

# Chief Health Officer Advice to Minister for Health

## Advice relating to the making of Pandemic Orders as required by section 165AL of the *Public Health and Wellbeing Act 2008*

Date of advice: 21 January 2022

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## Introduction and Summary of Advice

1. In response to the request from Victoria's Acting Minister for Health (**Acting Minister**) made on 17 January 2022, set out below is my advice as Victoria's Chief Health Officer, regarding whether the Acting Minister should mandate a third dose (booster) vaccine for workforces in primary and secondary schools, and early childhood education and care (**ECEC**) workplaces.
2. In providing this advice, I am aware of the legislative context in which the Acting Minister's request is made. Section 165A1 of the *Public Health and Wellbeing Act 2008 (Vic)* (**Act**) empowers the Acting Minister, at any time on or after the making of a Pandemic Declaration by the Premier, to make any order that the Acting Minister believes is reasonably necessary to protect public health. The Act requires that the public health response be proportionate to the public health risk that the disease (in this case, COVID-19) poses.
3. The measures that I recommend below respond to recent changes in the risk profile of education facilities, associated with the increased case numbers the Omicron variant of concern (**Omicron**) is driving throughout Victoria. Victoria is experiencing unprecedented and elevated rates of community transmission and, in the context of the upcoming commencement of the academic year, it is appropriate to mitigate the risks to returning staff and students, and the consequent risk to face-to-face learning.
4. I recommend that the Acting Minister consider continuing or instituting a range of public health measures in education facilities, including:
  - i. supporting the development and use of **COVIDSafe plans**;
  - ii. improving natural and mechanical **ventilation** of classrooms;
  - iii. maintaining current rules requiring the use of **face masks** when indoors;
  - iv. rapid antigen (**RA**) testing of staff and students; and
  - v. **promoting vaccination** of staff and students.
5. These measures may extend to mandating third doses of COVID-19 vaccination for school and ECEC workers where other less restrictive means have not or cannot adequately achieve a similar outcome in terms of third dose coverage, with a view to protecting the health and wellbeing of staff or maintaining the critical function of providing learning and education.
6. In making these recommendations, I have carefully considered the limits that some proposed measures place on human rights, and the objective of reducing a serious risk to public health. Additionally, I have considered whether the recommended measures are the least restrictive reasonably available by which to achieve the public health objective, as required by the *Charter of Human Rights and Responsibilities Act 2006 (Vic)* (**Charter**).

### How the Act Informs this Advice

7. The Act provides that, once the Premier has made a Pandemic Declaration, the Minister (or, in this case, the Acting Minister) may make any order that the Minister believes is reasonably necessary to protect public health.
8. If the Minister is considering making Pandemic Orders, the Minister must consult with and consider the Chief Health Officer's advice. This is my advice for the purpose of that provision.
9. The Acting Minister has sought advice about whether it is necessary or appropriate to mandate third dose vaccines workforces in primary schools, secondary schools, and ECECs, as a means of responding to the serious risk to public health that COVID-19 poses.
10. Section 3 of the Act defines the phrase "serious risk to public health" as:
  - a material risk that substantial injury or prejudice to the health of human beings has occurred or may occur having regard to:*
    - (a) the number of persons likely to be affected; the location, immediacy, and seriousness of the threat to the health of persons;*
    - (b) the nature, scale and effects of the harm, illness or injury that may develop; and*
    - (c) the availability and effectiveness of any precaution, safeguard, treatment, or other measure to eliminate or reduce the risk to the health of human beings.*
11. I have taken the Act's definition of "serious risk to public health" into account when giving this advice.

### This advice is based on the information that is available

12. I provide this advice based on the information available to me, which I have reviewed and assessed to ensure that it is relevant and reliable.
13. The impact of Omicron on individuals and the population is becoming clearer, and available evidence suggests that Omicron is more transmissible, associated with higher rates of reinfection, and demonstrates greater immune evasiveness compared to previous variants of concern (**VOC**). Although there is potentially a lower risk of severe illness and mortality, the very large number of cases have had a detrimental impact across various industries and sectors, even in settings where restrictive public health measures remain in place. With the anticipated commencement of the academic year following the summer holiday period, it is likely that education facilities will again become a setting of significant risk.

