Government of **Western Australia**
Department of **Health**

Our ref:
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Dear Premier

MANDATORY VACCINATION OF ESSENTIAL AND HIGH-RISK WORKERS IN WA

With the progression of the COVID-19 pandemic and the roll-out of the COVID-19 vaccines, I have recommended the mandating of COVID-19 vaccination for several different professional cohorts; these include hotel quarantine staff (28 April 2021), healthcare and health support workers (09 August 2021), mission critical police staff (25 August 2021), port workers (07 September 2021), freight and logistics workers (10 September 2021), resources workers (05 October 2021) and primary and community health workers (08 October 2021). The Australian Health Protection Principal Committee has also recommended the mandating of vaccination of residential aged care workers (29 June 2021) and residential disability support workers (09 July 2021). All of these are in different stages of implementation, with vaccine mandates covering hotel quarantine, residential age care facilities, mission-critical police areas and the high-risk areas in public and private hospitals now in place.

I am writing to provide further advice to protect the Western Australia (WA) community from the risk posed by the COVID-19 pandemic. It is my recommendation, as the Chief Health Officer, that further mandatory vaccination Directions are required for workforces that are at higher risk of exposure, have a greater potential to transmit to vulnerable populations or are themselves critical to the functioning of our society. I also recommend that the current vaccination mandates on workforces, which have been implemented to protect staff and the most vulnerable members of our community, be strengthened.

The Communicable Diseases Network Australia (CDNA) publication, *Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units* (Version 5.1, 8 October 2021) lists the occupational groups that are at increased risk of exposure as including: international border staff; workers supporting quarantine and isolation

services; air and maritime crew; and health care and aged care workers with direct patient contact. While the Directions in place for mandatory vaccination have covered some of these occupational groups, notably health, port and quarantine workers, they do not cover all groups at higher risk of exposure and the recommendations I now make seek to ensure that significant gaps are covered.

The CDNA Guidelines also describe settings that are 'high risk' for outbreaks of COVID-19 due to the high risk of transmission and potential for poor outcomes in the populations in these settings. The four 'high risk' settings identified by the CDNA National Guidelines are: residential care facilities, Aboriginal and Torres Strait Islander Communities, correctional and detention facilities, and meat processing facilities. Again, the recommendations I make below seek to enhance the public health protection measures for these settings, by ensuring a fully vaccinated workforce.

The reasons for this necessary public health action are outlined below under each of the worker group headings.

Border control and air transport

On 28 April 2021, I recommended that COVID-19 vaccination be mandated for hotel quarantine workers, as these workers were shown to be at high risk of transmission of COVID-19 through their contact with international hotel guests. Other workforce groups at higher risk of exposure to COVID-19 include exposed port workers and cross-border freight and logistic workers from high and extreme risk jurisdictions, which I recommended be required to be mandatorily vaccinated on 07 September 2021 and 10 September 2021 respectively.

With ongoing endemic spread of COVID-19 in countries overseas and ongoing and increasing outbreaks in Australia, staff that work at interstate border crossings, airports and those in the (interstate) air transport industry are amongst those people with the highest risk of exposure to COVID-19. Given the Delta strain is now the predominant strain in Australia and world-wide, the risk to this workforce has increased in the past 10 months, as Delta has proved to be more contagious than previous strains. While some elements of these workforces are already subject to mandatory vaccination requirements, including WA Police and healthcare workers, others are currently not covered.

This workforce uses personal protective equipment (PPE) as their main risk mitigation measure. Experience from health workers in hospital settings has shown that where PPE is worn for prolonged periods and/or not worn appropriately, transmission can result. In settings outside health care, where staff are less well practiced in PPE use and often need to wear PPE for prolonged periods, staff are at increased risk of PPE failure. The nature of the work undertaken by staff working at border control areas and in air transport is not always conducive to best practice physical distancing and reliable PPE practice, and, at times, work may be carried out in an environment that is not as well controlled as that of a hospital. While the PPE is supplemented by regular testing, which will help reduce the risk of significant spread into the community, mandating COVID-19

vaccination for the workers in border control and air transport settings will better protect them, their clients, family and the broader community.

