted by COVID-19 exposure, including airlines (like Qantas and Jetstar; cabin crew, pilots and airport workers by November 15 and all other employees by March 31 2022) and mining corporations like BHP (all workers and people entering BHP coal mines from January 2022). On 23 October 2021, Woolworths and Aldi announced that all staff across Australia will be required to be vaccinated for COVID-19 (applying from 31 March 2022 for Queensland).

As Queensland transitions to an environment where COVID-19 is endemic, it is inevitable that every Queenslander will eventually be exposed to COVID-19.

High vaccination coverage among workers in settings with the potential for exposure to COVID-19, particularly those serving vulnerable cohorts, will be a key determinant of health outcomes for Queenslanders and the impact of COVID-19 across the State.

With effective and safe vaccines, the public health response can begin to shift away from widespread restrictive social measures and limits on business (like density and gathering limits), and towards population vaccination coverage as a more enduring protection of public health.

Current vaccine mandates

Mandates in healthcare, quarantine and critical services

In Queensland, aligned with National Cabinet and AHPPC endorsed recommendations, vaccination against COVID-19 is currently a requirement for workers in the following high-risk settings:

- Hospitals and healthcare settings
- Queensland Health residential aged care facilities
- Hotel quarantine facilities

Vaccination against COVID-19 has also been mandated for all employees of the Queensland Police Service (QPS) by the Queensland Police Commissioner. This mandate was based on the rationale that COVID-19 challenges the ability of QPS to fulfil its policing role, and rapid transmission of COVID19 through the QPS would take police officers and staff members out of service while they undertake quarantine periods or recover from COVID-19. Reduced availability of police officers and staff members for deployment could threaten the ability of the QPS to serve the community.

All Australian jurisdictions have introduced mandatory vaccination requirements for healthcare workers across the public and private health sectors.

Mandates for public venues to support reopening borders

On 9 November 2021, the *Public Health and Social Measures linked to Vaccination Status: A Plan for 80% and Beyond* (PHSM Plan) was released. Once Queensland reaches 80 per cent double dose vaccination coverage, a requirement for COVID-19 vaccination will be introduced for workers at and visitors to pubs, clubs, cafés, cinemas, theatres, music festivals and a range of public-facing venues operated by the Queensland Government, including museums and galleries. The mandate will replace COVID-19 restrictions on density and gatherings at these venues.

The requirement is deliberately broad and focused on settings with high public attendance— focusing on recreational venues that are higher risk due to the nature of the setting (e.g. alcohol consumption, density, dancing), and those that attract a number of geographically and demographically diverse people, where COVID-19 exposure and transmission could lead to a widespread outbreak.

Achieving uniform vaccination coverage across workers and visitors at these locations provides a baseline level of protection against community transmission. It is intended to be preventive and are intended to mitigate risk to the community with an expected increase in cases and spread going forward. It is also likely that a meaningful proportion of patrons will be children under the age of 16 years, for whom a COVID-19 vaccine is currently not available. Ensuring uniform vaccination coverage among the adults in the identified settings will protect children and protect against more widespread outbreaks.

Unvaccinated visitors will not be able to enter vulnerable settings such as hospitals, residential aged care, disability care accommodation, and correctional facilities to further support a baseline level of protection. This requirement is distinct from accessing facilities to receive care, where vaccination will not be required. This requirement will introduce a baseline level of protection against COVID-19 ingress in these vulnerable facilities going forward, when it is expected that COVID-19 will be circulating more widely in the community, and reduces the likelihood of needing to introduce further restrictions at these facilities.

Identifying additional high-risk settings

Queensland borders are reopening, bringing an increased likelihood of COVID-19 ingress and outbreaks throughout the State, including in vulnerable communities and regions. It is critical that the potential for significant outbreaks is controlled to the maximum extent possible, particularly in light of emerging variants of concern (see section on Omicron below).

There is an immediate urgency for additional protections in settings with a high potential to seed an outbreak, affect vulnerable members of the community, and where an outbreak could directly impact on

the delivery of critical services. Employers and workers in these settings also have a responsibility to ensure the safety of visitors, clients, patients, and people in their care.

There are discrete factors that affect the risk profile of any given setting for the transmission and wider potential impact of COVID-19.

From a public health perspective, COVID-19 transmission risk is directly affected by the ability to physically distance, air flow (i.e. whether the environment is enclosed or outdoors), and the use of infection prevention and control measures (i.e. non-pharmaceutical interventions - masks and hand hygiene). The impact of COVID-19 is amplified by the presence of people vulnerable to the effects of COVID-19 (like unvaccinated people, the elderly, immunocompromised, those with comorbidities, and people with a disability), or where people from a wide geographic spread are exposed and COVID-19 can be transmitted to multiple regions, including vulnerable or remote communities.

More broadly, from a 'systems impact' perspective, in some cases a COVID-19 outbreak in a workplace can have substantial impacts beyond those immediately affected and their families—where an outbreak occurs among workers who provide services critical to the public, like a health care or emergency services setting, the impact on the available workforce and service provision can be even more widespread and long-lasting.

While vaccination coverage continues to increase at a whole-of-population level, as noted above the protective potential of vaccination against COVID-19 is also affected by differential vaccine uptake. COVID-19 has demonstrated extraordinary efficiency in seeking out unvaccinated and vulnerable people within communities, workplaces and industries. This has been evident in the nature and setting of major outbreaks of the Delta variant in NSW and VIC—including aged care facilities, schools and prisons—and repeated waves of infection overseas.

With the above risk factors taken into account, this Direction provides a framework for additional vaccine mandates in Queensland.

In the current iteration, priority high-risk settings are identified in the education, corrections, and aviation sectors. These are settings that, despite individual uptake of vaccines and prioritisation in the vaccine rollout, are more susceptible to COVID-19 transmission, and where an outbreak will have a potentially significant impact on the community. Table 1 at the end of this document describes the risk profile and evidence for COVID-19 transmission at these settings, and Table 2 provides a jurisdictional comparison for these and other currently mandated settings.

Schools and early education

The Queensland Government takes the position that schools are an essential service and should remain open wherever possible. This is consistent with the view of the Australian Health Protection Principals Committee (AHPPC). With border closures and sustained public health measures since the national stay at home orders (including school closures) in March 2020, extended or widespread school closures in Queensland have so far been largely avoided.

The COVID-19 vaccine has recently been made available to children aged 12-15 years in Australia. As at 2 December 2021, 76.3 per cent of Australian children aged 12 to 15 years have received at least one dose of the vaccine and 66.7 per cent of children are fully immunised.

Children under the age of 11 years comprise 15.3 per cent of Queensland's population. In the absence of an approved vaccine for children under the age of 12 years, young children are the single largest unvaccinated cohort in Australia. As COVID-19 begins to circulate more widely in Australia, young children will become the new front line of the COVID-19 pandemic.

Schools are environments where physical distancing is difficult to maintain, where groups of people spend extended periods of time together in an enclosed environment, and where other public health measures

such as physical distancing and mask wearing can be impractical, particularly in early childhood settings with very young children.

In Victoria (VIC) and New South Wales (NSW), numerous outbreaks were seeded in school and early childhood settings following easing of lockdown conditions. COVID-19 outbreaks reportedly closed more than 270 schools (two thirds of which were primary schools) and 300 childcare centres across NSW during October 2021, and in VIC dozens of schools have been linked to COVID-19 outbreaks.

A recent example of COVID-19 risk at the school setting for Queensland is the Indooroopilly Cluster earlier this year (August 2021). This outbreak—the biggest in Queensland to date—was seeded across four schools and over subsequent weeks resulted in 147 cases and 17,000 close and secondary household contacts in home quarantine.

At the beginning of the outbreak, although a large number of exposure venues were identified, with the exception of the index case and family, all community cases were detected in association with a limited number of exposure venues, namely the affected Brisbane schools, and a karate class. Transmission had occurred not only within but across schools, with a high degree of crossover including siblings at different schools.

During this outbreak, affected contacts were rapidly identified and placed into home quarantine. Because of this, the flow-on effects of the outbreak could be observed by day five of the outbreak, where 80 per cent of new daily cases were known household contacts of cases. By day eight 100 per cent of new daily cases were being detected among known close contacts. The transmission rate of the Delta variant in households, and arguably any enclosed environment where people spend lengthy periods of time in close contact, has been estimated at between 70 to 100 per cent.

Fortunately, acute infection with SARS-CoV-2 is generally associated with mild disease in children. Compared to adults, children are 25 times less likely to develop severe disease.

However, the effect of an outbreak among and on-transmission from this cohort has the potential to be much more widespread, in terms of the impact within schools and on households, including inter-generational exposure, as well as student and staff absences and disruptions to schools with closures during outbreaks.

As at 30 November 2021, according to Queensland Health reporting of vaccines administered by Hospital and Health Services, 39,059 school and early childhood staff have received their second dose of the COVID-19 vaccine. This does not include doses administered by primary care providers (including General Practice), or other Commonwealth facilities, and the true figure is likely to be higher.

The total number of school and early childhood education workers in Queensland is not known. To illustrate the potential scale and impact of exposure to COVID-19 among workers in education, a 2020 report by the Queensland College of Teachers, the peak regulatory body for the teaching profession in Queensland, reports over 110,000 approved teachers, with over 68 per cent of these employed in permanent or long-term temporary teaching positions. According to the report, half of all teachers–51.3 per cent—are over 45 years of age and 16.5 per cent are 60 years or older.

The severity of COVID-19 increases with age. People in their 30s who are not vaccinated are at four times the risk of a teenager of becoming sufficiently unwell from COVID-19. For people in their 50s, the risk is 40 times higher than that of a teenager of becoming very unwell, being hospitalised, or dying. The death rate for COVID-19 starts to increase for those over 50 years of age. Those under 50 years of age who are infected have a death rate of 0.2–0.4 per cent of those infected, while for those 50–59 years it rises to 1.3 per cent of those infected, then 3.6 per cent for 60–69 years and higher again into the older years.

This means that as well as being at increased risk of exposure to COVID-19 at the setting, over half of the employed teaching cohort in Queensland is at increased risk of moderate to severe illness, or death, from COVID-19. The rates of severe illness or death are even higher for people who have underlying conditions like diabetes, hypertension, or asthma.

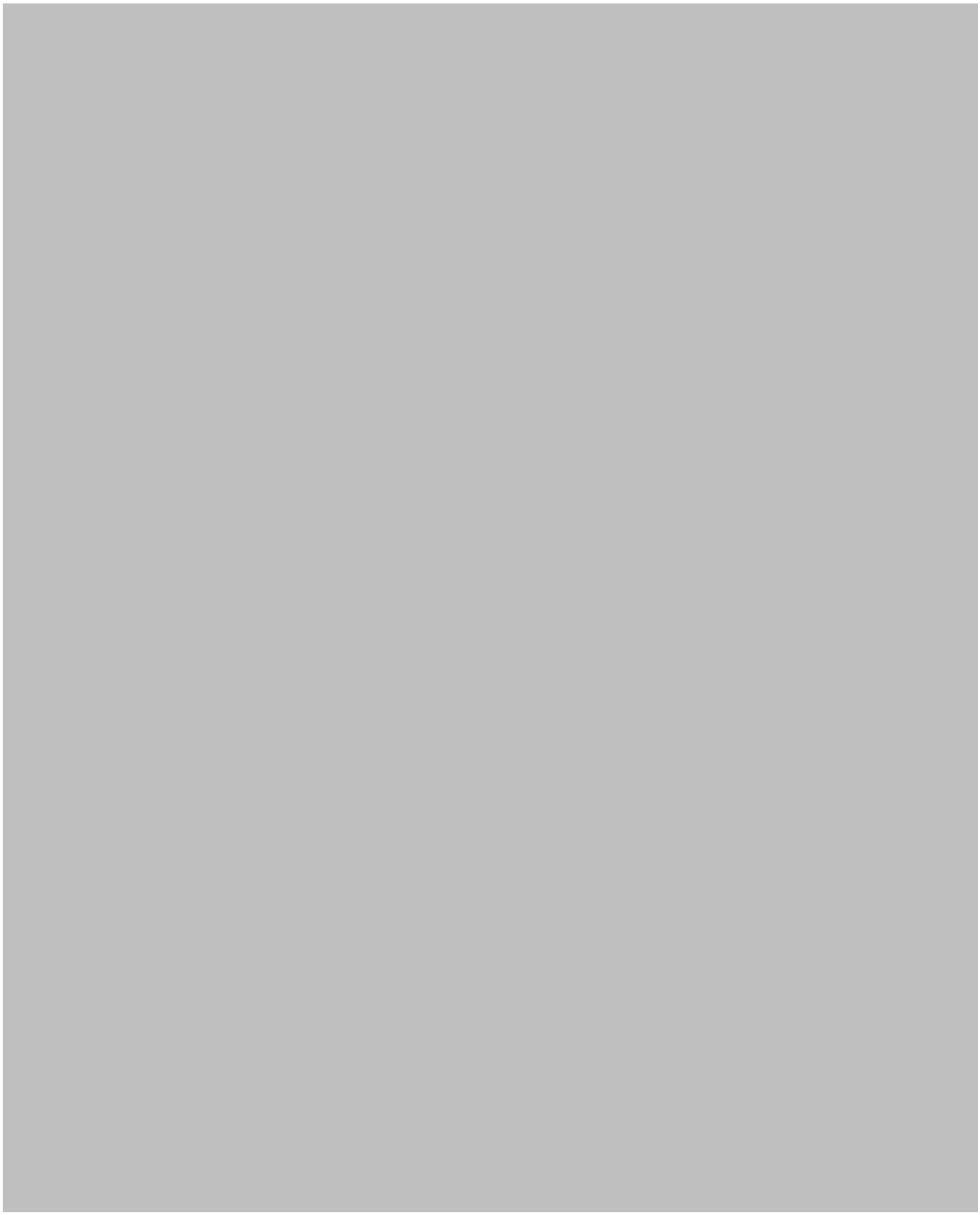
The AHPPC's *Statement on COVID-19, Schools and Reopening Australia* states that a primary goal for schools is to reduce transmission for the entire school community, protect the un-immunised population of students at school and maintain the ability of schools to remain open. Using actions from the hierarchy of controls, AHPPC notes that three specific principles apply to minimise disease in schools. These are (a) reducing opportunities for introduction of the virus, (b) reducing transmission of the virus if it is introduced, and (c) early use of containment measures if spread occurs.

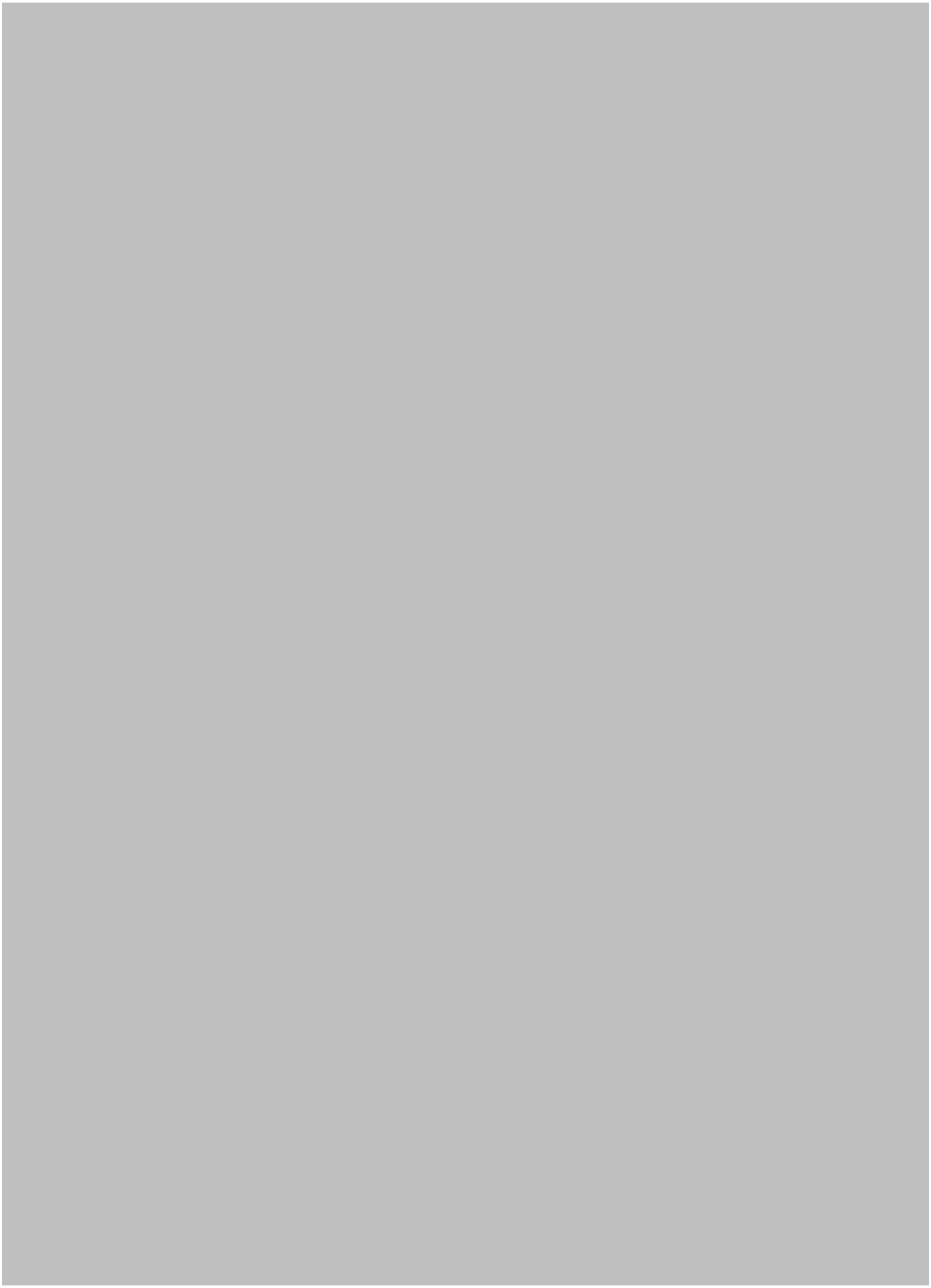
Vaccination offers a high level of individual protection for workers in schools and early childhood settings. Uniform vaccination among workers at school and early education, including childcare settings would contribute meaningfully to principles (a) and (b) described above.

While children under 12, and those over 12 who are unvaccinated, remain susceptible to COVID-19, their opportunities to acquire infection are reduced if the adults around them are vaccinated. This is a process called cocooning that is also used for other infectious diseases in infants. Notably, high vaccination rates amongst school family units are also a key protective factor.

All other Australian jurisdictions except for Queensland and Tasmania (TAS) have already introduced mandatory COVID-19 vaccination for workers in schools and early childhood settings (see Table 1 for a jurisdictional comparison at the end of this document).

In Queensland, for Department of Education employees, a range of vaccinations are strongly recommended depending on risk and exposure, but this would be the first mandatory vaccination for this cohort. Ensuring workers in schools and early education settings are uniformly vaccinated against COVID-19 will support AHPPC recommendations for schools, directly reduce risk to the workforce, help to protect against severe outbreaks and repeated school closures, sustain workforce capacity and reduce the risk of COVID-19 exposure to vulnerable people.





[redacted]

Engagement with the sector

Department of Education (DoE; Director-General and DDG) - conveyed the scope and rationale for the inclusion of 'Schools'. DoE undertook to engage with the broader private and independent sector to convey the policy intent.

[redacted]

Mandating vaccination for workers in identified high-risk settings

The Direction provides a framework to mandate vaccination for workers in high risk settings and sets these out in a Schedule. Consistent with the risk factors described earlier in this document, the Direction applies to workers in settings where:

- there is a higher risk of transmission of SARS-CoV-2, the virus that causes COVID-19
- the setting is accessed by a large number of vulnerable persons as service users, and/or
- a sudden reduction in available workforce due to COVID-19 impacts at the setting would significantly affect the continuity of critical services to the community with consequential public health and safety risks.

Settings in the Schedule in this iteration of the Direction are:

- Schools, childcare and early childhood education facilities
- Corrective service facilities (including police watch houses) and youth detention centres
- Airport premises and associated precincts

A vaccination requirement will apply to all workers who enter, work in, or provide services in a high-risk setting. The direction defines how a high-risk setting is identified by the Chief Health Officer and specifies the COVID-19 vaccination requirements and related obligations for workers and employers operating in a high-risk setting. The direction recognises that an employer may mandate vaccination for employees, where otherwise permitted at law, based on the requirements of a role.

