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

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Dear Premier

UPDATED CLOSE CONTACT DEFINITIONS AND PUBLIC HEALTH AND SOCIAL MEASURES

On 05 November 2021, I provided advice regarding the rationale for use of Public Health and Social Measures (PHSMs) to mitigate the spread of COVID-19 during an outbreak in Western Australia (WA). In my advice, I noted that PHSMs should be titrated according to the number of cases in the community, the pressure within the health system and the capacity of the State to respond to outbreaks and emergency situations. Since that time, WA has commenced, as a State, to transition to 'living with COVID'. Since February 2022, WA Health has been managing a COVID-19 outbreak due to the Omicron BA.2 variant, using the public health levers of Testing, Tracing, Isolation and Quarantine (TTIQ) and PHSMs, including masks. WA has now reached a point in the outbreak where it is suitable to review the use of these public health levers and to ensure that these are at a level that most appropriately supports the outbreak response while minimising adverse impacts on industry, schools and society. Specifically, given WA has now passed the peak of the current COVID-19 outbreak, it is appropriate to review our close contact definition, use of contact registers, testing requirements and capacity limits.

On review of the daily case numbers, WA reached its peak of COVID cases two weeks ago, on 29 March 2022, when the daily case number reached 9,754 new cases. Total active cases reached their peak of 54,064 cases on 01 April 2022. Since then, daily and overall active case numbers have declined slowly, with 7,426 new cases and 39,591 active cases reported on 12 April 2022. I anticipate that cases will continue to slowly decline, although changes to PHSMs and the TTIQ settings may lead to small increases in coming weeks. While WA has experienced hospitalisations, ICU admissions and deaths due to COVID-19, these have fortunately been below the expected numbers from the modelling data.

CLOSE CONTACT DEFINITION CHANGE

In my advice of 06 February 2022, regarding *Transitioning to a High Case Load Setting*, I described a proposed new 'close contact' definition. Following discussions about the interpretation of that definition, I provided further advice on 10 February 2022 to ensure that

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the definition was clear and easily understood, which was key to ensuring that there was good community understanding of these definitions, the likely actions that were to be taken when someone becomes a close contact and the importance of compliance with these measures to protect the safety of the community.

In my advice of 06 and 10 February 2022, I outlined how transmission of COVID-19 from a case to a contact is known to occur most readily and frequently between people who have very close contact with each other, with the most high-risk contacts of a case being in household and 'household-like' settings. I then noted that 'the next group of 'at risk' exposures were those that have had face-to-face contact without mask use, and then those that shared a small space, again, without mask use.

The subsequent definition on 10 February 2022 was:

'A close contact will be defined as:

- A household member or intimate partner of a person with COVID-19 who has had contact with them during their infectious period; or
- Someone who has had close personal interaction with a person with COVID-19 during their infectious period, where that interaction involved:
  - at least 15 minutes face to face contact where a mask was not worn by the exposed person and the person with COVID-19; or
  - greater than two hours within a small room, where masks have been removed for this period.
- Someone who is directed by WA Health that they are a close contact.'

This definition has been effectively used in the response to the current Omicron BA.2 variant outbreak, both before and after the introduction of the very high caseload settings from 10 March 2022, which, as outlined in my advice of 08 March 2022, allowed for:

- modification of the household close contact management protocol, to align with the national management approach;
- implementation of 'critical worker' quarantine arrangements; and
- implementation of modified quarantine arrangements for school children who are asymptomatic non-household close contacts, which will permit them to continue to attend school, with no additional testing required.

On 30 December 2021, the Australian Health Protection Principal Committee (AHPPC) issued a statement on the TTIQ settings in Australia and recommended a change to the close contact definitions in the context of high levels of COVID-19 community transmission. At that time, much of Australia, except for WA, was experiencing significant COVID-19 Omicron outbreaks. The outbreaks across Australia were leading to rapidly increasing numbers of new cases per day, but without the same rapid increase in hospitalisations and ICU admissions that had been of concern a month prior, when the main circulating variant was Delta. The new Omicron variant was showing itself to be more transmissible, but less severe, than the Delta variant. However, the very high caseload was overwhelming contact tracing efforts, which had already reached capacity in many jurisdictions. In addition, the close contact definitions in place were leading to unacceptable furloughing of high numbers of critical workers and increased disruption to societal functioning, including shortage of essential goods and services.