Residential and non-residential community care services

Protection of our most vulnerable members of society during the COVID-19 pandemic is of paramount public health concern and for this reason, as well as their exposure risk, I recommended that healthcare and health support workers in public and private hospitals and staff in residential aged care facilities be subject to mandatory vaccination on 06 August 2021 and 09 August 2021 respectively. In addition, I recommended on 08 October 2021 that further health worker groups in community health and primary health care settings be subject to mandatory vaccination requirements. The vaccination of these aged care and health worker groups is a necessary means of strengthening the protection of those people most vulnerable to COVID-19, including the elderly and those with serious medical conditions, who need to seek health care across a variety of settings. In addition to vulnerable groups that may interact with the healthcare system, there are a variety of vulnerable groups that necessarily interact with workers in community settings outside the healthcare setting. Consequently, I recommend strengthening the protections to those most vulnerable to the severe consequences of COVID-19 by mandating vaccination in workers who work in residential and non-residential community care services for vulnerable groups, employees working in prisons and those people who enter Remote Aboriginal Communities to work. In addition to containing a large proportion of vulnerable people, the residential community care, corrective services and Aboriginal community settings are at increased risk of serious disease, hospitalisation and premature death in large outbreaks should the disease be introduced, which will be further exacerbated by the reduced availability of specialised health services in rural and remote communities.

Community based care services provide support to cohorts of our society that are vulnerable for a range of reasons and circumstances, including, but not limited to, poor health (including mental health), lower socio-economic status, alcohol and/or drug dependence, domestic violence or older age. In general, all these groups are at higher risk of adverse outcomes from COVID-19 disease, just as they generally fare worse across a range of health indices. Where people need to access community services, they should be confident that their health will not be compromised while seeking the care and social support they require.

The residential and non-residential community care services that have workers for whom COVID-19 vaccination should be vaccinated include:

- disability services;
- mental health services;
- homelessness services;
- drug and alcohol services;
- child protection services; and
- services for Aboriginal people

The *CDNA National Guideline for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia* lists the features that make an outbreak in an aged care facility more likely to occur and these principles can be applied across a range of residential settings. Specifically, residential settings have the following features that increase the risk of an outbreak and/or promote the propagation of an outbreak, as the settings:

- support large numbers of people on site;
- allow large numbers of people to access the facility, which increases the chance of disease introduction;
- have large numbers of frequently touched surfaces, with common areas for large numbers of people;
- support an environment with work and living arrangements that involve proximity to others (i.e. is a densely populated environment);
- often have centralised processes operating across all areas;
- may have residents that are unable to consistently comply with isolation and infection control principles; and
- often have staff shortages and a need to use agency staff, who may not be familiar with the facility, its processes, residents and the infection control measures required.

Even if community services provide services to vulnerable groups in a non-residential setting, the services provided are high risk for outbreaks due to the reasons outlined above. Often the nature of their work in the community settings means other mitigation measures, such as physical distancing and wearing of masks, cannot be reliably maintained. Where the service does not provide any group activities, it is still the case that the individuals that access the services are likely to be vulnerable and more at risk of COVID-19 infection and the severe outcomes associated with COVID-19 disease.

Given their vital role in the community supporting vulnerable groups, it is critical that the workforce in these community care services are protected by vaccination. Vaccination represents an important intervention for the prevention of transmission of COVID-19 to the workforce and to the community with whom this workforce interacts.

Corrective services

Detention and correctional facilities are at high risk for COVID-19 introduction from the community, either through the staff, visitors or transferring prisoners, and the setting is prone to a large outbreak, leaving the prisoners vulnerable to severe outcomes.

Detention and correctional facilities are one of the four settings recognised by CDNA as 'high risk' requiring specially written guidelines for management of outbreaks (see *CDNA National Guideline for the Prevention, Control and Public Health Management of COVID-19 Outbreaks*). These facilities are well recognised to be at a high risk of outbreaks of COVID-19 due to many of the same reasons that are listed above for residential community care settings, with large numbers of people living on site, with common areas and central services.

Apart from their residential setting, the prison population also represents a vulnerable group, as they have a high proportion of prisoners that have one or more of the following risk factors for poor disease outcomes: social disadvantage, underlying poor health including chronic disease, high drug/alcohol dependence, Aboriginal and Torres Strait Islander background and, in some prisons, increasing elderly population. These factors increase the risk of severe outcomes of COVID-19 disease in this population.

Detention and correctional facilities represent an environment that may not always be controlled and one in which other protective measures, such as PPE use and physical distancing, cannot be reliably applied by the staff. Many prisoners will not be able to or will not participate in such mitigation measures. Vaccination of the workforce will add an important mitigation to disease transmission through the workforce and the prison system. In addition, the workforce of the corrective services represents another critical workforce that must be protected due to the important role they undertake supporting the prison system.