It is expected that any staff who enter a high-risk setting for the purposes of work, even if not their primary workplace would be in-scope for the vaccination requirement. This would include but not be limited to union officials, regulators, and contractors like maintenance staff.

To be clear the intent is not to mandate vaccination of the worker but to mandate that in certain higher-risk settings, only vaccinated persons may work.

It is recognised that in rare circumstances, a worker may be genuinely unable to be vaccinated due to a medical contraindication. Accordingly, and provided the contraindication is certified, the worker may continue to work in a high-risk setting where their work cannot be performed outside the setting. For their own and others' protection when at the setting, they will need to comply with PPE requirements consistent with requirements as set by the responsible person for the setting. They must also undertake daily COVID-19 PCR testing before commencing each work shift. A permanent vaccine exemption can only be granted on the grounds of previous anaphylaxis or severe adverse event attributed to the COVID-19 vaccine or vaccine component across all vaccines available for use in Australia, and it is not expected that many people will fall into this category. Staff with a temporary contraindication will be expected to complete their vaccination following the exclusion period.

From time to time there may be exceptional circumstances that result in a critical workforce shortage, such as illness, high demand or another emergent event, and there may be an occasion where there is a shortage of vaccinated workers. In this event, and to allow for the continued and safe delivery of services, the Direction provides that an unvaccinated worker may be permitted to enter, work in or provide services in the setting, for a short period until vaccinated workers can be recruited. This is subject to strict standards, including a risk assessment by the person responsible for the healthcare setting, PPE use and daily COVID-19 PCR testing by the worker. It is expected that this option only be exercised in extreme and sustained circumstances, where the shortage means a direct impact on patient or client care or the effective operation of the setting. An example is a shortage of more than 10 per cent of staff for a sustained period of 7 days or more among a small staff cohort, with the remaining skills mix and rostering unable to compensate for the shortage. Similarly, in an emergency where it is absolutely necessary, other unvaccinated workers, including contractors, may enter a high-risk setting to respond to an emergency, but must comply with PPE requirements.

The Direction is not intended to restrict visitors to the settings, or for users of the service to gain access – for example, students or parents at a school, or a person accessing an airport as a traveller. It should be noted that visitors to corrections facilities are required to be vaccinated under the PHSM Plan, with corrections considered a vulnerable facility in the same way as hospitals, aged care and disability accommodation facilities.

Further, the Direction is not intended to mandate COVID-19 vaccination for support people who are directly providing legal, advocacy, social welfare, mental health and wellbeing supports for vulnerable clients or users of a service, and is subject to PPE use as required by the responsible person and modified PCR surveillance testing. An example is an unvaccinated mental health support worker regularly provides support to a person detained at a corrective services facility who relies on continuity of face to face contact for their mental health and wellbeing and their health outcomes would be adversely impacted by a change in support arrangements. This arrangement is considered an exception and is at the discretion of the responsible person. The exception is provided for as in these circumstances, the risk to the individual is considered to outweigh the public health benefit of the policy.

Uniform vaccination coverage will protect staff and safeguard the community by minimising the risk of COVID-19 transmission within the workforce as well as to and from vulnerable cohorts (for schools and correctional facilities) and travellers (for airports) as COVID-19 becomes more widespread. Limiting transmission within these workplaces will also reduce the likelihood of workplace outbreaks and staff shortages that can impact on the delivery of these essential services.

Future implementation

As Queensland transitions to a 'living with COVID-19' future, COVID-19 will begin to be managed more like other vaccine-preventable diseases—public health restrictions are expected to reduce, and regulatory requirements will become more targeted. During the transition to endemic COVID-19, and particularly during the early stages, it will remain critically important to limit the transmission and spread of COVID-19, protect the health of Queenslanders, and sustain health system and contact tracing capacity.

Mandating uniform vaccination coverage for workers in identified high risk settings ensures that the spread of the virus among vulnerable cohorts and in higher-risk settings is slowed. This will safeguard against broader impacts on the community, industry, and the health system.

It is likely that high-risk settings will continue to be identified as the virus moves through the population. As noted above, without available vaccines, children are becoming new front line of the pandemic and schools and early childhood settings are increasingly recognised as key high-risk settings. The impact of waning immunity has not yet been tested in Queensland, and this may have unpredictable consequences across a range of settings and workplaces where vaccination may have been prioritised or seen rapid uptake early in the vaccine rollout.

Omicron variant

On November 26, the World Health Organization (WHO) classified a new variant, the Omicron or B.1.1.529 variant as a variant of concern. The first known confirmed infection was from a specimen collected on 9 November 2021 and the variant was first reported to the WHO from South Africa on 24 November 2021.

In recent weeks in South Africa infections have risen steeply, coinciding with the detection of this variant. It appears to be taking over dominance in some South African regions in less than two weeks.

The variant has a large number of mutations – 32 on the spike protein alone, compared to only 9 on the Delta variant, and preliminary evidence is suggesting that this variant may produce an increased risk of reinfection among people who have had COVID-19 previously. The transmissibility of the variant is currently unknown, although some early indications are that it is highly transmissible. The severity of disease is also unknown, although on balance it is considered unlikely that it causes more severe disease than other known variants. The effectiveness of vaccine against the variant is still under investigation, although current vaccines appear to remain effective against severe disease and death. Pfizer have indicated they expect to know within two weeks whether the variant is vaccine resistant. An advantage is that should another vaccine be required it is likely that a new mRNA vaccine could be produced and made available within months.

Public health considerations – 2 December 2021

Epidemiological situation

Queensland

- Queensland reported three (3) new COVID-19 cases in the previous 24 hours:
  - one case (fully vaccinated) detected on the Gold Coast with no known contact with another case.
  - two cases detected on day five of hotel quarantine, both with recent interstate travel (New South Wales and Victoria respectively).
- The total number of cases in Queensland stands at 2,133.
- Queensland is managing a total of 18 active cases, with 14 in the hospital (nil in ICU) and four awaiting transfer. There are currently no active First Nations cases in Queensland.
- There has been a significant increase in the number of people entering home quarantine, now permitted for many domestic arrivals under the Vaccine Plan after Queensland achieved 70 per cent vaccination coverage on 14 November.
- There are currently 10,721 people in quarantine: 7,354 people in home quarantine, 3,256 people in government hotel quarantine and 111 in alternate quarantine.
- As at 30 November 2021, a total of 3,158,650 Queenslanders aged 16 and over have been vaccinated with two doses of a COVID-19 vaccine, which amounts to 76.80 per cent of this cohort; 3,565,779 people – 86.65 per cent – have had at least one dose.

Emergence of Omicron variant

- On 26 November, the World Health Organization (WHO) classified a new variant, Omicron (or B.1.1.529) as a variant of concern. The first known confirmed infection was from a specimen collected on 9 November 2021.
- The variant was first reported to the WHO from South Africa on 24 November 2021.
- The variant has a large number of mutations (including 26-32 on the spike protein, which is considerably more than the Delta variant), and preliminary evidence is suggesting this variant may produce an increased risk of reinfection among people who have had COVID-19 previously.
- Omicron is being urgently investigated by researchers globally, with the WHO announcing it could take weeks for sufficient data and analysis to draw preliminary conclusions.
- There is currently insufficient information available to make conclusions on the transmissibility and disease severity of the variant. The effectiveness of available vaccines against the Omicron variant is also under investigation.

National

- As at 1 December, in the 24 hours prior jurisdictions have reported 1,440 newly confirmed cases.
- Australia has reported 87.4 per cent of the eligible population aged 16 years and over as fully vaccinated; 92.6 per cent have had at least one dose.
- NSW and Victoria, with sustained and widespread outbreaks of the Delta variant since June-July, are seeing a reduction in daily new cases in recent weeks with fluctuating, but generally downward trajectory. Noting wide-ranging lifting of restrictions and lockdown conditions, Queensland is monitoring case numbers in these jurisdictions as well as in the Australian Capital Territory (ACT) where daily positive cases have also been gradually falling since the start of the latest outbreak.
- A total of seven cases of Omicron variant have been recorded in Australia, with six in NSW and one in the Northern Territory (NT).
- Quarantine requirements for Australians returning from overseas to NSW, Victoria, ACT and South Australia were had started to ease in November. However, following the emergence of the Omicron variant, these jurisdictions have re-introduced restrictions for arrivals from countries of concern.

New South Wales

- NSW reported 251 new locally acquired COVID-19 cases and no new deaths in the past 24 hours; there have been 75,975 locally acquired cases and 574 deaths reported since 16 June.
- NSW is currently managing 160 cases in hospital, with 26 people in ICU (11 requiring ventilation).
- NSW has reported that 92.5 per cent of the eligible population aged 16 years and over is fully vaccinated and 94.6 per cent has received at least one dose.
- NSW has a range of movement and gathering restrictions in place for unvaccinated people, which will remain in effect until 15 December.

Victoria

- Victoria has reported 1,179 new locally acquired cases and six deaths in the last 24 hours; there now have been 102,131 locally acquired cases and 523 deaths reported since 16 June.
- Victoria is managing 299 cases in hospital, including 43 in intensive care (18 requiring ventilation).
- As at 1 December, 91 per cent of eligible Victorians aged 16 years and over are fully vaccinated of a COVID-19 vaccine and 93.4 per cent has received at least one dose.
- There are currently no restrictions in place for Victorians who are fully vaccinated.

Australian Capital Territory

- ACT has reported four new locally acquired cases and nil deaths in the last 24 hours; there have been 2,010 locally acquired cases and 11 deaths reported since 12 August.
- ACT is managing eight cases in hospital, with three people in intensive care, two of whom requiring ventilation.
- Over 95 per cent of eligible population in ACT aged 16 years and over are fully vaccinated.
- The vaccination rate of the population over 12 years old is 97.8 per cent fully vaccinated.

Northern Territory

- One new community case reported in past 24 hours. The Katherine and Robinson River outbreak now totals 59 cases (since 15 November 2021).
- As at 1 December, 77.9 per cent of eligible population in NT aged 16 years and over are fully vaccinated of a COVID-19 vaccine and 87.7 per cent has received at least one dose.
- The lockdown for Katherine has moved to a lockout from 27 November. During the lockout period, people inside the designated area are not permitted to leave and people outside are not able to enter, except for essential workers. This is due to lift on 7 December.

Global

- As at 1 December, more than 8,036 billion doses of COVID-19 vaccine have been administered globally (John Hopkins University).
- The cumulative number of confirmed cases reported globally is now over 263 million and the cumulative number of deaths is over 5.2 million (John Hopkins University).
- Globally, weekly case incidence plateaued during the week of 22-28 November 2021, with nearly 3.8 million confirmed new cases reported, similar to the previous week's figures. However, new weekly deaths decreased by 10 per cent in the past seven days as compared to the previous week, with over 47,500 new deaths reported.
- The African, Western Pacific and European Regions reported increases in new weekly cases of 93 per cent, 24 per cent and 7 per cent, respectively, while the Regions of the Americas and South-East Asia reported decreases of 24 per cent and 11 per cent, respectively. (Note: the increase in the African Region was largely due to batch reporting of antigen tests by South Africa last week, therefore the trends should be interpreted with caution.) New weekly deaths decreased by 36 per cent and 8 per cent in the Regions of the Americas and the Eastern Mediterranean, respectively, and increased by 26 per cent and 7 per cent in the South-East Asia and African Regions, respectively. (WHO).

Living with COVID-19

- The Queensland Government has launched a state-wide campaign to encourage Queenslanders to get vaccinated. There is a particular focus on encouraging increased uptake in regional and remote areas. Many of these areas currently have lower vaccination coverage than the State average.
- Booster COVID-19 vaccination doses for people who received their second dose at least six months ago have been available Designated COVID-19 Hospitals in Queensland from 1 November 2021.
- On 18 October 2021, Queensland released the COVID-19 Vaccine Plan to Unite Families. Under this plan, changes to border restrictions and quarantine requirements at increasing levels of state-wide vaccination coverage are described.
- At 70 per cent of Queensland's eligible population fully vaccinated (achieved on 15 November), anyone who has been in a declared domestic hotspot in the previous 14 days can travel into Queensland provided they are fully vaccinated; arrive by air; have a negative COVID-19 test in the previous 72 hours can undertake home quarantine for 14 days (subject to meeting conditions).
- At 80 per cent of Queensland's eligible population fully vaccinated (expected in early December) travellers from an interstate hotspot can arrive by road or air, with no quarantine required but must be fully vaccinated and have a negative COVID-19 test in the previous 72 hours. Direct international arrivals can undertake home quarantine subject to conditions set by Queensland Health, provided they are fully vaccinated and have a negative COVID-19 test in previous 72 hours.
- At 90 per cent of Queensland's eligible population fully vaccinated, it is expected there will be no entry restrictions or quarantine for vaccinated arrivals from interstate or overseas. Unvaccinated travellers will need to apply for a border pass, or enter within the international arrivals cap, and undertake quarantine.
- On 9 November 2021, the Queensland Government released its *Public Health and Social Measures linked to Vaccination Status: A Plan for 80% and Beyond*, which sets out measures variously applying to vaccinated and unvaccinated people aged 16 years and over.
- Under the Plan, once Queensland reaches 80 per cent double dose vaccination coverage there will be no COVID-19 density restrictions on pubs, clubs, cafés, cinemas, theatres, music festivals where all staff and attendees are fully vaccinated.

Public Health System capacity

- Currently, Queensland Public Health Units are working to ensure the Queensland community is complying with public health controls. Another key focus for Queensland's Public Health Units is to ensure that those directed to undertake quarantine, including home quarantine, comply with all requirements, including the testing regime.
- Additional restrictions are imposed and lifted in response to evidence of community outbreaks to ensure the safety of Queenslanders, and more specifically our most vulnerable people in residential aged care facilities, hospitals, and disability accommodation services.
- Cases of COVID-19 in the Queensland community have been managed well to date and it remains important to mitigate against widespread outbreaks. It is particularly important to quickly bring clusters under control with effective contact tracing and other protective measures to maintain the integrity of the health system to respond to non-COVID-19 related care.

Health Care System capacity

- Queensland will soon transition to the next phase of the COVID-19 response, which will involve wider circulation of COVID-19 in the Queensland community. Queensland Health has considered a range of epidemiological modelling, including scenario-based impacts to hospital capacity and workforce. This modelling, and lessons from the recent NSW and Victorian outbreaks, have identified that a flexible and high capacity health system delivery model is critical. It is expected that with increased vaccine

protection, the number of people requiring hospitalisation and intensive care in the event of an outbreak are likely to remain within hospital and health system capacity.

- As Queensland's response to COVID-19 has evolved, expert advisory groups, particularly the COVID-19 Response Group have further developed and refined Queensland Health's response plans. Particular consideration has been given to the impacts of the Delta variant and an increasing likelihood of a surge in cases as Queensland transitions to living with COVID-19.
- Queensland Health is operating a tiered health system response to activate additional capacity when triggers associated with increasing case numbers are met. This response includes expanding to hospitals and settings (such as homes) beyond the Designated COVID-19 Hospital Network, postponing elective surgeries, and leveraging private hospital capacity as required.
- The established Designated COVID Hospital Network can accommodate a moderate surge in cases, across both inpatient and at home care through Hospital in the Home (HITH) placements.
- Strategies are in place with private providers to minimise the interruption to urgent elective services should a wider community outbreak across Queensland impact on hospital and health service delivery. Strong partnerships with major private providers will assist public hospital systems to respond to a COVID-19 surge.

Community acceptance and adherence

- Queensland's public health measures have been generally well-received and met with compliance. The community have so far been largely supportive of public health measures.
- There are ongoing concerns of 'pandemic fatigue', particularly in vulnerable sections of the community, and associated non-compliance with public health measures nationally. However, the need for lockdowns or widespread restrictions is expected to reduce dramatically with increased vaccination coverage. Queensland, like other jurisdictions, is preparing to move into a new 'living with endemic COVID-19'.
- Emerging key issues relate to vaccine mandates imposed by state and territories in various settings, and the complexities of differing freedoms for vaccinated and unvaccinated people. State and territory mandates can vary considerably with local context, with vaccine mandates in some jurisdictions applying to the majority of the population.

Wastewater monitoring

- To strengthen surveillance capabilities and increase confidence that transmission is not occurring, Queensland conducts a surveillance program to detect traces of coronavirus in wastewater in 19 communities across the state.
- Wastewater monitoring systems detect viral fragments and can help experts determine where in the state there might be people with a current or recent COVID-19 infection. The system has significant value in its potential to serve as an early warning system for potentially undetected cases. It cannot pinpoint the exact source of the viral fragments.
- COVID-19 fragments were detected in wastewater samples collected from the Coombabah and Elanora wastewater treatment plants on 29 November.

Table 1. Jurisdictional comparison of COVID-19 vaccine mandates for workers in key high-risk settings (26 November 2021)

Cohort	Jurisdictional comparison [Note: date of second vaccination provided, unless otherwise specified]								
	National position	QLD	NSW	ACT	VIC	SA	TAS	WA	NT
[redacted]									
Education and childcare workers	Vaccination of staff encouraged by AHPPC	–	✓ 8 Nov	✓ 29 Nov	✓ 29 Nov	Booked 2nd dose by 11 Dec	–	✓ 31 Jan	✓ 24 Dec
[redacted]									

Table 2 - Risk factors and evidence of COVID-19 transmission at critical settings serving the Queensland population

SETTING	Risk factors within setting				Likelihood~	Consequence		EVIDENCE
	Worker mobility	Close proximity	Indoor environment	Other infection control measures*		Individuals	Community (outbreak)	

SETTING	Risk factors within setting				Likelihood~	Consequence		EVIDENCE
	Worker mobility	Close proximity	Indoor environment	Other infection control measures*		Individuals	Community (outbreak)	

SETTING	Risk factors within setting				Likelihood~	Consequence		EVIDENCE
	Worker mobility	Close proximity	Indoor environment	Other infection control measures*		Individuals	Community (outbreak)	
Schools and early education *Essential service*	*Moderate educator movement across setting; often cohorted*	*Cohorted groups in classrooms, spread within cohorts likely, gyms, canteens, assemblies*	*Enclosed spaces, classrooms may have improved airflow, outdoor learning*	*Can be impractical in early childhood settings; difficult to enforce*	*Multiple household contacts, widely connected community, children more likely asymptomatic*	*Unvaccinated children; impacts for older unvaccinated teaching staff higher*	*Household transmission, high crossover, family impact*	**QLD** - High transmission between students, staff and families in the Indooroopilly Cluster. - Qld's largest COVID-19 outbreak of 147 cases. In this cluster, 60 cases (40%) were students and 80 cases (54%) were household contacts. **NSW** - More than 270 schools and 300 childcare centres closed due to COVID-19 cases during October 2021; two thirds were primary schools. **National Centre for Immunisation Research and Surveillance (NCIRS) report (September 2021)[x]** - During the recent NSW outbreak (to end July 2021) there was a 5-fold higher rate of transmission (secondary attack rate 4.7%) than in 2020 (secondary attack rate 0.9%) in educational settings—reflective of increased transmissibility of Delta variant. - ECEC services experienced the highest rate of transmission (6.4%), as they remained fully open with high attendance rates. Transmission was highest between ECEC staff members (16.9%) and from an ECEC staff member to a child (8.1%). - High population-level rates of COVID-19 vaccination, including vaccination of school/ECEC staff, are critical. **United States** - The opening of schools contributed to a growth of COVID-19 cases by 5 percentage points—vaccines and mask-wearing in this setting identified as critical[xi] - CDC recommends that all teachers, staff and eligible students be vaccinated as soon as possible[xii]

[i] Australian Health Protection Principal Committee (AHPPC) statement on mandatory vaccination of all workers in health care settings | Australian Government Department of Health
[ii] Hospital-acquired SARS-CoV-2 infection in the UK's first COVID-19 pandemic wave - The Lancet
[iii] Australian Health Protection Principal Committee (AHPPC) statement on mandatory vaccination of aged care in-home and community aged care workers | Australian Government Department of Health
[iv] Australian Health Protection Principal Committee (AHPPC) statement on mandating vaccination for disability support workers | Australian Government Department of Health
[v] COVID-19 Vaccines for People with Disabilities | CDC
[vi] People with Certain Medical Conditions | CDC
[vii] Deaths involving COVID-19 by self-reported disability status during the first two waves of the COVID-19 pandemic in England: a retrospective, population-based cohort study - The Lancet Public Health
[viii] https://www.publicdefenders.nsw.gov.au/Documents/updated-report-impact-of-covid-19-on-nsw-prisoners-september-2021.pdf
[ix] https://jamanetwork.com/journals/jama/fullarticle/2768249
[x] https://www.ncirs.org.au/sites/default/files/2021-09/NCIRS%20NSW%20Schools%20COVID_Summary_8%20September%2021_Final.pdf
[xi] The association of opening K–12 schools with the spread of COVID-19 in the United States: County-level panel data analysis | PNAS
[xii] Guidance for COVID-19 Prevention in K-12 Schools | CDC

Response.Lead

From: Response.Lead.Engagement
Sent: Monday, 6 December 2021 1:08 PM
To: Melanie Nicholls
Cc: Kennedy Ben Shuli; Louise Norman; Julian Roney; Response.Lead.Engagement
Subject: RE: Home/Family daycare vaccine query

Hi Melanie,

Family day cares are captured. So yes, the vaccination requirement will apply in this setting.