### New Evidence on Omicron

14. In the short timeframe since it was first identified, Omicron has rapidly spread and is a significant driver of the current case surges reported globally.<sup>1</sup> The growth advantage of Omicron over Delta in the Australian population is clearly demonstrated through the unprecedented case numbers recently recorded across states and territories.<sup>2</sup> Omicron has been declared the dominant strain in Victoria and is driving the current surge in cases. Similar shifts have already been documented in South Africa<sup>3</sup>, the United Kingdom (UK),<sup>4</sup> the United States of America (USA)<sup>5</sup> and numerous European Union (EU) / European Economic Area (EEA) countries<sup>6</sup>

including Austria, Belgium, Denmark, Estonia, France, Ireland, Iceland, the Netherlands, Norway and Portugal.

15. Preliminary analyses reinforce that Omicron may have greater transmissibility and breakthrough infections in exposed individuals compared to Delta. In Omicron cases, the secondary attack rate (SAR; the probability of infection spreading to susceptible people within a group such as a household) is estimated to be 19%, and importantly the SAR also appears higher for Omicron than for Delta for contacts outside the household. In a UK based cohort study the risk of household transmission from an Omicron index case was 3.2 times as high as Delta cases.<sup>7</sup>
16. Growing evidence suggests that the risk of hospital presentation and admissions from Omicron is lower than Delta in adults, with analyses from the Imperial College of London reporting the risk of hospital presentation being 20-25% lower (and 40-45% lower for hospital admission).<sup>8</sup> Similar outcomes were reported from Gauteng, South Africa, where 4.9% of cases from the recent Omicron wave required hospitalisation compared to 18.9% from Beta and 13.7% from Delta outbreaks and 28.8% of hospital admissions from the Omicron wave involved severe illness, compared to 60.1% from Beta and 66.9% and Delta respectively.<sup>3,9</sup>
17. In relation to the younger population, recent trends in hospitalisation reported from the UK demonstrate a 3-fold rise in the admission rate for paediatric patients with COVID-19 infection in a 2-week timeframe from 26 December 2021 to 9 January 2022, with the greatest increase occurring in children under 5 years and in particular infants aged under 1 year. <sup>4</sup> In the USA, similar trends have been observed where a 12% weekly increase in paediatric admissions with COVID-19 infection for the week ending 6 January 2022 was recorded.<sup>10</sup> These trends have arisen during periods that coincide with the progressive dominance of Omicron in these countries. It is important to note that this trend likely reflects transmission which has occurred during both school term and the end of year holiday period.
18. With a greater number of children infected, we can expect that there will be a high volume of presentations to health services, as well as forward transmission to other – more vulnerable – members of the population facing a greater risk of morbidity and mortality and the general community to result in disruption to essential sectors and services.
19. Evidence on vaccine effectiveness continues to emerge and, although further real-world data is needed, available research suggests there is reduced protection from COVID-19 vaccines against transmission and poor health outcomes from infection with Omicron compared to Delta. According to a large case control analysis based on UK data,<sup>4</sup> vaccine effectiveness against symptomatic infection was significantly lower with Omicron despite two doses of COVID-19 vaccine. This modest protection also dramatically waned over time. Under this study, two doses of AstraZeneca vaccine conferred 45% - 50% protection against symptomatic infection with Omicron and this reduced to almost no effect from 20 weeks after the second dose. In comparison, those who had received two doses of Pfizer or Moderna vaccine demonstrated 65% - 70% effectiveness against symptomatic infection which also dramatically decreased to approximately 10% by 20 weeks after the second dose. Additional booster dosing with Pfizer vaccines improved effectiveness in the short term but this also appears to gradually diminish from 65% - 75% at 2 to 4 weeks, to 55% - 65% at 5 to 9 weeks and 45% - 50% from greater than

10 weeks after the booster dose. Nonetheless, this indicates that booster dosing can re-establish the same level of effectiveness against symptomatic infection as two doses, prior to waning. Vaccine effectiveness against hospitalisation seems more robust against Omicron as two doses of COVID-19 vaccine correlated with a 55% reduction in hospitalisation up to the 24-week mark and this improved further in the short-term following a booster dose which was associated with a 74% and 66% risk reduction in hospitalisation at 2 to 4 weeks and more than 10 weeks respectively following the booster dose.