Remote Aboriginal Community Workers

Remote Aboriginal Communities are at high risk of disproportionate adverse health outcomes because of the COVID-19 pandemic, due to the vulnerability of the community residents to the severe consequences of COVID-19. Remote Aboriginal Communities support residents that have an increased rate of chronic disease and there is an increased likelihood of an outbreak spreading in an uncontained manner throughout the community due to shared housing and extended family arrangements, the mobility of the population and the reduced access to medical care due to their remote location. Many Aboriginal people have multiple risk factors for severe disease outcomes, including underlying chronic disease and/or immunocompromise. For these reasons, it is of paramount importance that workers who are entering to work in Remote Aboriginal Communities are fully vaccinated.

The *CDNA National Guidance for Remote Aboriginal and Torres Strait Islander Communities for COVID-19* states that an uncontrolled outbreak in a remote community is expected to spread rapidly, due to overcrowded housing, close mixing in groups and between interconnected households. The recent outbreak in Wilcannia, NSW, exemplified this when the introduction of COVID-19 led to the infection of 152 residents in one month, representing 20% of the town's population.

Many Aboriginal Communities in remote settings in WA are many hundreds of kilometres from health care facilities that may be needed if a person with COVID-19 deteriorates requiring oxygen, ventilation and cardiopulmonary support. While one or two cases can potentially be cared for in regional hospitals, an outbreak in a remote Aboriginal community could mean that many people could require transport out of the region and on to Perth.

As many of these Aboriginal communities are generally closed to outside visitors, and the vaccination rates remain low compared to the general community, workers travelling into

the communities pose a risk of introduction and transmission of COVID-19 to these vulnerable populations. On this basis, it is my advice that anyone entering to work in a remote Aboriginal Community is vaccinated for COVID-19.

WA Police Force

On 25 August 2021, I recommended that the mission critical areas of the WA Police Force be subject to mandatory vaccination, as the continuity of their work is critical to broader public health and public safety. However, due to the WA Police Force comprising a very large workforce, their close interaction with the community, the unpredictable nature of the work they do, their interaction with vulnerable communities and the broader public health impact of that work, there is a strong public health benefit to mandating COVID-19 vaccination for the entire workforce. The public health benefits of vaccination in this group are two-fold. The WA Police Force, through the nature of their work, are at high risk of exposure and/or transmission of COVID-19 between their workers and members of the community, some of which are extremely vulnerable. The protective measures of PPE and physical distancing cannot always be adequately applied in situations that are uncontrolled and unpredictable, such as that which can occur in the line of police duty, including responses to accidents, protests and other incidents. As with other non-health workforces who are unaccustomed to wearing PPE, the risks of PPE failure in this workforce, particularly with prolonged use, is increased. Vaccination of the remaining WA Police Force staff will reduce the risk of this workforce from becoming infected, developing serious illness as the result of COVID-19 and further spreading the disease to vulnerable groups and the general community. Secondly, the WA Police Force represents a workforce that is critical to the functioning of our society, particularly at a time when there is a global pandemic and WA remains in a prolonged State of Emergency.

Department of Fire and Emergency Service

The Department of Fire and Emergency Services (DFES) workforce is at high risk of exposure to COVID-19 and represents another essential workforce for which I consider mandatory vaccination is justified on public health grounds. Transmission of COVID-19 in the DFES workplace, due to the role they play in responding to critical and life-threatening situations, their exposure to the broader community and their interactions with vulnerable communities on a daily basis, has the potential to cause serious illness in DFES staff, their families and members of the community

By the nature of their close interactions with the community, the DFES workforce may potentially be exposed to COVID-19 cases either knowingly or inadvertently. During their emergency work, DFES personnel are required to work closely with vulnerable groups, often in environments where limited controls may be in place that would otherwise reduce the opportunity for COVID-19 transmission to occur. As with police, the DFES workforce are unfamiliar with PPE use for mitigating infectious diseases and their ability to consistently use PPE appropriately is made difficult when this needs to be maintained over prolonged periods and in challenging environments. Vaccination, therefore, represents an important intervention for the prevention of transmission of COVID-19 to

the DFES workforce, to vulnerable groups with whom the workforce interacts and to the public.