Kind regards,
Aimee

Response Lead Engagement
COVID Response Division | Queensland Health

E [redacted]@health.qld.gov.au
W health.qld.gov.au
A 33 Charlotte Street, Brisbane QLD 4000

From: Melanie Nicholls [redacted]@health.qld.gov.au>
Sent: Monday, 6 December 2021 12:44 PM
To: Response.Lead.Engagement [redacted]@health.qld.gov.au>
Cc: Kennedy Ben Shuli [redacted]@health.qld.gov.au>; Louise Norman [redacted]@health.qld.gov.au>; Julian Roney [redacted]@health.qld.gov.au>
Subject: Home/Family daycare vaccine query

Hi all

CALD Community Leaders have been raising queries about whether the newly announced mandate for staff in education settings applies to staff working in Family Day Care arrangements. We have reviewed the information but haven't found anything on this. Family day care arrangements are quite common among some CALD communities, as well as in the broader community.

Melanie

From: Kennedy Ben Shuli <[redacted]@health.qld.gov.au>
Sent: Monday, 6 December 2021 12:33 PM
To: Melissa Bergin [redacted]@health.qld.gov.au>
Cc: Melanie Nicholls [redacted]@health.qld.gov.au>; Julian Roney [redacted]@health.qld.gov.au>
Subject: RE: Home Child care vaccine query

Hi Mel,

Can I please check if you are aware of any information around Childcare vaccine mandate? I wanted to find out if there is any specification of vaccine directive for **Home Childcare**?

The current mandate did not specify for the Home day-care. And I think this can be flagged as a gap in the messaging. Though no specification yet, there is a mention of different settings such as;

- kindergartens
- childcare centres

I checked on education site and they had some FAQ but no mention of home childcare https://alt-qed.qed.qld.gov.au/covid19/frequently-asked-questions

Would you please advise if there is any information that we can share with the community in regards to the home childcare vaccine mandate?

Thanks,
Kennedy

Kennedy Ben Shuli
Disability and Multicultural Health
Social Policy and Legislation Branch
Office of the Director-General & System
Strategy Division | Queensland Health

P 0[redacted] | m: 0[redacted]
E [redacted]@health.qld.gov.au
W health.qld.gov.au
A Level 9, 33 Charlotte Street

Chat with me on Teams!

Queensland Health acknowledges the Traditional Owners of the land, and pays respect to Elders past, present and future.

COVID-19 cases in state schools

Queensland's current COVID-19 response measures have helped to flatten the curve of coronavirus spread and have contributed to our state's continued success in limiting the number of cases and transmission in the community.

Queensland is now seeing very low rates of COVID-19 infection and Queensland schools have commenced a phased return to the classroom. This is based on the latest advice provided by the Australian Health Principal Protection Committee (AHPPC), which has identified schools as safe places for students and a low risk in relation to the spread of COVID-19.

Significant consideration has been given to this phased approach. Queensland Health has worked closely with the Department of Education to plan for this transition and the safety of staff, students and school communities has been at the forefront of all considerations.

On Monday 11 May 2020, Kindy, Prep, Year 1, Year 11 and 12 students returned to their state school or community kindergarten, joining children of essential workers, vulnerable children and children in designated Indigenous communities.

If low COVID-19 transmission rates continue, students in Years 2–10 will return to school from Monday 25 May 2020.

Further information regarding COVID-19 school operations is available here.

Frequently asked questions for parents and carers is available here.

This document outlines the ~~communications~~ processes that need to occur when the school becomes aware that someone has been tested, and also the actions required when they are informed that~~and when~~ a child, staff member, volunteer, parent or carer who has been on a school site in the 14 days prior to testing, is confirmed as positive for COVID-19.

The Queensland Catholic Education Commission and Independent Schools Queensland follow the lead of Department of Education.

Advice for school staff and parents

Evidence from overseas has indicated that far fewer children are affected by COVID-19 compared to adults, the number of transmissions from children to children and children to adults is far less than adult to adult and disease severity is greatest in older adults.

The biggest risk of transmission of COVID-19 in schools is between adults, and many of the arrangements put in place will enable appropriate distancing between the adults in and around school grounds.

The following measures will continue to be in place in schools:

- students and staff who are unwell must not attend school
- physical distancing of 1.5 metres is required by all adults
- adults must not gather in and around school grounds, car parks, school gates and outside classrooms
- parents should use stop, drop and go or similar facilities rather than walking their children into school
- students will engage in regular effective handwashing and hygiene protocols, including regularly washing hands with soap and water or using hand sanitiser and covering coughs and sneezes

- increased cleaning frequencies of high-touch surfaces such as light switches and door handles
- technology such as video conferencing used for gatherings, meetings and assemblies
- school swimming pools remain closed and excursions, camps, trips and interschool activities are postponed at this time.

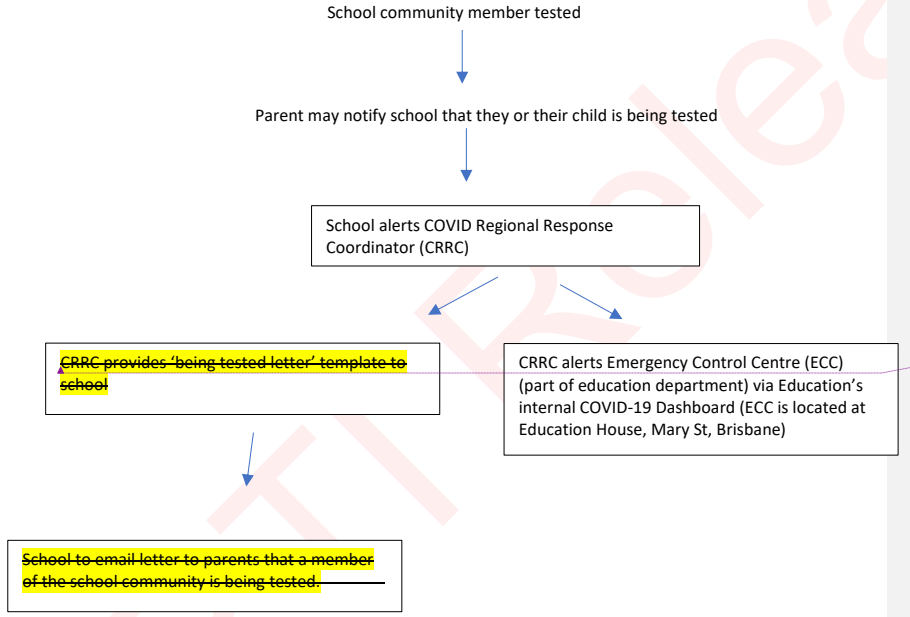
You should also continue to follow the same advice around hygiene to limit the spread of COVID-19.

What happens if there is a confirmed case associated with a school?

In the unlikely event that there is an outbreak of COVID-19 at a school, be assured that Queensland Health has the ability to respond rapidly and thoroughly to limit any transmission.

There are strict protocols in place at schools if a student, staff member, volunteer, parent or carer who has been on-site at a school in the 14 days prior to testing, is confirmed as positive to COVID-19.

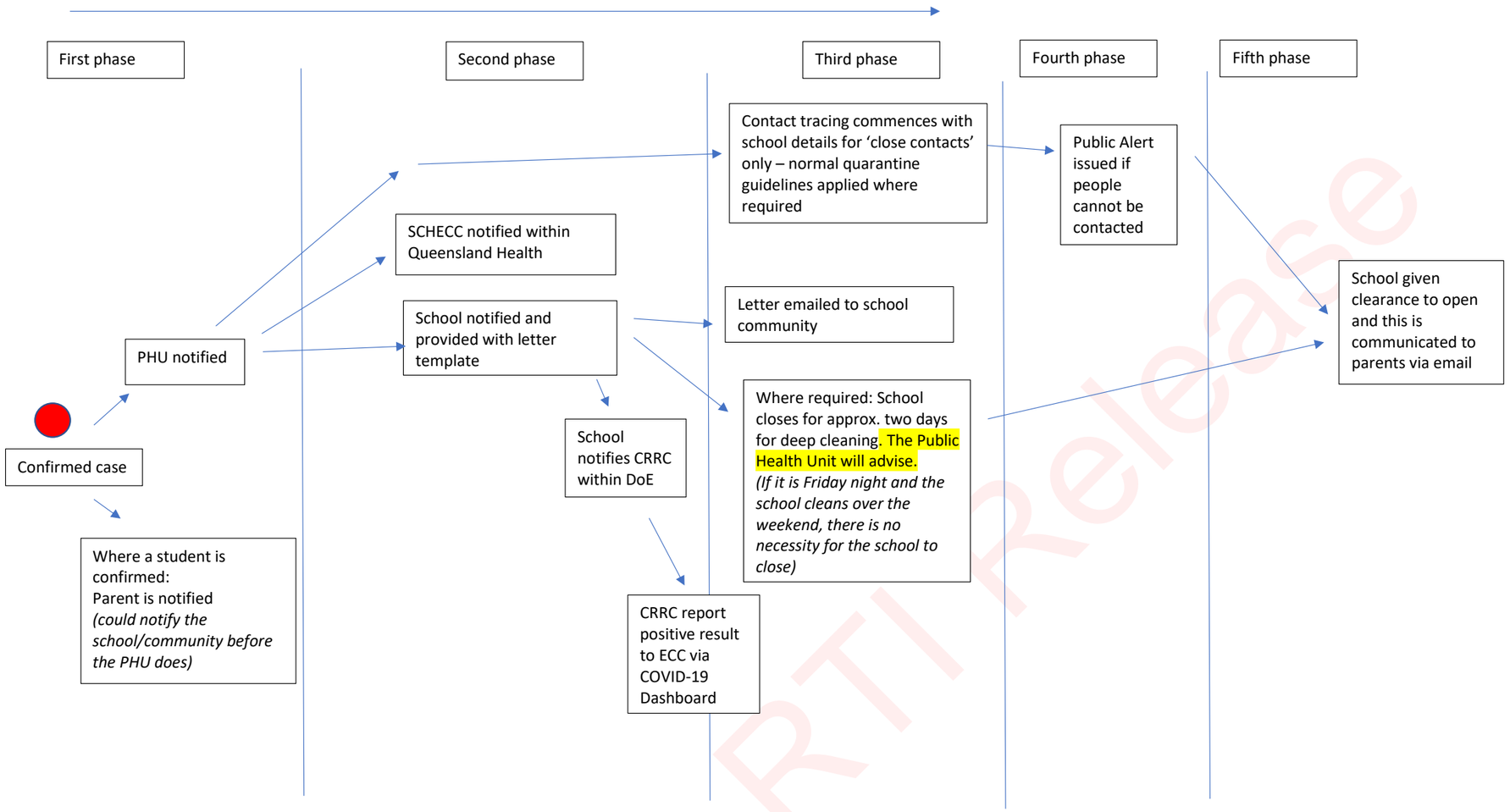
Testing – Department of Education process:



Formatted: Highlight

Query the need for the text in the boxes above. How is this helpful? This action may lead to significant concern in the school community that is unnecessary in the event the test is negative. Also may lead to issues with confidentiality, particularly with the first probable/possible cases. Additionally as the CHO has emphasised anyone with any relevant symptoms should be tested, this action may possibly be a deterrent to people seeking testing.

Identified positive – PHU and DoE process:



Can my immunocompromised child return to school?

If you have concerns about your child's health, you may wish to keep them home. This is okay and your child won't be marked as being absent, rather that they are learning from home.

If you are unsure about whether you should send your child to school, you should check with your doctor.

If you decide to keep your child at home, you will be responsible for them. Children can continue learning by accessing material such as those provided for parents on the learning@home website.

Make sure you let your school know if you choose to keep your child at home, either due to concerns about COVID-19 or if your child is ill for any other reason. When you contact the school you may wish to discuss support available to assist you with your child's learning at home.

Does my child need to present a medical certificate if they have recovered from COVID-19?

If you have self-quarantined for 14 days without any symptoms, you are free to go about your usual activities and return to school.

If your child develops symptoms and is instructed to self-isolate, a healthcare provider will let you know when you are no longer infectious and can return to school.

From: Peter Aitken
Sent: Friday, 10 December 2021 4:51 PM
To: publichealthdirections
Cc: Response.Lead.Engagement; Response Lead - Policy; Lynne McKinlay; James K Smith; CHO COVID
Subject: RE: FOR CHO APPROVAL: COVID- 19 Vaccination Requirements for Workers in a high-risk setting and Home Quarantine for Household Members of an Overseas Traveller

Approved
P

From: publichealthdirections [redacted]@health.qld.gov.au>
Sent: Friday, 10 December 2021 4:31 PM
To: Peter Aitken [redacted]@health.qld.gov.au>
Cc: Response.Lead.Engagement <[redacted]@health.qld.gov.au>; Response Lead - Policy [redacted]@health.qld.gov.au>; publichealthdirections [redacted]@health.qld.gov.au>; Lynne McKinlay [redacted]@health.qld.gov.au>; James K Smith [redacted]@health.qld.gov.au>; CHO COVID [redacted]@health.qld.gov.au>
Subject: FOR CHO APPROVAL: COVID- 19 Vaccination Requirements for Workers in a high-risk setting and Home Quarantine for Household Members of an Overseas Traveller

Afternoon Dr Aitken,

Please find attached:

- COVID- 19 Vaccination Requirements for Workers in a High-Risk Setting Direction
- Home Quarantine for Household Members of an Overseas Traveller Direction.

Note that we have not yet received DPC endorsement for these Directions, but at officer level we have been advised that they don't expect to have any feedback.

Also attached for each direction is a human rights statement and policy rationale.

The COVID- 19 Vaccination Requirements for Workers in a High-Risk Setting Direction will:

- Require workers in a high-risk setting to be vaccinated, unless they have a medical contraindication or are participating in a clinical COVID-19 vaccine trial. High-risk settings include early childhood, primary and secondary education settings, youth detention centres, police watch houses, prisons and airports.
- Require workers at high-risk settings must be vaccinated unless the person
    - a medical contraindication or
    - is participating in a clinical trial
    - is away from the occupied part of the high-risk setting, and has separate access
    - works when the high risk setting is not occupied by users or workers of the high-risk setting (for example, a school that privately hires out its hall or tennis courts).
- Workers who have a medical contraindication are required to undertake a daily PCR test.
- Allow an unvaccinated worker to work at the high-risk setting if there is a critical workforce shortages for a maximum period of one month. An unvaccinated worker will need to undertake a PCR test before starting work each day.
- Allow an unvaccinated worker to work at the high-risk setting if there is a critical support need. The person will need to undertake a PCR test within 24 hours of entering the high- risk setting.
- Allow unvaccinated people to enter for law enforcement and to respond to an emergency
- Requires employees to keep a record of workers vaccination status
- Commence on publication

The Home Quarantine for Household Members of an Overseas Traveller Direction will:

For your consideration and approval.

Kind regards,

Prue

From: publichealthdirections
Sent: Friday, 10 December 2021 6:57 PM
To: Peter Aitken
Cc: Response.Lead.Engagement; Response Lead - Policy; publichealthdirections; Lynne McKinlay; James K Smith; CHO COVID; SCB-Coronavirus
Subject: FW: FOR CHO APPROVAL: COVID- 19 Vaccination Requirements for Workers in a high-risk setting and Home Quarantine for Household Members of an Overseas Traveller
Attachments: CHO PHD COVID-19 Vaccination Requirements for Workers in a high risk setting Direction_v4.docx

Dear Dr Aitken,

Please find attached for your re-approval, an updated *Vaccination Requirements for Workers in a High-Risk Setting Direction.*

The amendment is at paragraph 28.

Kind regards,

Prue

From: publichealthdirections
Sent: Friday, 10 December 2021 4:31 PM
To: Peter Aitken [redacted]@health.qld.gov.au>
Cc: Response.Lead.Engagement [redacted]@health.qld.gov.au>; Response Lead - Policy [redacted]@health.qld.gov.au>; publichealthdirections [redacted]@health.qld.gov.au>; Lynne McKinlay [redacted]@health.qld.gov.au>; James K Smith [redacted]@health.qld.gov.au>; CHO COVID <[redacted]@health.qld.gov.au>
Subject: FOR CHO APPROVAL: COVID- 19 Vaccination Requirements for Workers in a high-risk setting and Home Quarantine for Household Members of an Overseas Traveller

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- Home Quarantine for Household Members of an Overseas Traveller Direction.

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- Require workers at high-risk settings must be vaccinated unless the person
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- Allow an unvaccinated worker to work at the high-risk setting if there is a critical support need. The person will need to undertake a PCR test within 24 hours of entering the high- risk setting.
- Allow unvaccinated people to enter for law enforcement and to respond to an emergency
- Requires employees to keep a record of workers vaccination status
- Commence on publication

The Home Quarantine for Household Members of an Overseas Traveller Direction will:

[redacted]

For your consideration and approval.

Kind regards,

Prue

Direction from Chief Health Officer in accordance with emergency powers arising from the declared public health emergency

COVID-19 Vaccination Requirements for Workers in a high-risk setting Direction

Public Health Act 2005 (Qld)
Section 362B

On 29 January 2020, under the *Public Health Act 2005*, the Minister for Health and Minister for Ambulance Services made an order declaring a public health emergency in relation to coronavirus disease (COVID-19). The public health emergency area specified in the order is for 'all of Queensland'. Its duration has been extended by regulation to 26 March 2022 and may be further extended.

Further to this declaration, I, Dr Peter Aitken, Chief Health Officer, reasonably believe it is necessary to give the following directions pursuant to s362B of the *Public Health Act 2005* to assist in containing, or to respond to, the spread of COVID-19 within the community.

Guidance

This public health direction applies to workers who enter, work in, or provide services in a high-risk setting. The direction defines how a high-risk setting is identified by the Chief Health Officer and specifies the COVID-19 vaccination requirements and related obligations for workers and employers operating in a high-risk setting. The direction recognises that an employer may mandate vaccination for employees, where otherwise permitted at law, based on the requirements of a role.

Preamble

1. This Public Health Direction applies to ***workers*** in settings where there is:
   (a) a high risk of transmission of the COVID-19 virus; or
   (b) the setting is used by a large number of vulnerable persons; or
   (c) a sudden reduction in available workforce due to COVID-19 cases or quarantine would significantly affect the continuity of critical services resulting in potential consequential public health and safety risks to the community.
2. This Public Health Direction supplements existing public health directions already made to contain or respond to the spread of COVID-19 by mandating vaccination of workers in healthcare settings, in quarantine facilities and in vulnerable facilities. Nothing in this public health direction reduces the requirements of those public health directions.

3. Separately from the requirements of Public Health Directions, under sections 362G and 362H of the *Public Health Act 2005*, an ***emergency officer (public health)*** can require a person to comply with additional directions if the emergency officer believes it is reasonably necessary to assist in containing, or to respond to, the spread of COVID-19 in the community.

Citation

4. This Public Health Direction may be referred to as the *COVID-19 Vaccination Requirements for Workers in a High-Risk Setting Direction.*

Commencement

5. This Public Health Direction applies from time of publication commences until the end of the declared public health emergency, unless it is revoked or replaced.

Application

6. This Public Health Direction applies to ***workers*** in a ***high-risk setting*** in the public, private and non-government sectors, and identifies the COVID-19 vaccination and related requirements for ***workers***, ***employers*** and ***responsible persons*** in ***high risk settings***.
7. This Public Health Direction does not apply to people who visit the ***high-risk setting*** to access or use its services, either for themselves or as a support person for someone else.
8. The requirements of this public health direction prevail where a ***worker*** is required to be vaccinated under this direction, and another public health direction also applies to the ***worker*** but does not require the worker to be vaccinated. The ***worker*** must comply with the ***COVID-19 vaccination requirements*** for ***workers*** in a ***high-risk setting***.