20. Further studies are necessary to draw substantive conclusions on the characteristics of Omicron and the longer-term impacts of interventions, but the preliminary evidence outlined in paragraphs 15 to 19 collectively demonstrate that COVID-19, and in particular Omicron, poses an ongoing and profound public health risk to the Victorian population.

#### Current epidemiological situation in Victoria

21. In the 24 hours before reporting on 18 January 2022, 8,848 new cases were confirmed on polymerase chain reaction (PCR) tests and 11,722 probable cases detected from rapid antigen (RA) tests reported to the Victorian Department of Health. All new confirmed cases have been deemed to be locally acquired and none have been attributed to overseas sources.
22. As of 18 January 2022, there are 236,177 active cases (confirmed and probable) in Victoria, so that approximately 3.55% of the Victorian population is known to be infected at the same time (with the actual proportion likely to be higher). As of 18 January 2022, there are 1,152 cases in hospital, of which 93 active cases are in intensive care units (ICUs) and 43 of these patients are receiving ventilatory support.
23. Throughout January 2022, Victoria has experienced the highest levels of community transmission recorded since the start of the COVID-19 pandemic. In the last 18 days, there have been 452,563 new cases, accounting for 71.1% of the total number of COVID-19 cases detected in Victoria throughout the pandemic

#### Epidemiology in the younger Victorian population

24. On review of the Victorian epidemiology of PCR confirmed cases, for the period 1 December 2021 to 17 January 2022 which overlaps with the emergence of Omicron in Victoria there were:
- 25,306 cases in the 0-9 age group (representing 58.2% of total cumulative confirmed cases for this age group throughout the pandemic and 7.2% of total confirmed cases in the overall population for this period). There were 135 hospitalisations (0.53% hospitalisation rate) and 5 ICU admissions (0.02% ICU admission).
  - 41,924 cases in the 10-19 age group (representing 69.4% of total cumulative confirmed cases for this age group through the pandemic and 11.9% of total confirmed cases in the overall population for this period). There were 99 hospitalisations (0.24% hospitalisation rate) and 6 admissions to the ICU (0.01% ICU admission rate).

For reference, the general hospitalisation rate was 0.99% and ICU admission rate was 0.08% across all age groups during this period.

### Outbreaks in the Victorian education sector

25. We can expect that case numbers will increase in these age groups following a return to education facilities as previously observed. Between 4 October 2021 and 19 December 2021, which are the weeks corresponding to term 4 of the academic year, the education sector recorded 1,676 outbreaks which were associated with 12,259 cases, and this translates to 57.6% of all outbreaks and 73.6% of all cases associated with a known outbreak for this period. The greatest COVID-19 activity was recorded in schools and ECEC settings:

- 544 outbreaks (18.7% of outbreaks for this period) in childcare, family day care and kindergarten with 1,997 cases (10.4% cases linked to outbreaks for this period)
- 657 outbreaks (22.6% of outbreaks for this period) in primary schools, with 6,873 cases (41.3% cases linked to outbreaks for this period)
- 235 outbreaks (8.1% of outbreaks for this period) in secondary schools with 1,497 cases (9.0% cases linked to outbreaks for this period)
- 129 outbreaks (4.4% of outbreaks for this period) in primary/secondary schools combined school, with 1,539 cases (9.2% cases linked to outbreaks for this period)
- 32 (1.1% of outbreaks for this period) in additional needs school, with 168 cases (1.0% cases linked to outbreaks for this period)
- 23 (0.8% of outbreaks for this period) in after school care, with 52 cases (0.3% cases linked to outbreaks for this period).

26. After 19 December 2021, only four outbreaks have been recorded for the education sector. Of note, this trend may not be wholly attributed to the school holiday period as there may be concurrent confounders and limitations such as the delayed investigation of acquisition and outbreak linkages as a result of the surge in caseloads and amendments to the case, contact and outbreak management policies, including changes to the threshold for outbreak declaration and reporting requirements of COVID-19 cases. That said, the school holiday period has very substantially reduced opportunities for outbreaks.