The DFES workforce represent a critical workforce, whose role in protecting our community and responding to emergencies must be safeguarded. The voluntary DFES workforce, while critical in their regional and rural areas, have a similar risk to the community. Vaccination should be encouraged in this workforce, but this group is not currently recommended for mandatory vaccination. The potential impacts of COVID-19 infection on the available DFES workforce, should a transmission event occur, could be significant. If staff are required to be furloughed due to close contact with a COVID-19 case, the continuity of essential DFES services could be jeopardised, leading to the unavailability of certain facilities, assets or infrastructure and support for the public in times of need. If an outbreak was to occur, unvaccinated staff would be vulnerable to infection and severe disease and represent a potential threat to the community in which they work. If an outbreak was to occur in a regional or remote setting, this could present significant community risks, including to vulnerable Aboriginal communities. COVID-19 vaccination of this workforce will reduce the propensity of transmission in this workforce and will reduce the impact of COVID-19 on the individuals within the workforce.

Abattoir and Meat-Processing Workers

According to the CDNA publication, *Coronavirus Disease 2019 (COVID 19) CDNA National Guidelines for Public Health Units* (Version 5.1, 8 October 2021), meat (including poultry) processing facilities may present a higher risk of COVID-19 transmission to workers. The Guidelines go on to outline that this increased risk for outbreaks of COVID-19 is related to production line work near others, limited hygiene measures due to tally driven work, temperature and humidity, and employer sponsored communal housing and transport.

Outbreaks of COVID-19 occurred in abattoirs in Victoria during the second wave of the Victorian COVID-19 outbreak in 2020, and many have been reported from overseas. Despite provision of advice to the industry regarding mitigation steps that can be taken, Victoria is again experiencing outbreaks in abattoirs in their third wave, due to the difficulties in managing transmission in these environments. Although PPE is often worn routinely in abattoirs, the environment is extremely conducive to the propagation of infection, such that usual PPE and physical distancing does not seem to be able to abate the risk. As surgical masks and other disposable face masks should be changed if they become damp or soiled, which is very frequent in the environment of the abattoir, the prolonged use of PPE in this environment becomes extremely challenging. In addition to the abattoir operating ‘floor’, abattoirs generally have multiple areas in which the workers come into close contact, with many surfaces that are high touch points, providing further opportunity for the transmission of COVID-19 in this environment. As a workforce group, abattoir and meat-processing workers have a high proportion of people who are from Culturally and Linguistically Diverse (CALD) backgrounds, who are themselves more vulnerable to infection with COVID-19 and the severe outcomes of infection, due to their relatively reduced access to health information and health care, and the combined impact

of other social factors, including low incomes, casualised work practices and often inadequate accommodation, on this group. For these reasons, it is my strong recommendation that COVID vaccination be mandated in this workforce.

Public Health Grounds

There are good public health grounds for mandating the COVID-19 vaccine in the workforces outlined above if the following conditions are met:

1. **There is a serious public health risk –** To date, there have been over 4.8 million deaths attributed to COVID-19 globally and 239 million cases. While Australia has been relatively protected due to effective public health measures, COVID-19 disease continues to cause major outbreaks in many parts of the world, particularly in parts of Asia, Europe and the United States. In the past four months, Australia has seen outbreaks of COVID-19 in several states, with ongoing community transmission in NSW, ACT and Victoria.

Among survivors, there is emerging evidence that there may be long-term consequences for those who have been infected but survive, even from mild disease. 'Long COVID-19' health implications may present a grave future public health problem.

As Western Australia largely has no community spread, the main source of cases of disease in WA and Australia is through persons arriving from infected interstate and international locations. In Western Australia, infectious incursions are most likely to occur through international or interstate arrivals. Protection of workers at our borders and those involved in air transport needs to be prioritised to reduce the likelihood of transmission to that workforce and beyond, into the community. Full vaccination of this cohort, combined with the other risk mitigation measures currently implemented, will greatly mitigate this serious public health risk.

The Delta variant strain of the SARS-CoV-2 virus has become the dominant strain in Australia, leading to several outbreaks including the current large outbreaks occurring in New South Wales (NSW) and Victoria. The Delta variant is significantly more contagious than previous strains of COVID-19 and there is emerging evidence that it leads to more severe outcomes, with nearly double the hospitalisation rate of those with the Alpha variant. People who have not been fully vaccinated against COVID-19 are most at risk.

The three vaccines provide excellent protection against the Delta variant, and, as demonstrated in the current NSW and Victoria outbreaks, serious disease is largely confined to the unvaccinated or partially vaccinated and is impacting more severely on younger age groups than previous variants. The vaccines also significantly reduce the rates of infection and subsequent spreading of the virus. It is vital to ensure all possible risk mitigation measures are in place to minimise the potential of COVID-19 transmission to the WA community.