PART 1 —WORKERS IN A HIGH-RISK SETTING

Worker

9. A ***worker*** must not enter and remain in, work in, or provide services in a ***high-risk setting*** unless the ***worker*** complies with the ***COVID-19 vaccination requirements*** in paragraph 17.

   Examples: a contractor, union official, regulator, auditor, courier, performer, or sales representative must comply with the COVID-19 vaccination requirements to work in a ***high-risk setting*** *even though they may only occasionally enter the setting as part of their work duties.*

10. An ***employer*** whose employees or contractors work in a ***high-risk setting*** must notify ***workers*** of the ***COVID-19 vaccination requirements*** and take all reasonable steps to ensure that a ***worker*** does not enter and remain in, work in, provide services or volunteer in a ***high-risk setting*** if the person does not meet the ***COVID-19 vaccination requirements*** or have a ***medical contraindication*** for ***COVID-19 vaccines.***

High-risk setting

11. A ***high-risk setting*** is a service, business or activity declared to be a ***high-risk setting*** by the Chief Health Officer in ***Schedule 2***.

12. Despite paragraph 11, if part of a ***high-risk setting*** is not ***co-located*** and meets the requirements in paragraph 13, a person engaged or employed to undertake work in that part of the ***high-risk setting*** is not subject to ***COVID-19 vaccination requirements***.

13. For paragraph 12 to apply, the part of a ***high-risk setting*** must:

    (a) be unoccupied by users and ***workers*** of the ***high-risk setting***; and

    (b) be physically separate from the occupied part of the ***high-risk setting*** or be secured and delineated so that users and ***workers*** of the ***high-risk setting*** cannot enter; and

    (c) not have shared points of access with the users and ***workers*** of the ***high-risk setting***; and

    (d) not be accessed by a person who uses the facilities (for example, toilets or lunchroom) in the ***high-risk setting***.

    Examples: Construction works on a free standing building not connected to an occupied high risk setting (new build or refurbishment) or installation of a modular building at a school or health campus

14. In addition to paragraph 13, if a person engaged or employed to undertake work in that part of the ***high-risk setting*** enters the occupied ***high-risk setting,*** the person must comply with the ***COVID-19 vaccination requirements.***

15. Despite paragraph 11, when a ***high-risk setting*** is not occupied by users and ***workers*** of the ***high-risk setting***, the ***COVID- 19 vaccination requirements*** do not apply.

    Example: If a school hall which is hired out on the weekends for taekwondo lessons, the taekwondo instructor does not need to meet the COVID- 19 vaccination requirements.

16. The ***responsible person*** for a ***high-risk setting*** must take reasonable steps to notify ***employers*** and ***workers*** in the ***high-risk setting*** of the ***COVID-19 vaccination requirements.***

*Note: a sole trader may be a **responsible person**, an **employer** and a **worker**.*

PART 2 —COVID-19 VACCINATION REQUIREMENTS

17. The ***COVID-19 vaccination requirements*** are that:

    (a) by 17 December 2021, a ***worker*** in a ***high-risk setting*** has received the first dose of a ***COVID-19 vaccine***; and

    (b) by 11.59pm AEST on 23 January 2022, a ***worker*** in a ***high-risk setting*** has received the prescribed number of doses of a ***COVID-19 vaccine***; and

    (c) as soon as reasonably practicable after each dose of the ***COVID-19 vaccine***, the ***worker*** must show evidence of having received the ***COVID-19 vaccine*** dose as provided in paragraph 19.

18. A ***worker*** in a ***high-risk setting*** must show evidence of having received the ***COVID-19 vaccine***:

(a) to their ***employer*** - where the ***worker*** is employed or engaged by, or volunteers for, a person who operates a business, activity or undertaking within a ***high-risk setting*** or who provides services or ***workers*** to the ***responsible person*** to work in the ***high-risk setting***; or

(b) to the ***responsible person*** - where the ***worker*** is employed or engaged by, or volunteers for, the ***responsible person*** for the ***high-risk setting***; or

(c) to the ***responsible person*** for the ***high-risk setting*** - where the ***worker*** is engaged directly or indirectly, including as a volunteer, to provide support or assistance to a student or to a prisoner or detainee at a ***high-risk setting***.

Examples:

Employees who work at an airport must be vaccinated and show evidence of their vaccination to their employer, for example an operator of a car rental agency.

A volunteer at an independent school must be vaccinated and must show evidence of their vaccination to the school Principal.

19. Evidence of ***COVID-19 vaccination*** (printed or electronic) includes:

(a) written confirmation of ***COVID-19 vaccination*** provided to the person as part of the vaccination process, such as a record of vaccine card; or

(b) vaccination information displayed on the Check in Qld app; or

(c) a COVID-19 digital certificate or printed vaccination certificate from the Australian Immunisation Register; or

(d) an online or printed immunisation history statement for ***COVID-19 vaccination***, including confirmation of a ***medical contraindication***; or

Note: A visitor's immunisation history statement can be obtained from the Australian Government using myGov, the Medicare mobile app or by calling the Australian Immunisation Register and requesting a statement to be posted.

*Note: If a person is unable to receive a **COVID-19 vaccination** because of a medical contraindication, they must provide* evidence of a ***medical contraindication.***

(e) an ***International COVID-19 Vaccination Certificate***:

(i) in a printed or electronic form from the Department of Home Affairs that confirms completion of an Australia Travel Declaration and vaccination against COVID-19 overseas; or

(ii) through Medicare online account through myGov or the Medicare mobile app; or

(iii) an official record of vaccination provided to the person when vaccinated against COVID-19 overseas.

PART 3 —EXCEPTIONS

Medical contraindication

20. Paragraph 9 does not apply to a ***worker*** who is unable to be vaccinated due to a ***medical contraindication*** where the ***responsible person*** for the ***high-risk setting***:

(a) assesses the risk to other staff, clients and other persons at the ***high-risk setting***; and

(b) the ***worker*** undertakes a ***COVID-19 PCR test*** before starting work each day and provides a negative test result to the ***responsible person*** for the ***high-risk setting*** as soon as reasonably practicable after the result is received; and

(c) the ***worker*** uses personal protective equipment as required by the ***responsible person*** for the ***high-risk setting***.

Note: results of the daily PCR test may not be available before the worker's shift starts and can be provided to the employer on a rolling basis when the results are received.

21. A ***worker*** in a ***high-risk setting*** to whom paragraph 20 applies must provide evidence of the ***medical contraindication***.

*Note: evidence of **medical contraindication** is a digital or paper COVID- 19 vaccine medical exemption recorded on the Australian Immunisation Register, or an Australian Immunisation Register immunisation medical exemptions form completed and signed by an eligible health professional for the COVID- 19 vaccine .*

22. Where the person has a temporary ***medical contraindication*** for being unable to receive the COVID-19 vaccination, paragraph 20 only applies for the period specified. If the ***medical contraindication*** continues beyond the specified period, the person must provide new evidence of a continuing ***medical contraindication*** or of their ***COVID-19 vaccination*** to comply with the ***COVID-19 vaccination requirements***.

Clinical trial

23. Paragraph 9 does not apply to a ***worker*** in a high-risk setting where:

(a) the ***worker*** is a participant in a ***COVID-19 vaccine trial;*** and

(b) the responsible ***person*** for the ***high-risk setting*** assesses the risk to other staff, users, clients and other persons in the high-risk setting and determines that the ***worker*** may continue to work in the ***high-risk setting.***

24. A ***worker*** in a ***high-risk setting*** to whom paragraph 23 applies must notify the ***responsible person*** for the ***high-risk setting*** as soon as reasonably practicable upon completion of their participation in a ***COVID-19 vaccine trial.***

25. The exception provided in paragraph 23 ceases to apply upon the earlier of:

(a) the trial COVID-19 vaccine being recognised by the Therapeutic Goods Administration; or

(b) the trial COVID-19 vaccine being approved for use in Australia by the Therapeutic Goods Administration; or

(c) the trial COVID-19 vaccine being rejected for use in Australia by the Therapeutic Goods Administration.

Responding to Critical Workforce Shortages

26. The ***responsible person*** for a ***high-risk setting*** may permit an ***unvaccinated worker*** to enter, work in, or provide services in the ***high-risk setting***, for a maximum period of one month until the critical workforce issue can be resolved, if:

(a) the responsible person has assessed the risk to other persons accessing the ***high-risk*** setting; and

(b) the ***responsible person*** reasonably believes it is necessary to respond to a ***critical workforce shortage*;** and

(c) personal protective equipment is used by the ***worker*** in the ***high-risk setting*** as required by the ***responsible person*** or the ***employer***; and

(d) the ***unvaccinated worker*** in the ***high-risk setting*** undertakes a ***COVID- 19 PCR test*** before starting work each day, and the test results are provided to the ***employer*** as soon as reasonably practicable after the ***worker*** receives the test result.

*Note: An **unvaccinated** worker in a **high-risk setting** may enter, work in, or provide services in a **high-risk setting** to respond to a **critical workforce shortage** while workers who meet the **COVID-19 vaccination requirements** are recruited or alternative arrangements are made to respond to the **critical workforce shortage**.*

Responding to Critical Support Needs

27. An ***unvaccinated worker*** is permitted to enter, work in, or provide services in the ***high-risk setting***, to provide support to a client or user of the ***high-risk setting***, for mental health or well-being and for legal or advocacy services, if:

(a) the ***responsible person*** has assessed the risk to other persons in the ***high-risk setting***; and

(b) the ***responsible person*** reasonably believes it is necessary to provide health, wellbeing, legal or advocacy support to a ***vulnerable person*** at the ***high-risk setting*;** and

(c) personal protective equipment is used by the ***unvaccinated worker*** in the ***high-risk setting*** ; and

(d) where the ***worker*** enters the ***high-risk setting*** for a single visit, a ***COVID-19 PCR test*** is undertaken by the ***unvaccinated worker*** within 24 hours of entry, and

(e) where the ***worker*** enters the ***high-risk setting*** on multiple consecutive days, a ***COVID-19 PCR test*** is undertaken by the ***unvaccinated worker*** before entering the ***high-risk setting*** each day, and the test results provided to the ***responsible person*** for the ***high-risk setting*** as soon as reasonably practicable when received.

Example: *an unvaccinated mental health support worker regularly provides support to a prisoner in a corrective services facility. The prisoner relies on continuity and face to face contact for their mental health and wellbeing and their health outcomes would be adversely impacted by a change in support arrangements.*

Emergency entry to high risk settings

28. An ***unvaccinated worker*** may enter a ***high-risk setting*** for any of the following purposes, and paragraph 9 does not apply:

(a) to respond to an emergency; or

(b) to undertake a legislated regulatory function; or

(c) as part of official union duties.

Examples: a contractor, who is not vaccinated, enters a school during school hours to fix flooding in the toilet block.

*There is a salmonella outbreak at a high-risk setting and an environmental health officer may investigate the setting, regardless of whether the person meets the **COVID-19 vaccination requirements** or is **unvaccinated**.*

29. An ***unvaccinated worker*** must advise the ***responsible person*** for the ***high-risk setting*** of the emergency entry and of their vaccination status as soon as is reasonably practicable. Use of the Check In Qld app will satisfy the requirements of this paragraph.

    Example: *an unvaccinated firefighter enters a school on a weekend, when the school is empty and locked up, in response to a fire alarm. The fire alarm is a false alert and the firefighter checks in to the school using their Check In Qld app. No further notification is required for the purposes of this public health direction (although other notifications to the school may be required).*

Entry to high risk settings for law enforcement

30. Where the ***responsible person*** for a ***high-risk setting*** is satisfied that a worker is entering for the purposes of law enforcement and disclosure of their compliance with the ***COVID-19 vaccination requirements*** is inconsistent with the law enforcement function, the ***responsible person*** may permit the ***worker*** to enter and remain in the ***high-risk setting*** without showing evidence of ***COVID-19 vaccination***, ***medical contraindication***, or of being a ***COVID-19 vaccine trial participant*** and the ***responsible person*** is not required to record details in relation to the ***worker***.

PART 4 – RECORD KEEPING REQUIREMENTS

31. An ***employer*** must:

    (a) keep a record of the COVID-19 vaccination status, the type of ***proof of COVID-19 vaccination, evidence of a medical contraindication,*** or evidence of being a ***COVID-19 vaccine trial participant*** for each ***worker***; and

    (b) if requested, provide the information collected under paragraph 31(a) to a ***public health officer***.

. PART 5 —OTHER MATTERS

32. Nothing in this public health direction prevents an employer from making a lawful direction requiring an employee to be vaccinated for COVID-19 where the employer has determined it is a requirement of the employee's role.

33. Nothing in this Public Health Direction prevents a ***worker*** who does not meet the ***COVID-19 vaccination requirements*** from entering or using the services of a ***high-risk setting*** as a client, or visitor or to accompany a person who uses the services of a ***high-risk setting***.

    Example: an unvaccinated plumber can only work on a school premises in an emergency, but can attend parent activities at the school. A relief teacher must meet the vaccination requirements to continue to work at a school, but may attend parent teacher interviews as a parent if unvaccinated, or other parental responsibilities.

PART 6 — DEFINITIONS

34. Definitions used in this Direction are in Schedule 1.

PART 7 — PENALTIES

A person to whom the direction applies commits an offence if the person fails, without reasonable excuse, to comply with the direction.

Section 362D of the *Public Health Act 2005* provides:

Failure to comply with public health directions

> A person to whom a public health direction applies must comply with the direction unless the person has a reasonable excuse.
> Maximum penalty—100 penalty units or 6 months imprisonment.

Dr Peter Aitken
Chief Health Officer
XX December 2021
Published on the Queensland Health website at xx:xx am/pm

SCHEDULE 1 - Definitions

For the purposes of this Public Health Direction:

Airport precinct means the:

- airport terminals; and
- outdoor passenger areas such as passenger transport areas including terminal car parks and taxi ranks; and
- areas where interstate or international freight or goods are unloaded, screened, processed or transferred.

Co-located means using shared facilities and staff and users of the high-risk setting move freely between the co-located functions or settings.

Example: a regional high school and a TAFE are co-located in a regional town. TAFE educators attend the high school to deliver some classes and high school students attend the TAFE facilities for some of their training. The educational settings share workshops and common areas. Workers in the TAFE that is co-located with the high school must comply with the COVID-19 vaccination requirements.

Example: part of a school's grounds are fenced off while construction of a gym is undertaken. While the construction work progresses, school staff and students are excluded from the construction site and the construction company has control of the site. The construction site is not co-located with the school and is not subject to the COVID-19 vaccination requirements that apply to the ***high-risk setting****.*

Corrective services facilities visitor means any visitor to a corrective services facility other than a personal visitor as defined In the *Corrective Services Act 2006.*

COVID-19 PCR test means tested for COVID-19 with an oropharyngeal and deep nasal swab for polymerase chain reaction (PCR) testing, but does not include a self-test.

COVID-19 vaccination requirements see paragraph 17.

COVID-19 vaccine is a vaccine for COVID-19 that is approved for use in Australia or recognised by the Therapeutic Goods Administration.

COVID-19 vaccine trial means a medical trial for a COVID-19 vaccine under either the Clinical Trial Notification or Clinical Trial Approval schemes regulated by the Therapeutic Goods Administration.

COVID-19 vaccine trial participant means a person who:

(a) is an active participant in a ***COVID-19 vaccine trial***; and

(b) provides a medical certificate or letter from a medical practitioner, registered under the *Health Practitioner Regulation National Law (Queensland)* associated with the ***COVID-19 vaccine trial*** confirming that:

  (i) the ***worker*** is participating in a Phase 3 or 4 ***COVID-19 vaccine trial***; and

  (ii) the ***worker*** has received at least one active dose of the COVID-19 vaccine being trialled.

Critical workforce shortage means a sustained workforce shortage in a ***high-risk setting*** that the ***responsible person*** for the ***high-risk setting*** considers may directly and significantly compromise the health or safety of other persons within the ***high-risk setting*** or the delivery of essential services to users of the ***high-risk setting***.

*Example: A critical workforce shortage may be a shortage of more than 10 per cent of staff for a sustained period of 7 days or more, however this will depend on the size of the **high-risk setting,** baseline staffing levels (including rostering arrangements and relief pool arrangements), and will depend on the nature and extent of the operational impacts on a vulnerable cohort.*

Eligible health professionals means any of the following:

- fellows of the Royal Australian College of General Practitioners (as defined by the *Health Insurance Act 1973 Cth*); or
- fellows of the Australian College of Rural and Remote Medicine (as defined by the *Health Insurance Act 1973 Cth)*; or
- on Medicare's Vocation Register of General Practitioners (as defined by the *Health Insurance Act 1973 Cth)*; or
- practice registrar on an approved 3GA training placement; or
- paediatrician; or
- public health physician; or
- infectious diseases physician; or
- clinical immunologist.

Emergency officer (public health) means an emergency officer appointed under the *Public Health Act 2005*.
*Note: Emergency officers appointed under the Public Health Act 2005 include **public health officers** and police.*

Employer means a person, or other legal entity that employs or otherwise engages a ***worker***.

High-risk setting is a type of service, business or activity declared to be a ***high-risk setting*** by the Chief Health Officer in ***Schedule 2***.

Medical contraindication means a temporary or permanent contraindication that is notified to the Australian Immunisation Register (AIR) by an ***eligible health professional*** completing an ***Australian Immunisation Register (AIR) immunisation medical exemptions form*** in relation to a person, and recorded on the person's Immunisation History Statement (IHS).

***Note:** a temporary vaccine exemption may apply until a specified date due to acute major illness, significant immunocompromise of short duration and recognised overseas vaccination.*

Responsible person for a ***high-risk setting*** means the person who is legally responsible for the setting, including in relation to compliance with regulatory and other requirements for the setting.

Example: the Principal of a school may be the responsible person; the Director General is the responsible person for a government department; a chief executive or Board Chair is the responsible person for a not for profit organisation. The responsible person may also be the employer.

Unvaccinated worker** means a person who does not meet the **COVID- 19 vaccination requirements.

Visitor means any person who enters a high-risk setting other than a ***worker*** and does not include a ***corrective services facility visitor.***

Vulnerable person means a person who is ineligible or unable to be vaccinated for COVID-19 because of their age or a ***medical contraindication***, or a person with underlying medical conditions that place them at greater risk of adverse impacts from COVID-19 even if they are vaccinated.

Example: children under the eligible age limit for COVID-19 vaccination; children who are immunocompromised or undergoing treatment that affects the efficacy of the vaccine; residents in residential aged care facilities; people with disabilities; patients in hospitals.

Worker includes a person who:

(a) is employed at a ***high-risk setting*** on a part-time, casual or full-time basis; or
(b) is a government employee whose duties involve attendance at a ***high-risk setting***; or
(c) undertakes work, whether paid or unpaid, at the ***high-risk setting***; or
(d) is a contractor providing services to or at the ***high-risk setting***; or
(e) is a ***corrective services facility visitor***; or
(f) is attending the high-risk setting in the context of duties relating to the administration, regulation, governance, managerial oversight, or legal framework relating to the ***high-risk setting***; or
(g) is a performer, presenter or other specialist entering the ***high risk setting*** as part of delivering an activity, function or event; or
(h) is a volunteer delivering a service in the ***high-risk setting***; or
(i) is undertaking a work placement related to an enrolled course of study

Examples: a contractor, union official, regulator, auditor, courier, performer, school crossing person, or sales representative must comply with the COVID-19 vaccination requirements to work in a high risk setting even though they may only occasionally enter the setting as part of their work duties.

Note: A worker who visits a high-risk setting as an incidental part of their duties but is not providing services within the high-risk setting, such as a delivery driver or taxi driver is not a worker at a high-risk setting.

SCHEDULE 2 – High-risk settings

High-risk settings
Early childhood, primary and secondary educational settings including: • schools and outdoor education facilities • other education facilities, including TAFE, that are ***co-located*** with a school • outside school hours care and vacation care • kindergartens, registered and licensed early childhood settings and family daycare providers

From: Response Lead - Policy
Sent: Friday, 10 December 2021 1:55 PM
To: publichealthdirections
Cc: Rachel Vowles; Kyle Fogarty; Response Lead - Policy; Daniel Williamson; CHO COVID; Lynne McKinlay
Subject: RE: FOR URGENT DCHO ENDORSEMENT: COVID- 19 Vaccination Requirements for Workers in a high-risk setting and Quarantine for
Attachments: Policy Rationale_Workers in high risk setting (COVID-19 vaccination requirements) Direction_DRAFT.docx

Hi Prue

As requested, please find attached updated draft PR for high-risk settings (updates highlighted in yellow).

As per standard process, we understand you will seek ODG / CHO approval as part of the broader package.

Kind regards
Denise.