When it recommended changing the close contact definition, AHPPC acknowledged contact tracing efforts were no longer able to identify considerable numbers of cases and close contacts, and stated that a change to the TTIQ settings was needed “to support public health sustainability, social cohesion and economic recovery”. With declining contact tracing effectiveness, in the context of a more transmissible but less severe variant, AHPPC recommended that jurisdictions should consider changing to a ‘household’ and ‘household-like (4 hour)’ close contact definition and should reduce the quarantine time to 7 days. The AHPPC stressed that other population health approaches, including public health and social measures (PHSMs) and ongoing vaccination efforts would be key to keeping cases at a manageable level that did not overwhelm the hospital system.

Since early January 2022, all jurisdictions, other than South Australia (SA) and WA, have adopted the national ‘close contact’ definition. SA moved to the national close contact definition on 26 March 2022, having had a similar definition to the current WA definition. While there are some slight differences, all now accept that close contacts are those people that spend a considerable amount of time (>4 hours) in a house or household-like setting without masks. The differences in transmission potential that are currently being observed may be due to differences in PHSMs, which should only cautiously be changed at the same time as the TTIQ settings.

Under the high caseload settings, WA Health is no longer trying to identify all possible contacts of a case, but those who are most at risk of contracting COVID, while maintaining an approach that allows society to keep functioning without mass furloughing of workers and unnecessary quarantining of people. The risk of missing a case with these definitions is offset by protections afforded by a highly vaccinated population and the Level 1 PHSMs in place, including mask use.

As case numbers fall, a change to the close contact definition used in WA is now required. While the community has worked hard to comply with the existing close contact constraints, this has impacted on businesses and social functioning and there is significant fatigue from the current systems. Furloughing of staff and managing quarantine arrangements, while necessary during high caseloads, has been disruptive to businesses and the workforces impacted. Schools and the early childhood education sector have also performed a very active role in management of close contacts from their environments, and this has greatly increased the workload of staff as well as being a source of inconvenience and difficulty for facilities and families.

As occurred in the other jurisdictions, the contact tracing systems were utilised to their maximum capacity, and their effectiveness is now decreasing. Moving to a revised ‘close contact’ definition may lead to a manageable increase in COVID cases as people are infected in non-household and social settings. On a background of decreasing cases generally, this is expected to have only a marginal impact, particularly in the context of ongoing PHSMs. In my advice of 24 March 2022, I noted that the PHSMs remain the principal measure available to control the growth of the current outbreak. This continues to be the case and will remain so as WA changes the TTIQ close contact definition. The new definitions will be easier to apply and should improve compliance, as WA Health is now receiving increasing reports of both intentional and innocent non-compliance with the current rules.

It is therefore my recommendation, as Chief Health Officer, that the close contact definition in WA should be changed on or after 14 April 2022 and a 'close contact' should now be defined as follows:

A close contact is:

- a household member or intimate partner of a person with COVID-19 who has had contact with them during their infectious period; or
- 'household like', whereby someone who has had close personal interaction with a person with COVID-19 during their infectious period, such that the interaction involved:
  - greater than four hours (cumulative over 24 hours) in a residential setting (home, accommodation facility), where masks have been removed by the contact and the case for all of this period; or
- someone who is directed by WA Health that they are a close contact.

This new definition should take effect from 12:01am on 14 April 2022, with those people who are existing close contacts under the old definition, but not meeting the new definition, no longer required to quarantine from this time, provided they are asymptomatic and not awaiting a COVID test result.

CONTACT REGISTERS

In my advice of 24 March 2022, I recommended that QR codes and contact tracing registers should be reduced to only those venues with Proof of Vaccination requirements. With a change to the 'close contact' definition to a 'household or household-like' close contact only, the QR code and contact registers will no longer be required to capture people who were previously close contacts due to their interactions at hospitality and other venues. I therefore recommend that the requirement for QR codes and contact registers be removed from *all venues* from the time of implementation of the new 'close contact' definition. The notable exceptions to this will be facilities with vulnerable cohorts, including hospitals, disability services and residential aged care facilities, who should continue to restrict visitors in line with the current settings and keep a register of all visitors; noting that the latter arrangement is not mandated by Directions, but through the implementation of local policies.