2. **The vaccine is safe and effective –** All persons in WA are currently being offered one of three vaccines, being the Comirnaty (Pfizer), the Spikevax (Moderna) vaccine or the

AstraZeneca vaccine, all of which have completed a rigorous safety evaluation prior to registration by the Therapeutic Goods Administration (TGA). In addition, the vaccines have been given safely around the world in hundreds of millions of doses. Recent studies in the United Kingdom have shown the Pfizer vaccine to be highly effective in preventing clinical disease generally and serious disease particularly, including against the Delta variant. The Pfizer vaccine has been demonstrated to be effective in preventing infection in individuals and subsequently reduce community spread to others in the community, particularly those who are more vulnerable, such as those over 70 years of age and those who cannot be vaccinated on medical grounds. The COVID-19 vaccines also reduce the incidence and severity of "Long COVID-19'.

3. **The mandating of the vaccine is proportionate.** According to the principle of proportionality, additional measures are justified when the restrictions placed on individuals are both minimised and proportionate to the expected advantages offered by the more coercive policy. Although voluntary compliance by these workers would be preferable to mandates, the inconsistent uptake of the vaccine leaves me, as the Chief Health Officer, with limited options. Unvaccinated workers in settings in which exposure is likely, and/or the propensity for outbreaks is high, and/or where vulnerable people may be inadvertently exposed to COVID-19, can cause tremendous harm.

4. **The mandate is lawful and reasonable.** On 13 August 2021, the Fair Work Ombudsman advised that employers may be able to require employees to get vaccinated where it is:
    - required by a specific law (e.g. Public Health Order);
    - permitted by an industrial instrument (e.g. award, agreement, contract); or
    - lawful and reasonable, as assessed on a case by case basis.

    "Reasonable" considers factors like the nature of the workplace (e.g. the extent of public contact) and the extent of community transmission in the relevant location. The Ombudsman noted that the three tiers where mandatory vaccination would be considered "reasonable" were:

    - Likely to be reasonable:
        - Tier 1: employees required to interact with people with an increased risk of being infected with COVID-19 (e.g. hotel quarantine/border control)
        - Tier 2: close contact with people vulnerable to COVID-19 (e.g. aged care, Aboriginal communities)
    - Dependent on circumstances (e.g. likeliness of transmission):
        - Tier 3: interaction with other employees or the public (e.g. essential retail)

    In this instance, mandating vaccines for the workers outlined, for the reasons outlined above, would be considered reasonable on the grounds of both an increased risk of being infected with COVID-19 (Tier 1) and likely close contact with vulnerable populations (Tier 2).

    In summary, I recommend that the following workforce groups should be mandated to be vaccinated to reduce the possible impacts of COVID-19 on their workforce and the community members which they serve:

- border control and air transport workers;
- residential and non-residential community care services workers;
- corrective services workers;
- remote Aboriginal community workers;
- WA Police Force workers (all areas);
- Department of Fire and Emergency Service workers (excluding voluntary workers); and
- abattoir and meat-processing workers.

Further details on the workers covered in Group 1 (the above group) are outlined in Attachment 1. Attachment 1 provides further guidance on current groups mandated, the next groups planned to be mandated (Group 1) and further groups where it is anticipated that further mandates may be required, either in the advent of an outbreak and subsequent lockdown or in preparation for opening of interstate and international borders, with subsequent outbreaks (Group 2). Finally, the Attachment outlines critical workforces where consideration would be given to allowing them to continue work in a lockdown or periods of restrictions, but only if all staff working are fully vaccinated (Lockdown Group). This will decrease transmission risks and prevent impact on delivery of critical services.

In developing Directions under the *Public Health Act 2016*, the preferred option is that unvaccinated workers not be allowed to enter or work in their workplaces where, in their roles, they may encounter exposed members of the public or work in roles that requires direct contact with public in situations in which other preventive measures cannot easily be taken. This still allows choice by the individual not to take the vaccine, but may require them to seek other employment. This approach to mandating the vaccine is proportionate to the risk, the efforts made to encourage the voluntary uptake of the vaccine and the benefits achieved.

I am of the view, as the Chief Health Officer, that, for the reasons outlined above, the benefits outweigh the risks of mandatory vaccination for these workforces and that this should be implemented as soon as practicable. I further recommend that mandatory vaccination be required by way of Directions issued under the *Public Health Act 2016*. This would require all workers who work in these Group 1 areas to be vaccinated on or after 01 December 2021. There would also be a further requirement for full vaccination by 01 January 2022.

Yours sincerely

Dr Andrew Robertson, CSC PSM
CHIEF HEALTH OFFICER

19 October 2021

Att.