Queensland Government

Denise Brown
Response Lead – Policy
COVID Response Division | Queensland Health

P [redacted]
E [redacted]@health.qld.gov.au
W health.qld.gov.au
A L9, 33 Charlotte Street, Brisbane, QLD 4000

Queensland Health acknowledges the Traditional Owners of the land, and pays respect to Elders past, present and future.

From: publichealthdirections [redacted]@health.qld.gov.au>
Sent: Friday, 10 December 2021 11:54 AM
To: Lynne McKinlay <[redacted]@health.qld.gov.au>
Cc: Rachel Vowles [redacted]@health.qld.gov.au>; Kyle Fogarty [redacted]@health.qld.gov.au>; CHO COVID <[redacted]@health.qld.gov.au>; Response Lead - Policy [redacted]@health.qld.gov.au>
Subject: FOR URGENT DCHO ENDORSEMENT: COVID- 19 Vaccination Requirements for Workers in a high-risk setting and Quarantine for

Morning Lynne,

Please find attached the:

- COVID- 19 Vaccination Requirements for Workers in a High-Risk Setting
- Home Quarantine for Household Members of an Overseas Traveller Direction.

The COVID- 19 Vaccination Requirements for Workers in a High-Risk Setting will:

- Require workers in a high-risk setting to be vaccinated, unless they have a medical contraindication or are participating in a clinical COVID-19 vaccine trial
- High-risk settings include early childhood, primary and secondary education settings, youth detention centres, police watch houses, prisons and airports.
- Workers at high-risk settings must be vaccinated. Exceptions to this is are:
    - if the person has a medical contraindication or
    - is participating in a clinical trial
    - is away from the occupied part of the high-risk setting, and has separate access
    - is if the high-risk setting is not occupied by users or workers of the high-risk setting (for example, a school that privately hires out its hall or tennis courts).

The Home Quarantine for Household Members of an Overseas Traveller Direction will:

Kind regards,

Prue

COVID-19 Public Health Rationale
COVID-19 Vaccination Requirements for Workers in a high-risk setting Direction

10 DECEMBER 2021

DRAFT NOT GOVERNMENT POLICY

Overarching intent

The overarching intent of the *Workers in high-risk settings (COVID-19 Vaccination Requirements) Direction* (the Direction) is to protect the health of the community and workers in identified high-risk settings for COVID-19, reduce the risk of COVID-19 transmission and outbreaks and safeguard the provision of critical services in Queensland. The Direction sets out mandatory COVID-19 vaccination requirements for workers in high-risk settings, and extends to other persons who work as a volunteer, contractor, student, whether employed by the responsible person for the setting or performing the work under another arrangement. The Direction states that by 23 January 2022, workers must have received their second dose of a TGA approved COVID-19 vaccine to enter, work in, or provide services in a high-risk setting.

By mandating COVID-19 vaccination for workers in this way, the risk of COVID-19 transmission within high risk settings and into the Queensland community is reduced. This Direction builds on existing COVID-19 vaccine mandates for workers in healthcare and other related high-risk settings, like quarantine facilities.

In the current iteration of the Direction, the following settings are identified as high-risk:

- Schools and early education
- Correctional and detention facilities (including youth detention)
- Airports

A risk analysis for these settings is described in this rationale, and summarised in Table 2 at the end of this document. The Direction complements existing mandatory vaccination requirements in other Queensland Public Health Directions. The policy position aligns with mandates in place in nearly all Australian jurisdictions, as outlined in Table 1 at end of this document. This Direction is deliberately broad and will allow for additional high-risk settings to be declared going forward.

Where a worker at an identified setting is captured under an existing COVID-19 vaccine requirement (such as healthcare workers), this Direction does not extend the timeframes for these cohorts.

Agency and sector engagement for this Direction occurred with relevant areas within Government, including the Department of Education, Department of Communities, Youth Justice and Multicultural Affairs and Queensland Corrective Services. A range of external stakeholders were also engaged, including tourism and aviation representatives, including major airports and airlines. Feedback on the policy and approach was consistently supportive.

Broadening existing COVID-19 vaccination mandates to workers across a wider range of high-risk settings enhances protection against COVID-19 across Queensland and creates a uniform standard of protection for workers and the community.

Background and rationale at 10 December 2021

Queensland's response to the COVID-19 pandemic has been very successful to date. Large scale outbreaks in Queensland have been prevented with a rapid and decisive public health response. The emergence of the Delta variant early this year and its rapid spread around the globe changed the COVID-19 context and led to widespread outbreaks around the world. Nationally almost every State and Territory

in Australia has faced local transmission of the Delta variant and New South Wales (NSW) and Victoria (VIC) experienced widespread and sustained outbreaks of COVID-19 from June 2021.

Effective vaccines for COVID-19 that prevent severe illness and reduce transmission for current variants are now widely available and endorsed by Australia's Therapeutic Goods Administration (TGA). Queensland Health is strongly encouraging and promoting COVID-19 vaccination state-wide. High vaccination coverage is essential to protect the community, the health system, and the economy.

Prior to COVID-19, immunisation programs have been able to successfully achieve 'herd immunity' for many deadly diseases, including measles and pertussis (whooping cough). True herd immunity means enough of the population is immunised that vulnerable groups who cannot be vaccinated are safe from disease. It has become apparent that herd immunity may not be possible with COVID-19, and particularly the Delta variant, because of its highly infectious nature, breakthrough infections among vaccinated people, and emerging evidence of waning vaccine derived immunity after as little as six months.

The protective potential of vaccination against COVID-19 at a population level is also affected by differential vaccine uptake rates among cohorts or in some communities. This is particularly problematic for settings where vulnerable people are present, or where there is an increased risk of rapid and widespread transmission.

In response and to maximise baseline protection, COVID-19 vaccine mandates for workers, and in some cases, visitors to a setting, are becoming more common both in Australia and globally. These mandates support uniform protective coverage in settings that are higher risk for workers and the community. Vaccine mandates are widely accepted and are a safe, low-impost and high impact way of reducing the risk of COVID-19 transmission, illness, and death.

Vaccination for workers has been mandated by a number of industries that are impacted by COVID-19 exposure, including airlines (like Qantas and Jetstar; cabin crew, pilots and airport workers by November 15 and all other employees by March 31 2022) and mining corporations like BHP (all workers and people entering BHP coal mines from January 2022). On 23 October 2021, Woolworths and Aldi announced that all staff across Australia will be required to be vaccinated for COVID-19 (applying from 31 March 2022 for Queensland).

As Queensland transitions to an environment where COVID-19 is endemic, it is inevitable that every Queenslander will eventually be exposed to COVID-19.

High vaccination coverage among workers in settings with the potential for exposure to COVID-19, particularly those serving vulnerable cohorts, will be a key determinant of health outcomes for Queenslanders and the impact of COVID-19 across the State.

With effective and safe vaccines, the public health response can begin to shift away from widespread restrictive social measures and limits on business (like density and gathering limits), and towards population vaccination coverage as a more enduring protection of public health.

Current vaccine mandates

Mandates in healthcare, quarantine and critical services

In Queensland, aligned with National Cabinet and AHPPC endorsed recommendations, vaccination against COVID-19 is currently a requirement for workers in the following high-risk settings:

- Hospitals and healthcare settings
- Queensland Health residential aged care facilities
- Hotel quarantine facilities

Vaccination against COVID-19 has also been mandated for all employees of the Queensland Police Service (QPS) by the Queensland Police Commissioner. This mandate was based on the rationale that COVID-19 challenges the ability of QPS to fulfil its policing role, and rapid transmission of COVID19

through the QPS would take police officers and staff members out of service while they undertake quarantine periods or recover from COVID-19. Reduced availability of police officers and staff members for deployment could threaten the ability of the QPS to serve the community.

All Australian jurisdictions have introduced mandatory vaccination requirements for healthcare workers across the public and private health sectors.

Mandates for public venues to support reopening borders

On 9 November 2021, the *Public Health and Social Measures linked to Vaccination Status: A Plan for 80% and Beyond* (PHSM Plan) was released. From 17 December, following Queensland reaching 80% vaccination coverage, a requirement for COVID-19 vaccination will be introduced for workers at and visitors to pubs, clubs, cafés, cinemas, theatres, music festivals and a range of public-facing venues operated by the Queensland Government, including museums and galleries. The mandate will replace COVID-19 restrictions on density and gatherings at these venues.

The requirement is deliberately broad and focused on settings with high public attendance— focusing on recreational venues that are higher risk due to the nature of the setting (e.g. alcohol consumption, density, dancing), and those that attract a number of geographically and demographically diverse people, where COVID-19 exposure and transmission could lead to a widespread outbreak.

Achieving uniform vaccination coverage across workers and visitors at these locations provides a baseline level of protection against community transmission. It is intended to be preventive and are intended to mitigate risk to the community with an expected increase in cases and spread going forward. It is also likely that a meaningful proportion of patrons will be children under the age of 16 years, for whom a COVID-19 vaccine is currently not available. Ensuring uniform vaccination coverage among the adults in the identified settings will protect children and protect against more widespread outbreaks.

Unvaccinated visitors will not be able to enter vulnerable settings such as hospitals, residential aged care, disability care accommodation, and correctional facilities to further support a baseline level of protection. This requirement is distinct from accessing facilities to receive care, where vaccination will not be required. This requirement will introduce a baseline level of protection against COVID-19 ingress in these vulnerable facilities going forward, when it is expected that COVID-19 will be circulating more widely in the community, and reduces the likelihood of needing to introduce further restrictions at these facilities.

Identifying additional high-risk settings

Queensland borders are reopening, bringing an increased likelihood of COVID-19 ingress and outbreaks throughout the State, including in vulnerable communities and regions. It is critical that the potential for significant outbreaks is controlled to the maximum extent possible, particularly in light of emerging variants of concern (see section on Omicron below).

There is an immediate urgency for additional protections in settings with a high potential to seed an outbreak, affect vulnerable members of the community, and where an outbreak could directly impact on the delivery of critical services. Employers and workers in these settings also have a responsibility to ensure the safety of visitors, clients, patients, and people in their care.

There are discrete factors that affect the risk profile of any given setting for the transmission and wider potential impact of COVID-19.

From a public health perspective, COVID-19 transmission risk is directly affected by the ability to physically distance, air flow (i.e. whether the environment is enclosed or outdoors), and the use of infection prevention and control measures (i.e. non-pharmaceutical interventions - masks and hand hygiene). The impact of COVID-19 is amplified by the presence of people vulnerable to the effects of COVID-19 (like unvaccinated people, the elderly, immunocompromised, those with comorbidities, and people with a disability), or where people from a wide geographic spread are exposed and COVID-19 can be transmitted to multiple regions, including vulnerable or remote communities.

More broadly, from a 'systems impact' perspective, in some cases a COVID-19 outbreak in a workplace can have substantial impacts beyond those immediately affected and their families—where an outbreak occurs among workers who provide services critical to the public, like a health care or emergency services setting, the impact on the available workforce and service provision can be even more widespread and long-lasting.

While vaccination coverage continues to increase at a whole-of-population level, as noted above the protective potential of vaccination against COVID-19 is also affected by differential vaccine uptake. COVID-19 has demonstrated extraordinary efficiency in seeking out unvaccinated and vulnerable people within communities, workplaces and industries. This has been evident in the nature and setting of major outbreaks of the Delta variant in NSW and VIC—including aged care facilities, schools and prisons—and repeated waves of infection overseas.

With the above risk factors taken into account, this Direction provides a framework for additional vaccine mandates in Queensland.

In the current iteration, priority high-risk settings are identified in the education, corrections, and aviation sectors. These are settings that, despite individual uptake of vaccines and prioritisation in the vaccine rollout, are more susceptible to COVID-19 transmission, and where an outbreak will have a potentially significant impact on the community. Table 1 at the end of this document describes the risk profile and evidence for COVID-19 transmission at these settings, and Table 2 provides a jurisdictional comparison for these and other currently mandated settings.

Schools and early education

The Queensland Government takes the position that schools are an essential service and should remain open wherever possible. This is consistent with the view of the Australian Health Protection Principals Committee (AHPPC). With border closures and sustained public health measures since the national stay at home orders (including school closures) in March 2020, extended or widespread school closures in Queensland have so far been largely avoided.

The COVID-19 vaccine has recently been made available to children aged 12-15 years in Australia. As at 2 December 2021, 76.3 per cent of Australian children aged 12 to 15 years have received at least one dose of the vaccine and 66.7 per cent of children are fully immunised.

Children under the age of 11 years comprise 15.3 per cent of Queensland's population. In the absence of an approved vaccine for children under the age of 12 years, young children are the single largest unvaccinated cohort in Australia. As COVID-19 begins to circulate more widely in Australia, young children will become the new front line of the COVID-19 pandemic.

Schools are environments where physical distancing is difficult to maintain, where groups of people spend extended periods of time together in an enclosed environment, and where other public health measures such as physical distancing and mask wearing can be impractical, particularly in early childhood settings with very young children.

In Victoria (VIC) and New South Wales (NSW), numerous outbreaks were seeded in school and early childhood settings following easing of lockdown conditions. COVID-19 outbreaks reportedly closed more than 270 schools (two thirds of which were primary schools) and 300 childcare centres across NSW during October 2021, and in VIC dozens of schools have been linked to COVID-19 outbreaks.

A recent example of COVID-19 risk at the school setting for Queensland is the Indooroopilly Cluster earlier this year (August 2021). This outbreak—the biggest in Queensland to date—was seeded across four schools and over subsequent weeks resulted in 147 cases and 17,000 close and secondary household contacts in home quarantine.

At the beginning of the outbreak, although a large number of exposure venues were identified, with the exception of the index case and family, all community cases were detected in association with a limited

number of exposure venues, namely the affected Brisbane schools, and a karate class. Transmission had occurred not only within but across schools, with a high degree of crossover including siblings at different schools.

During this outbreak, affected contacts were rapidly identified and placed into home quarantine. Because of this, the flow-on effects of the outbreak could be observed by day five of the outbreak, where 80 per cent of new daily cases were known household contacts of cases. By day eight 100 per cent of new daily cases were being detected among known close contacts. The transmission rate of the Delta variant in households, and arguably any enclosed environment where people spend lengthy periods of time in close contact, has been estimated at between 70 to 100 per cent.

Fortunately, acute infection with SARS-CoV-2 is generally associated with mild disease in children. Compared to adults, children are 25 times less likely to develop severe disease.

However, the effect of an outbreak among and on-transmission from this cohort has the potential to be much more widespread, in terms of the impact within schools and on households, including inter-generational exposure, as well as student and staff absences and disruptions to schools with closures during outbreaks.

As at 08 December 2021, according to Queensland Health reporting of vaccines administered by Hospital and Health Services, 41,718 school and early childhood staff have received their second dose of the COVID-19 vaccine. This does not include doses administered by primary care providers (including General Practice), or other Commonwealth facilities, and the true figure is likely to be higher.

The total number of school and early childhood education workers in Queensland is not known. To illustrate the potential scale and impact of exposure to COVID-19 among workers in education, a 2020 report by the Queensland College of Teachers, the peak regulatory body for the teaching profession in Queensland, reports over 110,000 approved teachers, with over 68 per cent of these employed in permanent or long-term temporary teaching positions. According to the report, half of all teachers–51.3 per cent—are over 45 years of age and 16.5 per cent are 60 years or older.

The severity of COVID-19 increases with age. People in their 30s who are not vaccinated are at four times the risk of a teenager of becoming sufficiently unwell from COVID-19. For people in their 50s, the risk is 40 times higher than that of a teenager of becoming very unwell, being hospitalised, or dying. The death rate for COVID-19 starts to increase for those over 50 years of age. Those under 50 years of age who are infected have a death rate of 0.2–0.4 per cent of those infected, while for those 50–59 years it rises to 1.3 per cent of those infected, then 3.6 per cent for 60–69 years and higher again into the older years.

This means that as well as being at increased risk of exposure to COVID-19 at the setting, over half of the employed teaching cohort in Queensland is at increased risk of moderate to severe illness, or death, from COVID-19. The rates of severe illness or death are even higher for people who have underlying conditions like diabetes, hypertension, or asthma.

The AHPPC's *Statement on COVID-19, Schools and Reopening Australia* states that a primary goal for schools is to reduce transmission for the entire school community, protect the un-immunised population of students at school and maintain the ability of schools to remain open. Using actions from the hierarchy of controls, AHPPC notes that three specific principles apply to minimise disease in schools. These are (a) reducing opportunities for introduction of the virus, (b) reducing transmission of the virus if it is introduced, and (c) early use of containment measures if spread occurs.

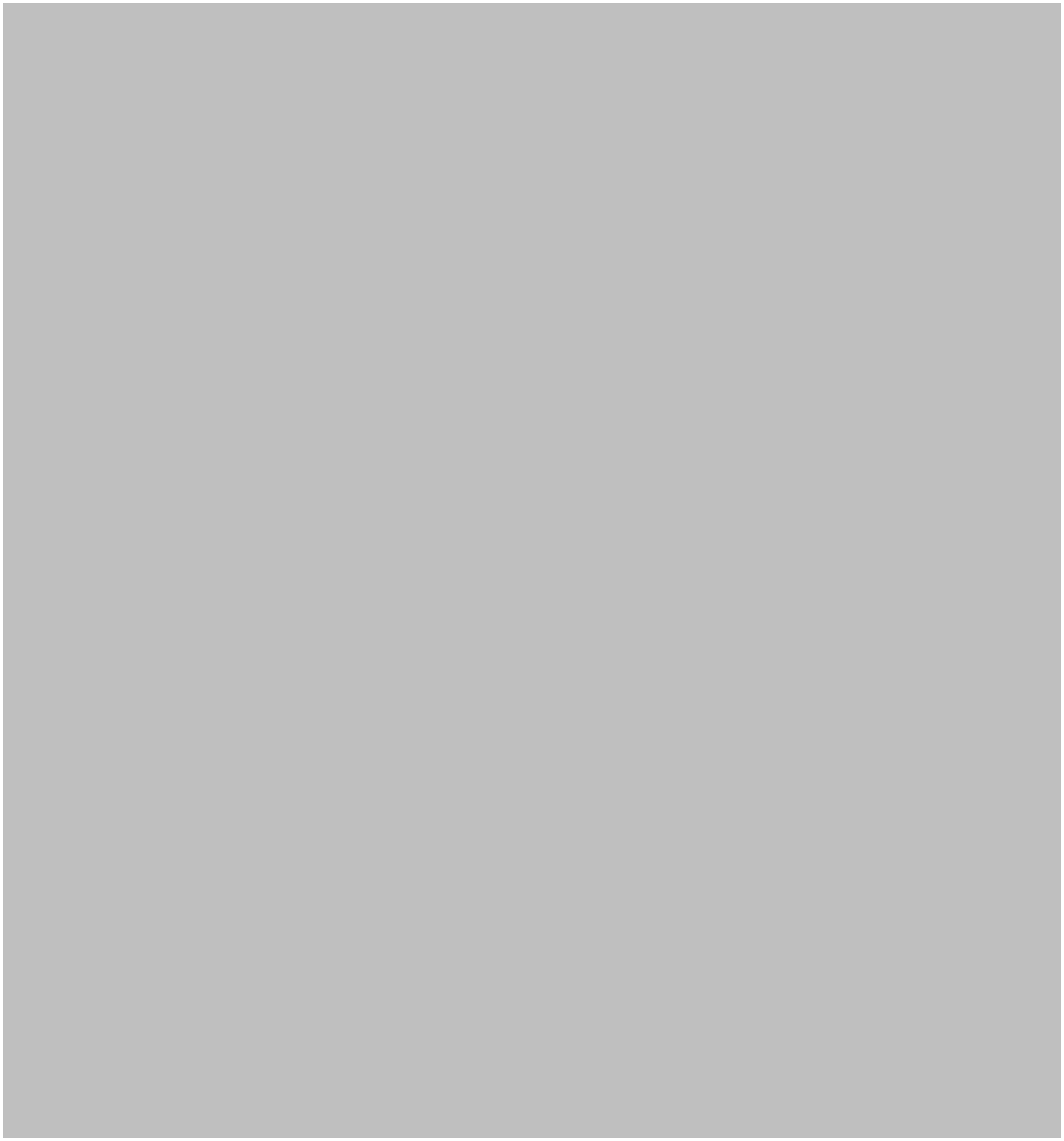
Vaccination offers a high level of individual protection for workers in schools and early childhood settings. Uniform vaccination among workers at school and early education, including childcare settings would contribute meaningfully to principles (a) and (b) described above.