TESTING TRAVELLERS ARRIVING TO WA

On 18 February 2022, I provided advice regarding our Western Australia (WA) border, which recommended that the border should open to travellers without the need to quarantine on 05 March 2022. In my advice, I recommended that all incoming travellers be required to undertake a COVID-19 test (RAT or PCR) after arrival. While the initial purpose was to protect the WA community from further exacerbation of the local outbreak from introduced cases, the post-arrival testing of travellers is no longer a useful measure and may be causing unintended consequences.

The *COVID Transition (Interstate and International Border) Directions* require any arriving traveller to undertake Rapid Antigen Testing (RAT) within 12 or 24 hours of arrival, depending if they have arrived via Perth airport or into WA via another way. This testing requirement was a proportionate response to the opening of WA's border in March 2022; however, the

intention was to review this requirement after 4 weeks to assess its continuing utility in the context of a very high caseload setting in the WA community. The testing requirement should now be reconsidered.

Post arrival testing is unlikely to be detecting significant numbers of cases and may have the unintended consequence of providing false reassurance to travellers and residents with whom they interact. Approximately 2% of cases in the current outbreak are identified as overseas or interstate travellers. As outlined in the RAT advice of 03 March 2022, widespread asymptomatic testing is not recommended, due to the false reassurance such a test provides to a person, and the false positive rate of approximately 1-2%, which can lead to non-cases being isolated for 7 days. There is also little value in testing travellers who are not themselves close contacts, particularly when they are coming into an environment that is now likely to be of a similar risk to the one from which they have travelled.

There is an increasing number of people entering WA who have had COVID interstate or overseas. For people who are recovering from COVID-19, this testing requirement is contrary to national medical advice, as it is recognised that a person who is recovering from COVID may shed (non-infectious) virus particles for some months, making the interpretation of such tests difficult. It is recognised that a person who has had COVID recently will not get reinfected within 12 weeks of the end of their isolation period.

Given the decreasing benefits of post-arrival testing, the requirement should be revised. The following is recommended from 12:01am on 14 April 2022:

- remove all requirements for testing people entering WA from interstate or overseas; and
- continue providing free RAT tests and communication material at the airports to encourage symptomatic testing for all travellers.

CHANGES TO PUBLIC HEALTH AND SOCIAL MEASURES POST-PEAK

Since the commencement of the WA outbreak on 17 January 2022, WA has implemented a range of PHSMs in a staged approach, with Level 1 PHSMs implemented on 18 February 2022 and Level 2 PHSMs on 03 March 2022. On 24 March 2022, I made recommendations regarding the downgrading of PHSMs from Level 2 to Level 1, where I advised that these measures should not be fully implemented until two weeks after the peak of Omicron cases had been reached in WA. I further noted that some PHSMs should be maintained, even once Level 1 PHSMs are reinstated. I will elaborate on these below.

As outlined in my advice of 24 March 2022, and given WA is now two weeks past the peak of cases, I recommend that WA returns to Level 1 PHSMs as proposed, with the relaxation of capacity limits in hospitality venues, events, private functions and homes. The Level 1 PHSMs still require density limits of one person per 2sqm in public venues and events, which remains important in managing community spread among the ongoing cases. Despite the success achieved in WA's outbreak response to date, I do recommend that we proceed with caution and maintain some of the Level 2 PHSMs, including mask use for children aged 8-11 years and visitor restrictions at residential aged care facilities, disability care facilities, and hospitals, in line with the current restrictions.

RECOMMENDATIONS

Based on the current stage of WA's Omicron outbreak, I recommend, as Chief Health Officer, that TTIQ and PHSM settings should be adjusted from 12:01am on 14 April 2022 as follows:

- the 'close contact' definition should change to a 'household or household-like' close contact definition, as specified above;
- the requirement for QR codes and contact registers should be removed from all venues (other than current arrangements in hospitals, disability and residential aged care facilities);
- post-arrival testing requirements for all international and domestic travellers should cease;
- capacity limits on venues, events, private functions and homes should be removed;
- restrictions on visitors to hospitals, disability services and residential aged care facilities should continue, as per current requirements; and
- current mask requirements should continue.

I will continue to monitor the situation and provide further public health advice as required.

Yours sincerely

Dr Andrew Robertson
CHIEF HEALTH OFFICER

13 April 2022