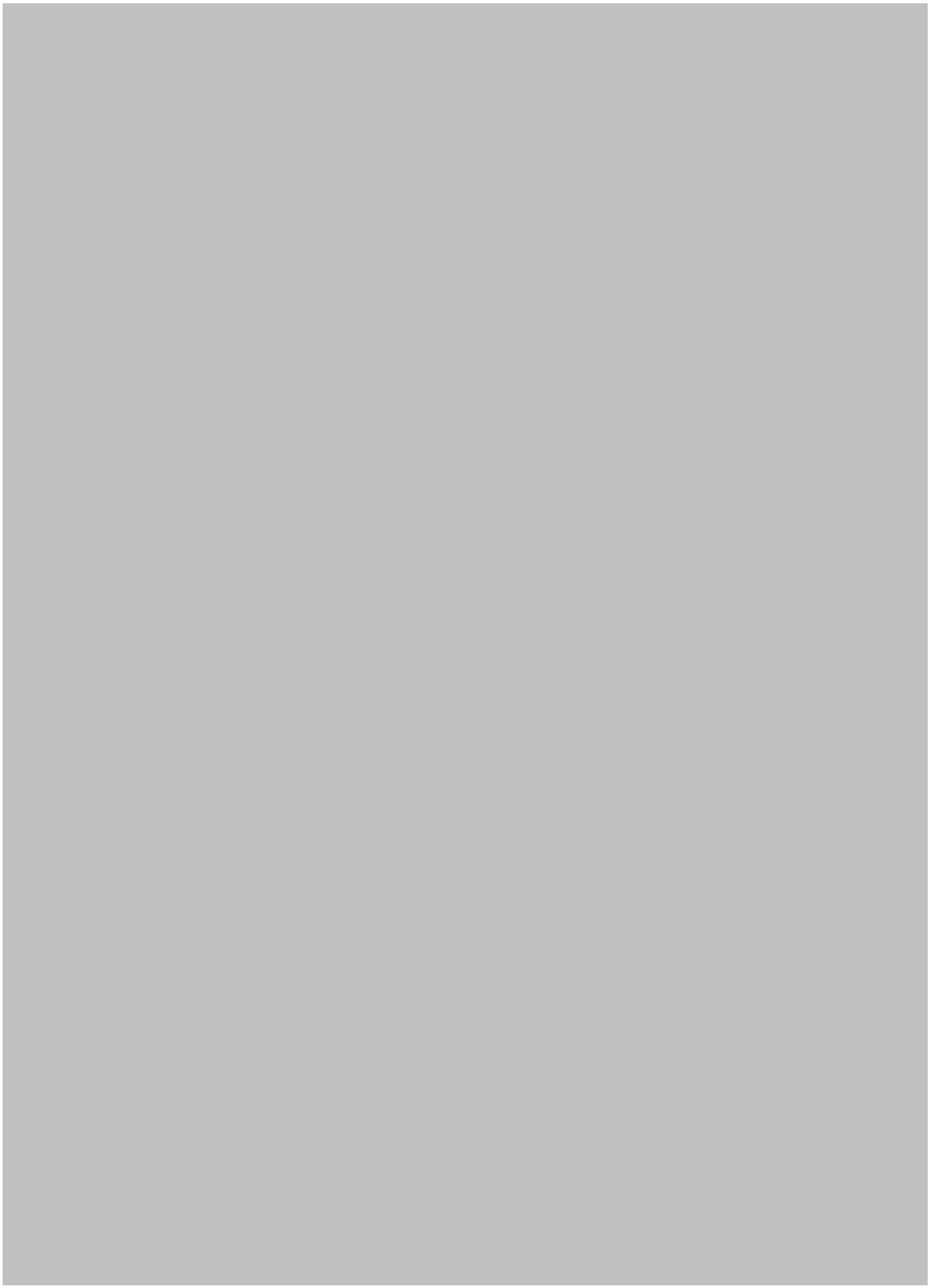
While children under 12, and those over 12 who are unvaccinated, remain susceptible to COVID-19, their opportunities to acquire infection are reduced if the adults around them are vaccinated. This is a process

called cocooning that is also used for other infectious diseases in infants. Notably, high vaccination rates amongst school family units are also a key protective factor.

All other Australian jurisdictions except for Queensland and Tasmania (TAS) have already introduced mandatory COVID-19 vaccination for workers in schools and early childhood settings (see Table 1 for a jurisdictional comparison at the end of this document).

In Queensland, for Department of Education employees, a range of vaccinations are strongly recommended depending on risk and exposure, but this would be the first mandatory vaccination for this cohort. Ensuring workers in schools and early education settings are uniformly vaccinated against COVID-19 will support AHPPC recommendations for schools, directly reduce risk to the workforce, help to protect against severe outbreaks and repeated school closures, sustain workforce capacity and reduce the risk of COVID-19 exposure to vulnerable people.





[redacted]

Engagement with the sector

Department of Education (DoE; Director-General and DDG) - conveyed the scope and rationale for the inclusion of 'Schools'. DoE undertook to engage with the broader private and independent sector to convey the policy intent.

[redacted]

Mandating vaccination for workers in identified high-risk settings

The Direction provides a framework to mandate vaccination for workers in high risk settings and sets these out in a Schedule. Consistent with the risk factors described earlier in this document, the Direction applies to workers in settings where:

- there is a higher risk of transmission of SARS-CoV-2, the virus that causes COVID-19
- the setting is accessed by a large number of vulnerable persons as service users, and/or
- a sudden reduction in available workforce due to COVID-19 impacts at the setting would significantly affect the continuity of critical services to the community with consequential public health and safety risks.

Settings in the Schedule in this iteration of the Direction are:

- Schools, childcare and early childhood education facilities
- Corrective service facilities (including police watch houses) and youth detention centres
- Airport premises and associated precincts

A vaccination requirement will apply to all workers who enter, work in, or provide services in a high-risk setting. The direction defines how a high-risk setting is identified by the Chief Health Officer and specifies the COVID-19 vaccination requirements and related obligations for workers and employers operating in a high-risk setting. The direction recognises that an employer may mandate vaccination for employees, where otherwise permitted at law, based on the requirements of a role.

It is expected that any staff who enter a high-risk setting for the purposes of work, even if not their primary workplace would be in-scope for the vaccination requirement. This would include but not be limited to union officials, regulators, and contractors like maintenance staff.

However, a person engaged or employed to undertake work in an area of the high-risk setting that is not co-located, will not be required to meet COVID-19 vaccination requirements. This provision only applies where the area is not occupied by the users or workers of the high risk setting; is physically separated from the occupied part of the high-risk setting and users or workers cannot gain access to the area; and has no shared points of access with users and workers of the high risk setting. Under these requirements, the risk of COVID-19 transmission is substantially minimised as the users and workers of the high risk setting are physically excluded from the work site.

For example, part of a school's grounds are fenced off while construction of a gym is undertaken. While the construction work progresses, school staff and students are not permitted to enter the construction site and the construction company has control of the site. The construction site is not co-located with the school and is therefore not subject to the COVID-19 vaccination requirements that apply to the high-risk setting.

To be clear the intent is not to mandate vaccination of the worker but to mandate that in certain higher-risk settings, only vaccinated persons may work.

It is recognised that in rare circumstances, a worker may be genuinely unable to be vaccinated due to a medical contraindication. Accordingly, and provided the contraindication is certified, the worker may continue to work in a high-risk setting where their work cannot be performed outside the setting. For their own and others' protection when at the setting, they will need to comply with PPE requirements consistent with requirements as set by the responsible person for the setting. They must also undertake daily COVID-19 PCR testing before commencing each work shift. A permanent vaccine exemption can only be granted on the grounds of previous anaphylaxis or severe adverse event attributed to the COVID-19 vaccine or vaccine component across all vaccines available for use in Australia, and it is not expected that many people will fall into this category. Staff with a temporary contraindication will be expected to complete their vaccination following the exclusion period.

An exception to vaccination requirements is also provided for workers in a high risk setting who are active participants in a COVID-19 vaccine trial. Participation in clinical trials is important to ensure the continued availability of safe and effective COVID-19 vaccines and forms an integral component in the transition from elimination to 'living with COVID-19'. This provision will ensure that the current Direction does not create unnecessary barriers to the participation in such trials, and to remove any contradiction with similar exceptions for vaccination mandates in other Queensland Public Health Directions or Queensland Health Employment Directives.

This exception only applies where the person engaging or employing the worker has assessed the risk to other staff, users, clients and other persons in the high-risk setting and determines that the worker may continue to work in that setting. The worker must provide a medical certificate or letter from a medical practitioner to confirm active participation in the trial and that the worker has received at least one dose of the COVID-19 vaccine being trialled. The requirement for at least one dose of the trial vaccine is expected to provide a level of protection against COVID-19 and will assist to reduce the risk of transmission.

The COVID-19 vaccine trial exception ceases when the trial vaccine is recognised, approved or rejected for use in Australia by the TGA at which time mandatory vaccination requirements apply.

From time to time there may be exceptional circumstances that result in a critical workforce shortage, such as illness, high demand or another emergent event, and there may be an occasion where there is a shortage of vaccinated workers. In this event, and to allow for the continued and safe delivery of services, the Direction provides that an unvaccinated worker may be permitted to enter, work in or provide services in the setting, for a short period until vaccinated workers can be recruited. This is subject to strict standards, including a risk assessment by the person responsible for the healthcare setting, PPE use and daily COVID-19 PCR testing by the worker.

It is expected that this option only be exercised in extreme and sustained circumstances, where the shortage means a direct impact on patient or client care or the effective operation of the setting. An example is a shortage of more than 10 per cent of staff for a sustained period of 7 days or more among a small staff cohort, with the remaining skills mix and rostering unable to compensate for the shortage. Similarly, in an emergency where it is absolutely necessary, other unvaccinated workers, including contractors, may enter a high-risk setting to respond to an emergency, but must comply with PPE requirements.

The Direction is not intended to restrict visitors to the settings, or for users of the service to gain access – for example, students or parents at a school, or a person accessing an airport as a traveller. It should be noted that visitors to corrections facilities are required to be vaccinated under the PHSM Plan, with corrections considered a vulnerable facility in the same way as hospitals, aged care and disability accommodation facilities.

Further, the Direction is not intended to mandate COVID-19 vaccination for support people who are directly providing legal, advocacy, social welfare, mental health and wellbeing supports for vulnerable clients or users of a service, and is subject to PPE use as required by the responsible person and modified PCR surveillance testing. An example is an unvaccinated mental health support worker regularly provides support to a person detained at a corrective services facility who relies on continuity of face to face contact

for their mental health and wellbeing and their health outcomes would be adversely impacted by a change in support arrangements. This arrangement is considered an exception and is at the discretion of the responsible person. The exception is provided for as in these circumstances, the risk to the individual is considered to outweigh the public health benefit of the policy.

Uniform vaccination coverage will protect staff and safeguard the community by minimising the risk of COVID-19 transmission within the workforce as well as to and from vulnerable cohorts (for schools and correctional facilities) and travellers (for airports) as COVID-19 becomes more widespread. Limiting transmission within these workplaces will also reduce the likelihood of workplace outbreaks and staff shortages that can impact on the delivery of these essential services.

Future implementation

As Queensland transitions to a 'living with COVID-19' future, COVID-19 will begin to be managed more like other vaccine-preventable diseases—public health restrictions are expected to reduce, and regulatory requirements will become more targeted. During the transition to endemic COVID-19, and particularly during the early stages, it will remain critically important to limit the transmission and spread of COVID-19, protect the health of Queenslanders, and sustain health system and contact tracing capacity.

Mandating uniform vaccination coverage for workers in identified high risk settings ensures that the spread of the virus among vulnerable cohorts and in higher-risk settings is slowed. This will safeguard against broader impacts on the community, industry, and the health system.

It is likely that high-risk settings will continue to be identified as the virus moves through the population. As noted above, without available vaccines, children are becoming new front line of the pandemic and schools and early childhood settings are increasingly recognised as key high-risk settings. The impact of waning immunity has not yet been tested in Queensland, and this may have unpredictable consequences across a range of settings and workplaces where vaccination may have been prioritised or seen rapid uptake early in the vaccine rollout.

Omicron variant

On November 26, the World Health Organization (WHO) classified a new variant, the Omicron or B.1.1.529 variant as a variant of concern. The first known confirmed infection was from a specimen collected on 9 November 2021 and the variant was first reported to the WHO from South Africa on 24 November 2021.

In recent weeks in South Africa infections have risen steeply, coinciding with the detection of this variant. It appears to be taking over dominance in some South African regions in less than two weeks.

The variant has a large number of mutations – 32 on the spike protein alone, compared to only 9 on the Delta variant, and preliminary evidence is suggesting that this variant may produce an increased risk of reinfection among people who have had COVID-19 previously. The transmissibility of the variant is currently unknown, although some early indications are that it is highly transmissible. The severity of disease is also unknown, although on balance it is considered unlikely that it causes more severe disease than other known variants. The effectiveness of vaccine against the variant is still under investigation, although current vaccines appear to remain effective against severe disease and death. Pfizer have indicated they expect to know within two weeks whether the variant is vaccine resistant. An advantage is that should another vaccine be required it is likely that a new mRNA vaccine could be produced and made available within months.

Public health considerations – 10 December 2021

Epidemiological situation

Queensland

- Queensland reported nine new COVID-19 cases in the previous 24 hours including:
    - 1 case is locally acquired, contact not identified and detected in community.
    - 4 cases are locally acquired with interstate travel, 2 were detected in hotel quarantine and 2 were detected in the community.
    - 2 cases are locally acquired, contact of a confirmed case and detected in community.
    - 1 case is overseas acquired and detected in hotel quarantine.
- Today's new cases have not been linked to recent cases on the Gold Coast.
- The total number of cases in Queensland stands at 2,166.
- Queensland is managing a total of 45 active cases, with 25 in hospital (nil in ICU), 11 in Hospital in the Home and nine awaiting transfer. There are currently no active First Nations cases in Queensland.
- Queensland has recorded two cases of the Omicron variant of COVID-19, one case reported on 6 December was detected in hotel quarantine in Cairns and the second case reported on 4 December was detected in Brisbane.
- There has been a significant increase in the number of people entering home quarantine, now permitted for many domestic arrivals under the Vaccine Plan after Queensland achieved 70 per cent vaccination coverage on 14 November.
- There are currently 9,309 people in quarantine: 5,699 people in home quarantine (including 4,404 from interstate hotspots), 3,456 people in government hotel quarantine and 154 in alternate quarantine.
- As at 9 December 2021, a total of 3,294,626 Queenslanders aged 16 and over have been vaccinated with two doses of a COVID-19 vaccine, which amounts to 80.11 per cent of this cohort; 3,615,247 people – 87.90 per cent – have had at least one dose.
- As at 9 December 2021, a total of 148,330 Queenslanders aged 12-15 years have been vaccinated with two doses of a COVID-19 vaccine, which amounts to 54.91 per cent of this cohort; 178,058 people – 65.91 per cent – have had at least one dose.

Emergence of Omicron variant

- On 26 November, the World Health Organization (WHO) classified a new variant, the Omicron or B.1.1.529 variant as a variant of concern.
- The first known confirmed infection was from a specimen collected on 9 November 2021.
- The variant was first reported to the WHO from South Africa on 24 November 2021.
- The variant has a large number of mutations (including 32 on the spike protein alone, compared to only nine on the Delta variant), and preliminary evidence is suggesting this variant may produce an increased risk of reinfection among people who have had COVID-19 previously.
- Omicron is being urgently investigated by researchers globally, with the WHO announcing it could take weeks for sufficient data and analysis to draw preliminary conclusions.
- There is currently insufficient information available to make conclusions on the transmissibility and disease severity of the variant. The effectiveness of available vaccines against the Omicron variant is also under investigation. The variant is detectable through current PCR testing.
- As at 10 December, there are over 1,400 cases of the Omicron variant of concern in over 57 countries, including at least 45 cases in Australia.
- At this stage, the primary risk of Omicron incursion into Queensland is from other Australian jurisdictions with minimal quarantine requirements (Victoria, New South Wales) for international arrivals.
- On Saturday 27 November, the Commonwealth announced a range of new measures in response to the new variant. Anyone who is not an Australian citizen or their dependents and who has been in nine countries in Southern Africa in the past 14 days cannot travel to Australia. Australian citizens and their

dependents are required to go into supervised quarantine on arrival. The nine countries are South Africa, Namibia, Zimbabwe, Botswana, Losoto, Eswatini, The Seychelles, Malawi and Mozambique.
- Australia has also suspended flights from these countries and several jurisdictions have tightened travel restrictions.
- On 29 November, the Australian government they have been in discussions with the CEOs of Pfizer and Moderna and have prepared a contract for variants.
- On 3 December ATAGI recommended that there is to be no change to booster timeframes in light of the Omicron variant.

National

- As at 9 December, in the 24 hours prior jurisdictions have reported 1,669 newly confirmed cases, including locally and internationally acquired. There are at least 14,807 active cases nationwide.
- As at 9 December, Australia has reported 88.71 per cent of the eligible population aged 16 years and over as fully vaccinated; 93.13 per cent has had at least one dose.
- As at 9 December, Australia has reported 68.91 per cent of the eligible population aged 12-15 years as fully vaccinated; 77.09 per cent has had at least one dose.
- On 10 December the Australian Government confirmed that Australia's COVID-19 vaccination program will be extended to all children aged 5 to 11 years from 10 January 2022, after the Australian Government accepted recommendations from the Australian Technical Advisory Group on Immunisation (ATAGI).
- NSW and Victoria, with sustained and widespread outbreaks of the Delta variant since June-July, are seeing a reduction in daily new cases in recent weeks with fluctuating, but generally downward trajectory. Noting wide-ranging lifting of restrictions and lockdown conditions, Queensland is monitoring case numbers in these jurisdictions as well as in the Australian Capital Territory (ACT) where daily positive cases have also been gradually falling since the start of the latest outbreak.
- As at 8 December 2021, at least 45 Omicron cases have been detected in Australia, including 42 in NSW, two in Queensland and one in the Northern Territory.
- Quarantine requirements for Australians returning from overseas to NSW, Victoria, ACT and South Australia had started to ease in November. However, following the emergence of the Omicron variant, these jurisdictions have re-introduced restrictions for arrivals from countries of concern.
- South Australia opened its borders to NSW, Victoria and the ACT on 23 November. Since then, there have been 61 new cases.

New South Wales

- NSW reported 516 new COVID-19 cases and nil new deaths in the past 24 hours; there have been 78,907 locally acquired cases and 580 deaths reported since 16 June.
- NSW is currently managing 158 cases in hospital, with 24 people in ICU (nine requiring ventilation).
- As at 9 December, NSW has reported that 93.01 per cent of the eligible population aged 16 years and over is fully vaccinated and 94.72 per cent have received at least one dose.
- As at 9 December, NSW has reported that 77.46 per cent of the eligible population aged 12-15 years is fully vaccinated and 81.38 per cent have received at least one dose.
- NSW has now recorded 42 cases of the Omicron COVID-19 variant, with the multiple cases infectious in the community. At least 21 of these cases are linked to a cluster related to schools and a gym in Regents Park.
- NSW has a range of movement and gathering restrictions in place for unvaccinated people, which will remain in effect until 15 December when NSW is expected to reach 95% vaccination coverage of its population aged 16 years and over.

Victoria

- Victoria has reported 1,203 new locally acquired cases and two deaths in the last 24 hours; there now have been 112,987 locally acquired cases and 591 deaths reported since 16 June.

- Victoria is managing 313 cases in hospital, including 61 active cases and 43 cleared cases in intensive care (25 of whom require ventilation).
- As at 9 December, Victoria has reported that 91.53 per cent of its eligible population aged 16 years and over is fully vaccinated and 93.53 per cent have received at least one dose.
- As at 9 December, Victoria has reported that 80.62 per cent of its eligible population aged 12-15 years is fully vaccinated and 87.45 per cent have received at least one dose.
- There are currently no restrictions in place for Victorians who are fully vaccinated.

Australian Capital Territory

- ACT has reported six new locally acquired cases and nil new deaths in the last 24 hours; there have been 2,061 locally acquired cases and 12 deaths reported since 12 August.
- ACT is managing five cases in hospital, with two people in intensive care, neither of whom requires ventilation.
- As at 9 December, ACT has reported that 98.88 per cent of its eligible population aged 16 years and over is fully vaccinated and >99 per cent have received at least one dose.
- As at 9 December, ACT has reported that 96.42 per cent of its eligible population aged 12-15 years is fully vaccinated and >99 per cent have received at least one dose.

Northern Territory

- The NT has reported nil new community cases in past 24 hours. The Katherine and Robinson River outbreak now totals 64 cases since 15 November 2021.
- The first Omicron case in the Northern Territory was reported on 29 November. This case was a traveller who returned to Australia on a repatriation flight from South Africa on 25 November 2021. This case was in quarantine at the time of detection.
- As at 9 December, NT has reported that 80.17 per cent of its eligible population aged 16 years and over is fully vaccinated and 88.19 per cent have received at least one dose.
- As at 9 December, NT has reported that 59.23 per cent of its eligible population aged 12-15 years is fully vaccinated and 74.00 per cent have received at least one dose.
- Katherine moved to a lockout from 27 November. During the lockout period, people inside the designated area are not permitted to leave and people outside are not able to enter, except for essential workers. Following an extension, Katherine, Binjari and Rockhole exited lockdown on 8 December with a mask mandate in place until 15 December.
- Due to the occurrence of community transmission of COVID-19 and persistent positive wastewater results in Katherine East, targeted COVID-19 testing stations will be established to help identify undetected cases.

Global

- As at 10 December, there have been over 268 million confirmed COVID-19 cases, 5.28 million confirmed COVID-19 related deaths and 8.324 billion COVID-19 vaccine doses administered (Source: John Hopkins University).
- In the week to 5 December, weekly COVID-19 case incidence plateaued, with over 4 million confirmed new cases. However, new weekly deaths increased by ten per cent compared to the previous week, with over 52,500 new deaths reported (Source: WHO).
- In the week to 5 December, cases increased in two of the six WHO regions – America and Africa Regions. An increase in weekly deaths was reported in two of the six regions - by 49 per cent in the South-East Asia region and 38 per cent in the America region (Source: WHO).

Living with COVID-19

- The Queensland Government continues to progress its state-wide campaign to encourage Queenslanders to get vaccinated. There is a particular focus on encouraging increased uptake in

regional and remote areas. Many of these areas currently have lower vaccination coverage than the Queensland average.

- From Monday 1 November, Designated COVID-19 Hospitals in Queensland are offering booster COVID-19 vaccination doses for people who received their second dose at least six months ago.
- On 18 October 2021, Queensland released the COVID-19 Vaccine Plan to Unite Families. Under this plan, changes to border restrictions and quarantine requirements at increasing levels of state-wide vaccination coverage are described.

- From 70% of Queensland's eligible population fully vaccinated (19 November), anyone who has been in a declared domestic hotspot in the previous 14 days can travel into Queensland provided they:
    - are fully vaccinated
    - arrive by air
    - have a negative COVID-19 test in the previous 72 hours
    - undertake home quarantine for 14 days, subject to meeting conditions.
- At 80% of Queensland's eligible population fully vaccinated (80% milestone reached 9 December, measures to commence 13 December):
    - Fully vaccinated travellers from a domestic COVID-19 hotspot can arrive by road or air, with no quarantine required but must have had a negative COVID-19 test in the previous 72 hours and agree to get a further COVID-19 PCR test on day five of their stay in Queensland.
    - Fully vaccinated direct international arrivals can undertake home quarantine subject to conditions set by Queensland Health, provided they are fully vaccinated and have a negative COVID-19 test in previous 72 hours.
- At 90% of Queensland's eligible population fully vaccinated, there will be no entry restrictions or quarantine for vaccinated arrivals from interstate or overseas.
    - Unvaccinated travellers will need to apply for a border pass, enter within the international arrivals cap, and undertake a period of quarantine.

- On 9 November 2021, the Queensland Government released its *Public Health and Social Measures linked to Vaccination Status: A Plan for 80% and Beyond*, which sets out measures variously applying to vaccinated and unvaccinated people aged 16 years and over. The associated Direction was published on 7 December and will come into effect on 17 December.
- Under the Plan, there will be no COVID-19 density restrictions on pubs, clubs, cafés, cinemas, theatres, music festivals if all staff and attendees are fully vaccinated.
- On 9 December, Queensland's *Quarantine for International Arrivals (No.16)* was published, regarding the above noted changes to the requirements for international arrivals from 13 December.
- On 9 December, Queensland's *Border Restrictions Direction (No.56)* was published, regarding the above noted changes to arrivals from domestic COVID-19 hot spots from 13 December.

Public Health System capacity

- Currently, Queensland Public Health Units are working to ensure the Queensland community is complying with public health controls. Another key focus for Queensland's Public Health Units is to ensure that those directed to undertake quarantine, including home quarantine, comply with all requirements, including the testing regime.
- Additional restrictions are imposed and lifted in response to evidence of community outbreaks to ensure the safety of Queenslanders, and more specifically our most vulnerable people in residential aged care facilities, hospitals, and disability accommodation services.
- While cases of COVID-19 in the Queensland community have been managed well to date, it is important to mitigate against widespread outbreaks. It is particularly important to quickly bring clusters under control with effective contact tracing and other protective measures to maintain the integrity of the health system to respond to non-COVID-19 related care.

Health Care System capacity

- Queensland will soon transition to the next phase of the COVID-19 response, which will involve wider circulation of COVID-19 in the Queensland community. Queensland Health has considered a range of epidemiological modelling, including scenario-based impacts to hospital capacity and workforce. This modelling, and lessons from the recent NSW and Victorian outbreaks, have identified that a flexible and high capacity health system delivery model is critical. It is expected that with increased vaccine protection, the number of people requiring hospitalisation and intensive care in the event of an outbreak are likely to remain within hospital and health system capacity.
- As Queensland's response to COVID-19 has evolved, expert advisory groups, particularly the COVID-19 Response Group (CRG) have further developed and refined Queensland Health's response plans. Particular consideration has been given to the impacts of the Delta variant and an increasing likelihood of a surge in cases as Queensland transitions to living with COVID-19.
- To support health system delivery in this new phase of COVID-19, Queensland Health is operating a tiered health system response to activate additional capacity when triggers associated with increasing case numbers are met. This response includes expanding to hospitals and settings (such as homes) beyond the Designated COVID-19 Hospital Network, postponing elective surgeries, and leveraging private hospital capacity as required.
- The established Designated COVID Hospital Network can accommodate a moderate surge in cases, across both inpatient and at home care through Hospital in the Home (HITH) placements.
- Strategies are in place with private providers to minimise the interruption to urgent elective services should a wider community outbreak across Queensland impact on hospital and health service delivery. Strong partnerships with major private providers will assist public hospital systems to respond to a COVID-19 surge.

Community acceptance and adherence

- Queensland's public health measures have been generally well-received and met with compliance. The community have so far been accepting and supportive of public health measures.
- There are ongoing concerns of 'pandemic fatigue', particularly in vulnerable sections of the community, and associated non-compliance with public health measures nationally. However, the need for lockdowns or widespread restrictions is expected to reduce dramatically with increased vaccination coverage. Queensland, like other jurisdictions, is preparing to move into a new 'living with COVID-19' phase of the pandemic.
- With lengthy periods of restriction in some jurisdictions (i.e. NSW and Victoria), as well as new vaccine-related mandates and public health and safety measures coming into effect, a number of protests have been held in recent months, principally in east-coast states.
- The key issue in the medium-term is likely to be in relation to vaccine mandates, and the complexities of differing freedoms for vaccinated and unvaccinated people. State and territory mandates vary with local context. For example, Victoria and NSW, managing widespread outbreaks and health systems at capacity have mandated vaccination across many industries and settings, including construction, education, and other authorised workforces including retail. In the context of very low case numbers and strict requirements throughout the pandemic, Western Australia has announced mandatory vaccine requirements across almost every sector, estimated to affect up to 75% of the population, with similar vaccine requirements also announced by the Northern Territory.

Wastewater monitoring

- To strengthen surveillance capabilities and increase confidence that transmission is not occurring, Queensland conducts a surveillance program to detect traces of coronavirus in wastewater in 19 communities across the state.
- Wastewater monitoring systems detect viral fragments and can help experts determine where in the state there might be people with a current or recent COVID-19 infection. The system has significant

value in its potential to serve as an early warning system for potentially undetected cases. It cannot pinpoint the exact source of the viral fragments.

- There have been positive wastewater detections at the Merrimac, Coombabah, Pimpama and Capalaba wastewater treatment plants on 8 December 2021.

Table 1. Jurisdictional comparison of COVID-19 vaccine mandates for workers in key high-risk settings (26 November 2021)

Cohort	Jurisdictional comparison [Note: date of second vaccination provided, unless otherwise specified]								
	National position	QLD	NSW	ACT	VIC	SA	TAS	WA	NT
Education and childcare workers	Vaccination of staff encouraged by AHPPC	–	✓ 8 Nov	✓ 29 Nov	✓ 29 Nov	Booked 2nd dose by 11 Dec	–	✓ 31 Jan	✓ 24 Dec

Table 2 - Risk factors and evidence of COVID-19 transmission at critical settings serving the Queensland population

SETTING	Risk factors within setting				Likelihood~	Consequence		EVIDENCE
	Worker mobility	Close proximity	Indoor environment	Other infection control measures*		Individuals	Community (outbreak)	

SETTING	Risk factors within setting				Likelihood~	Consequence		EVIDENCE
	Worker mobility	Close proximity	Indoor environment	Other infection control measures*		Individuals	Community (outbreak)	

SETTING	Risk factors within setting				Likelihood~	Consequence		EVIDENCE
	Worker mobility	Close proximity	Indoor environment	Other infection control measures*		Individuals	Community (outbreak)	
Schools and early education *Essential service*	*Moderate educator movement across setting; often cohorted*	*Cohorted groups in classrooms, spread within cohorts likely, gyms, canteens, assemblies*	*Enclosed spaces, classrooms may have improved airflow, outdoor learning*	*Can be impractical in early childhood settings; difficult to enforce*	*Multiple household contacts, widely connected community, children more likely asymptomatic*	*Unvaccinated children; impacts for older unvaccinated teaching staff higher*	*Household transmission, high crossover, family impact*	**QLD** - High transmission between students, staff and families in the Indooroopilly Cluster. - Qld's largest COVID-19 outbreak of 147 cases. In this cluster, 60 cases (40%) were students and 80 cases (54%) were household contacts. **NSW** - More than 270 schools and 300 childcare centres closed due to COVID-19 cases during October 2021; two thirds were primary schools. **National Centre for Immunisation Research and Surveillance (NCIRS) report (September 2021)[x]** - During the recent NSW outbreak (to end July 2021) there was a 5-fold higher rate of transmission (secondary attack rate 4.7%) than in 2020 (secondary attack rate 0.9%) in educational settings—reflective of increased transmissibility of Delta variant. - ECEC services experienced the highest rate of transmission (6.4%), as they remained fully open with high attendance rates. Transmission was highest between ECEC staff members (16.9%) and from an ECEC staff member to a child (8.1%). - High population-level rates of COVID-19 vaccination, including vaccination of school/ECEC staff, are critical. **United States** - The opening of schools contributed to a growth of COVID-19 cases by 5 percentage points—vaccines and mask-wearing in this setting identified as critical[xi] - CDC recommends that all teachers, staff and eligible students be vaccinated as soon as possible[xii]

*PPE, Mask wearing, hand hygiene
~Mobility of cohort and extent of community access

[i] Australian Health Protection Principal Committee (AHPPC) statement on mandatory vaccination of all workers in health care settings | Australian Government Department of Health
[ii] Hospital-acquired SARS-CoV-2 infection in the UK's first COVID-19 pandemic wave - The Lancet
[iii] Australian Health Protection Principal Committee (AHPPC) statement on mandatory vaccination of aged care in-home and community aged care workers | Australian Government Department of Health
[iv] Australian Health Protection Principal Committee (AHPPC) statement on mandating vaccination for disability support workers | Australian Government Department of Health
[v] COVID-19 Vaccines for People with Disabilities | CDC
[vi] People with Certain Medical Conditions | CDC
[vii] Deaths involving COVID-19 by self-reported disability status during the first two waves of the COVID-19 pandemic in England: a retrospective, population-based cohort study - The Lancet Public Health
[viii] https://www.publicdefenders.nsw.gov.au/Documents/updated-report-impact-of-covid-19-on-nsw-prisoners-september-2021.pdf
[ix] https://jamanetwork.com/journals/jama/fullarticle/2768249
[x] https://www.ncirs.org.au/sites/default/files/2021-09/NCIRS%20NSW%20Schools%20COVID_Summary_8%20September%2021_Final.pdf
[xi] The association of opening K–12 schools with the spread of COVID-19 in the United States: County-level panel data analysis | PNAS
[xii] Guidance for COVID-19 Prevention in K-12 Schools | CDC

Public Health Directions – Human Rights Assessment

COVID-19 Vaccination Requirements for workers in a high-risk setting Direction

Title	*COVID-19 Vaccination Requirements for workers in a high risk setting Direction*
Date effective	XX December 2021

Background

The *COVID-19 Vaccination Requirements for workers in a high-risk setting Direction* (Direction) is issued by the Chief Health Officer pursuant to the powers under section 362B of the Public Health Act 2005.

This analysis should be read in conjunction with the Human Rights Statement of Compatibility prepared in accordance with section 38 of the *Human Rights Act 2019* with respect to the Public Health and Other Legislation (Public Health Emergency) Amendment Bill 2020. This Bill amended the *Public Health Act 2005* to enable the Chief Health Officer to issue directions that are reasonably necessary to assist in containing or responding to the spread of COVID-19.

Purpose of the Direction

The purpose of the *COVID-19 Vaccination Requirements for workers in a high-risk setting Direction* is to reduce the impact of COVID-19 on individuals and the Queensland Health system by providing an operational framework for vaccination requirements for workers in identified high risk settings.

In preparing the Direction, risks to the health and safety of Queenslanders were identified and the current epidemiological situation, both in and beyond Queensland, were considered. The risks and epidemiological situation are more fully set out in the Policy Rationale that informed the Direction, and form part of the purpose of the Direction. As the below human rights analysis draws on the information contained in the Policy Rationale, they should be read together.

Widespread COVID-19 transmission in high risk settings where there are high numbers of vulnerable people or where the nature of the setting increases the risk of transmission can significantly increase the risk of transmission within the setting and into the community, and has the potential for significant adverse effects for vulnerable patients and clients accessing high risk settings.

Mandatory vaccination can help reduce the risk of transmission and the impacts on those who access services at the high-risk setting.

How the Direction Achieves the Purpose

Outlining the vaccination requirements for workers in high risk settings will help to reduce the impacts on individuals, particularly vulnerable individuals, with the anticipated spread of COVID-19 once Queensland borders open to other Australian States and Territories

The Direction achieves this by identifying settings considered by the Chief Health Officer to be high risk settings based on specified criteria and by providing COVID-19 vaccination requirements for those settings, and requiring proof of COVID-19 vaccination, or evidence of medical contraindication, for compliance with those requirements or for eligibility for an exemption. The Direction does not affect an employer's right to require COVID-19 vaccination of employees where their role requires it.

Human Rights Engaged

The human rights engaged by the Direction are:

- Right to equality (section 15)
- Right to life (section 16)
- Consent to medical treatment (section 17)
- Freedom of movement (section 19)
- Freedom of thought, conscience, religion and belief (section 20)
- Freedom of expression (section 21)
- Peaceful assembly and freedom of association (section 22)
- Right of equal access to the public service (section 23)
- Right to privacy (section 25)
- Right to non-interference with family and protection of family (sections 25 and 26)
- Right of children to protection in their best interests (section 26)
- Cultural rights of Indigenous and non-Indigenous peoples (sections 27 and 28)
- Right to humane treatment when deprived of liberty (section 30)
- Right to education (section 36)
- Right to health services (section 37)

- Right to equality (section 15): Every person has the right to recognition as a person before the law and the right to enjoy their human rights without discrimination. Every person is equal before the law and is entitled to equal protection of the law without discrimination. Every person is entitled to equal and effective protection against discrimination. Discrimination includes direct and indirect discrimination on the basis of a protected attribute under the *Anti-Discrimination Act 1991*, such as age, pregnancy, impairment or religious belief. Because the definition is inclusive, discrimination under the *Human Rights Act* also likely covers additional analogous grounds, which may include conscientious belief (however, it is considered that vaccination status or employment status in a particular industry will not be protected attributes as these are not immutable characteristics: *Miron v Trudel* [1995] 2 SCR 418, 496-7 [148]). The direction may result in people with protected attributes being treated differently (for example, a person with a genuine religious objection to vaccines may not be able to continue their employment working in a school or business in an airport precinct). But not all differential treatment amounts to direct or indirect discrimination.

  However, it is considered that the direction does not directly or indirectly discriminate on the basis of any other protected or analogous attribute. A person with an impairment in the form of a medical contraindication will be treated by the direction in the same way as a person who is vaccinated (provided they are able to provide proof). Further, the policy prevents people from entering and remaining in, working in or providing services in certain businesses because they are unvaccinated, not because they have one of those protected or analogous attributes. This means there is no direct discrimination on the basis of an impairment, pregnancy, religious belief or conscientious belief.

  Broadly, indirect discrimination is an unreasonable requirement that applies to everyone but has a disproportionate impact on people with an attribute (such as a religious or conscientious objection to vaccines). Preventing unvaccinated people from entering and remaining in, working in or providing services in certain businesses may have a disproportionate impact on people who are pregnant or who have a religious or conscientious objection to vaccines. However, it is considered that the requirements under the direction are reasonable in light of the public health rationale. Because the requirement is reasonable, there is no indirect discrimination on the basis of an impairment, pregnancy, religious belief or conscientious belief.

- Right to life (section 16): The right to life places a positive obligation on the State to take all necessary steps to protect the lives of individuals in a health emergency. This right is an absolute right. The Direction promotes the right to life by protecting the health, safety and wellbeing of people in the Queensland, in particular vulnerable Queenslanders, by placing vaccination requirements on those who work in high risk settings.

  On the other hand, as with any medical intervention, requiring a person to be vaccinated may come with a small risk of unintended consequences, some of which may be life threatening. Presently, in Australia, the Therapeutic Goods Administration has found that 9 deaths were linked to a COVID-19 vaccination (not necessarily caused by a COVID-19 vaccination) (of the more than 39 million doses that have been administered so far).[1]

  Human rights cases in Europe have held that the possibility that a small number of fatalities may occur does not mean that the right to life is limited by a compulsory vaccination scheme (*Application X v United Kingdom* (1978) 14 Eur Comm HR 31, 32-3; *Boffa v San Marino* (1998) 92 Eur Comm HR 27, 33). Arguably, the right to life is engaged (that is relevant), but not limited, by the proposed direction. As noted above, the right to life is promoted by the proposed direction.

- Right not to be subjected to medical treatment without full, free and informed consent (section 17(c)): Section 17(c) of the Human Rights Act provides that a person must not be subject to medical treatment without the person's full, free and informed consent.

  Medical treatment for the purposes of section 17(c) includes administering a drug for the purpose of treatment or prevention of disease, even if the treatment benefits the person (*Kracke v Mental Health Review Board* (2009) 29 VAR 1, 123 [576]; *De Bruyn v Victorian Institute of Forensic Mental Health* (2016) 48 VR 647, 707 [158]-[160]). While the direction will prevent workers from entering a high risk setting for work if they are not vaccinated, the direction will not compel anyone to be vaccinated without their consent. Arguably, this means that the right in section 17(c) is not limited (*Kassam v Hazzard* [2021] NSWSC 1320, [55]-[70]). However, international human rights cases suggest the right may be limited in circumstances where a person is left with little practical choice but to receive the treatment (*GF v Minister of COVID-19 Response* [2021] NZHC 2526, [70]-[72]). It is possible that the proposed direction will leave people with little practical choice but to receive a vaccine, so that while consent is given, that consent may not be full and free for the purposes of section 17(c).

- Freedom of movement (section 19): Every person lawfully within Queensland has the right to move about freely within Queensland. The Direction limits the freedom of movement by restricting who may enter and work in high risk settings according to their vaccination status. While freedom of movement is limited, the restriction on movement is not so severe that the right to liberty in section 29 is also limited (*Loielo v Giles* (2020) 63 VR 1, 59 [218]).

- Freedom of thought, conscience and religion (section 20) and freedom of expression (section 21): Section 20 of the *Human Rights Act* provides that a person has the right to freedom of thought, conscience, religion and belief. Some people have deeply held religious or conscientious objections to vaccines. For example, the Catholic Church has previously advised against using vaccine products that use cell lines derived from an aborted foetus (such as AstraZeneca), unless another vaccine (such as Pfizer) is not available. The effect of the direction is that people with a conscientious or religious objection to vaccines will not be able to enter and remain in, work in or provide services in

[1] <https://www.tga.gov.au/periodic/covid-19-vaccine-weekly-safety-report-02-12-2021>.

a high-risk setting if they have not received a first dose of a COVID-19 vaccine, after 17 December 2021, and have not received the prescribed number of doses by midnight 23 January 2022.

Freedom of religion in section 20 also encompasses a right not to be coerced or restrained in a way that limits the person's freedom to have or adopt a religion or belief (separate from the freedom to manifest their religion or belief). Similarly, freedom of expression in section 21 encompasses a right to hold an opinion without interference. At international law these are absolute rights (*Christian Youth Camps v Cobaw Community Health Service* (2014) 50 VR 256, 395 [537]). However, nothing in the proposed direction would coerce a person to believe a particular thing or not to hold a particular opinion. It would only limit a person's manifestation of that belief or opinion. Accordingly, those aspects of those rights are not limited by the proposed direction.

- Right to peaceful assembly and freedom of association (section 22): Freedom of assembly and association upholds the rights of individuals to gather together in order to exchange, give or receive information, to express views or to conduct a protest or demonstration for any peaceful purpose and to associate with each other. The freedom of association includes a right to form and join trade unions. The Direction may limit the rights to peaceful assembly and association through the vaccination requirements placed on workers in high risk settings. For example, people who are not vaccinated will not be able to associate through their work with like-minded people in high-risk settings, and unvaccinated union officials will not be able to visit unions members in high-risk settings.

- The right of access to the public service (section 23): Under section 23(2)(b) of the *Human Rights Act*, everyone has a right of equal access to the public service and public office. A risk of dismissal from the public service may engage this right (UN Human Rights Committee, *Communication No 203/1986*, 34th sess, UN Doc Supp No 40 (A/44/40) Appendix (4 November 1988) [4] ('*Hermoza v Peru*')). The effect of the proposed direction is that some public service employees may need to be vaccinated in order to be able to continue in their role, such as people working at schools and corrective services facilities, including youth detention centres.

- Right to property (section 24): Everyone has the right to own property and to not be arbitrarily deprived of that property. 'Property' encompasses all real and personal property interests. One right in the bundle of rights which make up 'ownership' is the right to decide who to allow onto one's property. The proposed direction interferes with that right by stipulating that certain businesses which are high-risk settings cannot allow unvaccinated workers to enter and remain in, work in or provide services in the property owned or occupied by the business. 'Property' may also include the right to practise a profession (*Malik v United Kingdom* [2012] ECHR 438, [89]-[93]). The right to property will only be engaged where the relevant property interest is held by a natural person. Section 24(2) also only protects against deprivations of property which are 'arbitrary'. As arbitrary in this context means (among other things) disproportionate, it is convenient to consider whether the impact is arbitrary below when considering whether the impact is justified (following the approach in *Minogue v Thompson* [2021] VSC 56, [86], [140]).

- Right to privacy (section 25): There are a number of different aspects of the right to privacy that may be engaged.

  First, the proposed direction would require workers to share personal information, such as their vaccination status. Requiring a person to disclose personal information interferes with privacy (*DPP (Vic) v Kaba* (2014) 44 VR 526, 564 [132]). Arguably, the freedom to impart information under section 21(2) includes a freedom not to impart information (*Slaight*

Communications Inc v Davidson [1989] 1 SCR 1038, 1080). However, a limit on this right would add no more to the interference with privacy.

Second, the right to privacy includes a right to bodily integrity (*Pretty v United Kingdom* (2002) 35 EHRR 1, [61]; *PBU v Mental Health Tribunal* (2018) 56 VR 141, 179 [125]). This right will be limited by compulsory vaccination, whether as an involuntary treatment, or where there are repercussions for failing to vaccinate, such as an inability to access services (*Vavřička v The Czech Republic* (European Court of Human Rights, Grand Chamber, Applications nos. 47621/13 and 5 others, 8 April 2021) [263]).

Third, because the right to privacy encompasses an individual's right to establish and develop meaningful social relations (*Kracke v Mental Health Review Board (General)* (2009) 29 VAR 1, [619]-[620]), the right to privacy may also incorporate a right to work of some kind and in some circumstances (*ZZ v Secretary, Department of Justice* [2013] VSC 267, [72]-[95]). The direction may engage this right by interfering with the ability of people to make and maintain social and professional connections and may engage a person's right to work by requiring that they be fully vaccinated to work in certain businesses.

The right to privacy in section 25(a) will only be limited if the interference with privacy is 'unlawful' or 'arbitrary'. As these raise questions that are addressed in considering whether any limit is justified, it is convenient to consider these questions at the next stage when considering justification (following the approach in *Minogue v Thompson* [2021] VSC 56, [86], [140]).

- Right to non-interference with family (section 25) and protection of families (section 26): Section 25(a) of the *Human Rights Act* protects a right not to have one's family unlawfully or arbitrarily interfered with. The proposed direction may interfere with a person's family, for example, by preventing an unvaccinated family member from working in the same school as their child, and the direction may also interfere with a parent's decision about their child's education and childcare arrangements. However, the direction makes clear that a worker is not prevented from using the services of the high-risk setting as a client or visitor, so any such impact is likely to be minimal if it arises at all. Again, whether the interference is lawful and non-arbitrary will be considered below when considering whether the interference is justified. The proposed direction may also limit the support available to vulnerable children in education settings by requiring vaccination of workers who visit them within the education setting.

  Section 26(1) of the *Human Rights Act* recognises that families are the fundamental group unit of society and are entitled to be protected by society and the State. That right is an 'institutional guarantee'. Compared to the individual protection of families in section 25(a), '[t]he true significance of [section 26(1)] lies not in the warding off of State interference but rather in the protected existence of the family' (Schabas, U*N International Covenant on Civil and Political Rights: Nowak's CCPR Commentary* (NP Engel, 3rd ed, 2019) 633-4 [1]-[2], 639 [12]). The proposed direction does not limit the right of families to be protected under section 26, because the proposed direction does not threaten the existence of the family as an institution of society.

- Best interests of the child (section 26): Under section 26(2) of the *Human Rights Act*, every child has the right, without discrimination, to the protection that is in their best interests as a child. The right recognises that special measures to protect children are necessary given their vulnerability due to age. The best interests of the child should be considered in all actions affecting a child, aimed at ensuring both the full and effective enjoyment of all the child's human rights and the holistic development of the child. 'The child's right to health … and his or her health condition are central in assessing the child's best interest.' In all decisions about a child's health, 'the views of the child must also be given due weight

based on his or her age and maturity' (UN Committee on the Rights of the Children, *General comment No 14*, UN Doc CRC/C/GC/14 (29 May 2013) 9). The proposed direction seeks to safeguard the best interests of the child by requiring vaccination of those who work closely with children, and are in regular close proximity with them in education settings.

The proposed direction protects the best interests of the child by preventing unvaccinated persons from entering or remaining in, working in or providing services in youth detention centres (with some exceptions), in order to prevent the risk of an outbreak amongst youths in the youth detention centre. However, by doing so, the direction may also limit other aspects of the right of children to protection in their best interests by, for example, preventing visits from support workers.

- Cultural rights – generally (section 27) and Cultural rights – Aboriginal peoples and Torres Strait Islander peoples (section 28): Section 27 of the *Human Rights Act* protects the rights of all people with particular cultural, religion, racial and linguistic backgrounds to enjoy their culture, declare and practise their religion, and use their language in community. It promotes the right to practise and maintain shared traditions and activities and recognises that enjoying one's culture is intertwined with the capacity to do so in connection with others from the same cultural background. Section 28 provides that Aboriginal and Torres Strait Islander peoples hold distinct cultural rights as Australia's first people and must not be denied the right, together with other members of their community, to live life as an Aboriginal or Torres Strait Islander person who is free to practise their culture.

  The proposed direction may limit cultural rights in a number of ways. For example, it requires workers who visit prisoners and students to be vaccinated. In some areas, there may be limited numbers of specialist workers available to effectively support vulnerable students and prisoners in a culturally appropriate way. Requiring them to be vaccinated may further reduce the available culturally appropriate support options.

- Right to humane treatment when deprived of liberty (section 30): Under section 30(1) of the *Human Rights Act*, any person deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person. That right is relevant whenever prisoners are 'subjected to hardship or constraint other than the hardship or constraint that results from the deprivation of liberty'. The right is relevant to this direction because it may impact a prisoner's connection to family and the community through support workers with some exceptions to ensure continuity of care and support for mental health and wellbeing and for legal and advocacy support. A similar point applies to youth detention centres. However, whether the right is in fact 'limited' must take into account that 'although prisoners do not forgo their human rights, their enjoyment of many of the rights and freedoms enjoyed by other citizens will necessarily be compromised by the fact that they have been deprived of their liberty' (*Castles v Secretary, Department of Justice* (2010) 28 VR 141, 169 [108]-[110]; *Owen-D'Arcy v Chief Executive, Queensland Corrective Services* [2021] QSC 273, [239]). As the exceptions are designed to provide essential supports, it is considered that the right not to be subjected to cruel, inhuman or degrading treatment or punishment under section 17(b) is also not limited.

- Right to education (section 36): Every child has the right to have access to primary and secondary education appropriate to the child's needs. Every person has the right to have access, based on the person's abilities, to further vocational education and training that is equally assessable to all. The value underlying the right to education is empowerment:

'as an empowerment right, education is the primary vehicle by which economically and socially marginalized adults and children can lift themselves out of poverty and obtain the means to participate fully in their communities' (Committee on Economic, Social and Cultural Rights, *General Comment No 13: The right to education (article 13 of the Covenant)*, 21st sess, UN Doc E/C.12/1999/10 (8 December 1999) 1 [1]).

As the direction applies to schools and other education settings designated as high-risk settings, it may impact on the right to education of students attending those settings, by potentially reducing the availability of teachers and other persons providing support in the delivery of education. On the other hand, the right to education is strengthened by reducing the risk of education delivery being interrupted by an outbreak in those settings.

- Right to health services (section 37): Every person has the right to access health services without discrimination and must not be refused necessary emergency medical treatment. An objective of the proposed direction is to avoid a surge in hospitalisations once borders reopen. Preventing hospitals from being overwhelmed ensures access to health serves and thereby protects the right in section 37.

In summary, the proposed direction seeks to protect and promote the right to life, the right to protection in the best interests of the child and the right of access to education and health services (sections 16, 26, 36 and 37). On the other hand, the proposed direction limits or may limit the right not to receive medical treatment without full, free and informed consent (section 17(c)), freedom of movement (section 19), freedom of conscience and religion (section 20(1)), the freedom not to impart information (section 21(2)), freedom of peaceful assembly and association (section 22), the right of equal access to the public service (section 23), property rights (section 24), the right to privacy (which may include privacy of personal information, a right to bodily integrity and aspects of the right to work) (section 25(a)), the right to non-interference with family (section 25(a)), cultural rights of Indigenous and non-Indigenous peoples (sections 27 and 28) and the right to education (section 36).

Compatibility with Human Rights

The direction will be compatible with human rights if the limits it imposes are reasonable and justified.

A limit on a human right will be reasonable and justified if:

- it is imposed under law (section 13(1));
- after considering the nature of the human rights at stake (section 13(2)(a));
- it has a proper purpose (section 13(2)(b));
- it actually helps to achieve that purpose (section 13(2)(c));
- there is no less restrictive way of achieving that purpose (section 13(2)(d)); and,
- it strikes a fair balance between the need to achieve the purpose and the impact on human rights (section 13(2)(e), (f) and (g)).

Are the limits imposed 'under law'? (section 13(1))

The Chief Health Officer is authorised to give the proposed direction under section 362B of the *Public Health Act* if they reasonably believe the direction is necessary to assist in containing, or to respond to, the spread of COVID-19 within the community.

The nature of the rights that would be limited (section 13(2)(a))

What is at stake, in human rights terms, is the ability of all people to take part in all aspects of community life. The direction implicates the ability of people to lead dignified lives, integrated in their community. Requiring people to choose between vaccination and a life integrated in their community, including their work, brings into play the principle that people are entitled to make decisions about their own lives and their own bodies, which is an aspect of their individual personality, dignity and autonomy (*Re Kracke and Mental Health Review Board* (2009) 29 VAR 1, 121-2 [569], 123 [577]). When it comes to people with genuine religious and conscientious objections, one of the values that underpins a pluralistic society like Queensland is 'accommodation of a wide variety of beliefs', including beliefs about health and vaccinations (*R v Oakes* [1986] 1 SCR 103, 136 [64]). Creating consequences for a person's employment also affects a person's dignity and autonomy through work. Those values at stake inform what it is that needs to be justified.

Proper purpose (section 13(2)(b))

The purpose of the proposed direction is to reduce the impact on individuals (particularly vulnerable people in high-risk settings) as well as the impact on the health system from spread of the COVID-19 within the broader community once Queensland borders open to other States and Territories. This can only be achieved by setting vaccination requirements for high risk settings in order to contain and prevent the spread of the virus.

The aim of protecting public health is a proper purpose. As noted above, protecting people in the community from the risk of COVID-19 promotes their human rights to life (section 16) and access to health services (section 37). At international law, the right to health includes '[t]he prevention, treatment and control of epidemic, endemic, … and other diseases': *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) article 12(2)(c). The purpose of protecting and promoting human rights is necessarily consistent with a society 'based on human dignity, equality and freedom' (section 13(2)(b) of the *Human Rights Act*).

Suitability (section 13(2)(c))

The limits on human rights will help to achieve the intended purposes. The available evidence to date is that vaccination against COVID-19 helps to reduce the risk of being infected and transmitting the virus on to others (even if the vaccine is not 100 percent effective).[2] This means vaccinated workers in high risk settings will be less likely to be infected by other workers in their workplace. Further, they are less likely to transmit the virus on to others, particularly the vulnerable cohorts and community members in the high risk settings. If they do contract COVID-19, their symptoms will be less severe and less likely to result in hospitalisation reducing the flow on of critical impacts to vulnerable cohorts and the wider community.

Requiring people to provide proof of vaccination to their employer helps to provide an environment that limits the opportunities for transmission of COVID-19 and protects both vulnerable cohorts who are unable to be vaccinated, or are in an environment that has a higher risk of transmission due to limited freedom of movement and/or a large concentration of people with the potential for rapid transmission in the event of exposure to COVID-19.

[2] Australian Technical Advisory Group on Immunisation (ATAGI), *Clinical guidance on use of COVID-19 vaccine in Australia in 2021 (v7.4)* (29 October 2021) 26-32.

The rational connection is not undermined by providing exceptions for people with a medical contraindication. Even with those exceptions, it is still the case that a greater proportion of workers in high-risk settings will be vaccinated.

Necessary (section 13(2)(d))

The following less restrictive alternatives were considered:

- applying the vaccination requirement to fewer settings;
- allowing a wider range of exemptions (such as a genuine religious objection);
- requiring settings to adopt a range of control measures such as social distancing, face masks and improving ventilation.

As to the first alternative of applying the direction to fewer venues, the Policy Rationale for the proposed direction explains that each of the categories of venues are included in the direction because they are high-risk. For example, prisons are included because the risks of COVID-19 to prisoners are higher. Prisoners typically have a lower health status and the enclosed environment of prisons gives rise to the risk of super-spreader events[3]. Education settings are included because there are large numbers of children who are unable to be vaccinated, studying and participating in sport and other activities in close proximity. Airports have large numbers of people travelling from hotspots and gathering in relatively small spaces as they onward travel.

Removing any of these categories of high-risk setting would not achieve the purpose of reducing the risks of COVID-19 transmission to the same extent as the direction in its current form.

As to the second option of allowing a wider range of exemptions, any additional exemptions would come at greater risk of COVID-19 transmission. Accordingly, this option would not be as effective in achieving the public health objective. Further, assessing the genuineness of a person's religious or conscientious belief would be extremely difficult in each individual case and resource-intensive given the scope of the direction. Accordingly, this alternative option would also not be reasonably practicable.

The third option is to require the settings covered by the direction to implement an alternative suite of control measures, such as social distancing and face masks. However, these alternative control measures, alone or in combination, are unlikely to be equally as effective as a vaccination requirement. The Therapeutic Goods Administration advises that '[v]accination against COVID-19 is the most effective way to reduce deaths and severe illness from infection.'[4] Further, the precautionary principle applied by epidemiologists provides that, 'from a purely public health perspective, all reasonable and effective measures to mitigate th[e] risk should ideally be put in place', not merely some of those measures (*Palmer v Western Australia [No 4]* [2020] FCA 1221, [79]). In particular, vaccination and face masks are not mutually exclusive. It is true that face mask requirements have been relaxed in South East Queensland in advance of the borders reopening, but they may be reintroduced if necessary, alongside vaccination requirements. Further, it is not clear that face masks would necessarily be less restrictive of human rights. A requirement to be vaccinated may be more intrusive of

[3]< https://www.aihw.gov.au/reports/australias-health/health-of-prisoners>, <https://nypost.com/2021/02/06/federal-executions-were-likely-covid-19-superspreader-events/>.

[4] <https://www.tga.gov.au/periodic/covid-19-vaccine-weekly-safety-report-04-11-2021>.

human rights for an individual in the short-term (as it involves medical treatment). However, a requirement to wear a face mask would impact all people – whether vaccinated or not – on a day-to-day basis.

In considering whether the limits on human rights are the least restrictive means, it is relevant that a number of safeguards are built in.

- The direction includes safeguards on the collection of vaccination information, including only requiring evidence to be sighted and not retained and requiring that records be kept by the employer and not by others. This is reinforced by part 7A, division 6 of the *Public Health Act* which sets out safeguards for personal information collected, including protection against direct or derivative use of the information in criminal proceedings (thereby safeguarding the right not to testify against oneself in section 32(2)(k) of the *Human Rights Act*).
- There are exceptions to the requirement to provide proof of vaccination in emergency situations. The exceptions based on risk to physical safety promote the right to security of the person in section 29(1) of the *Human Rights Act*.
- The direction is also in effect for a temporary period. The vaccination requirements within the direction will be regularly reassessed by the Chief Health Officer, and in particular once the population reaches 90 per cent double vaccination, with the opportunity to open up the community and economy further to everyone regardless of vaccination status.

There is no less restrictive, equally effective and practicable way to reduce the risk of COVID-19 transmission in the community. Accordingly, the limits on human rights are necessary to achieve the direction's public health objective.

Fair balance (section 13(2)(e), (f) and (g)

The purpose of the Direction is to reduce the risk of COVID-19 spreading within vulnerable cohorts in high-risk settings and the community, as well as driving vaccination uptake. The benefits of achieving this purpose include reduced impacts on individuals and the health system as more COVID-19 circulates in the community. It also provides the opportunity to open up the Queensland community and economy further to everyone regardless of vaccination status. The benefit also translates to a reduced impact on the health care system by preventing the significant pressure on the health care system caused by the spread of COVID-19 in the community. Conversely, a failure to mitigate the risk of transmission would likely result in loss of life.

On the other side of the scales, these benefits come at the cost of deep and wide impacts on some people, especially people who are not vaccinated against COVID-19. Some people may be effectively locked out of their work. While incentivising vaccination protects public health, it may interfere with a person's autonomy to make decisions about their bodies and their own health, and it may effectively force people to go against their deeply-held conscientious or religious beliefs.

When considering the weight of the impact on human rights, it should be emphasised that human rights come with responsibilities (reflected in clause 4 of the preamble to the *Human Rights Act*). As human rights cases overseas have held, individuals have a 'shared responsibility' or 'social duty' to vaccinate against communicable diseases 'in order to protect the health of the whole society' (*Pl ÚS 16/14* (Constitutional Court of the Czech Republic, 27 January 2015) 17 [102]; *Acmanne v Belgium* (1984) 40 Eur Comm HR 251, 265; *Boffa v San Marino* (1998) 92 Eur Comm HR 27, 35; *Solomakhin v Ukraine* [2012] ECHR 451, [36]; *Vavřička v The Czech Republic* (European Court of Human Rights, Grand Chamber,

Applications nos. 47621/13 and 5 others, 8 April 2021) [279], [306] (majority), [2] (Judge Lemmens)). That is, people have a choice not to get vaccinated, but if they exercise that choice, they are putting the health, livelihoods and human rights of others in their community at risk. The right to exercise that choice carries less weight on the human rights side of the scales.

On balance, the importance of limiting the spread of COVID-19 within Queensland (taking into account the right to life) and reducing the impacts on individuals and the health system outweighs the impact on other human rights. Indeed, it is difficult to overstate the importance to society of addressing the risk posed by a pandemic. Ultimately, the Direction strikes a fair balance between the human rights it limits and the need to reduce the risk of COVID-19 spreading within Queensland.