### Test results

27. In the 24 hours before reporting on 18 January 2022, 39,725 PCR test results were received. The test positivity rate for the 7 days up to 16 January 2022 was 31.58%. This indicates is an extremely high rate of community transmission and, when considering the additional cases detected on RA tests and the relative scarcity of RA tests, indicates there may be a substantial yet unquantified number of undiagnosed cases in the community.

### Vaccinations

28. The COVID-19 vaccine rollout continues across Victoria. In the 24 hours prior to 17 January 2022, 29,759 vaccine doses were administered in Victoria contributing to a total of 12,131,999 doses administered across the State since 22 February 2021.<sup>11</sup> As of 18 January 2022, it is estimated that a total 93.3% of all Victorians aged 12 years and over have received at least two

doses of a COVID-19 vaccine while 15.2% of Victorians aged 5-11 years have received their first dose of a COVID-19 vaccine.<sup>11</sup>

29. The Australian Technical Advisory Group on Immunisation (ATAGI) expanded the provisional approval of the Pfizer vaccine for use in the 5 to 11 year old demographic on 8 December 2021,<sup>12</sup> and this was enacted in the vaccine rollout from 10 January 2022.<sup>13</sup> Despite this expanded use, it is important to highlight that primary school aged children will not be able to achieve full vaccination prior to the commencement of the academic year and based on the current recommended interval between doses it will realistically be later into Term 1 of the academic year.
30. Booster dose vaccinations involve a further dose of COVID-19 vaccine within the ATAGI recommended period (currently more than 3 months) following the primary course of vaccination.<sup>14</sup> Currently in Victoria, 25.9% of the 18 and over population have received either a booster or third dose. It should be noted, however, that there is a lack of cohort-specific data regarding the uptake of booster dose vaccinations for the education sector. There is no data on third dose coverage in those with underlying medical conditions, and none on intention-to-receive sentiments. The absence of any sector-specific point-in-time or trend data on these indicators makes the decision to extend or not the mandate to include a third dose problematic.
31. As explained in paragraph 19, the observed effectiveness of COVID-19 vaccination against transmission and severe illness is reduced with Omicron compared to Delta with only two doses. Booster dosing appears to confer greater protection, particularly against severe disease, but ATAGI is yet to approve this measure in the general population aged under 18 years which effectively excludes most of the student population. The US Centers for Disease Control and Prevention have approved COVID-19 boosters for ages 12-15 so this might be expected in coming months in Australia.

### **Necessary or appropriate public health measures**

32. The commencement of the 2022 academic year and return to work after the festive summer holiday period will result in increased opportunities for viral incursion, transmission and outbreaks amongst children, students, and staff in education facility settings. Interactions within education facility settings often occur in close proximity and for a prolonged duration, frequently in enclosed shared spaces, which increases the likelihood of transmission. Previous experience outlined in paragraph 25 shows the significant number and scale of outbreaks that can arise in these settings.
33. The public health measures that I commend to the Minister for school and ECEC settings are intended to be implemented as a suite that act synergistically to protect the health and wellbeing of the workforce and student body. A collective approach is especially important given that students' and staff capabilities vary, including for the same individual within different contexts facing different demands.
34. The measures are discussed below in paragraphs **Error! Reference source not found.** to **Error! Reference source not found.** and include:

- i. supporting the development and use of **COVIDSafe plans** that promote measures such as hand hygiene and physical distancing;
- ii. improving **ventilation** in school buildings and kindergarten services;
- iii. maintaining current rules requiring the use of **face masks** when indoors;
- iv. rapid antigen (**RA**) testing of staff and students; and
- v. **promoting vaccination** amongst eligible children and students;

35. I commend these measures to the Acting Minister, which I consider will reduce the risks in the school and ECEC settings that are likely to accompany the new academic year and improve direct protection to the education workforce. These elements also align with the requirements of existing Pandemic Orders, aimed at managing the risks of Omicron generally. I also understand that these measures align with the Victorian Government's *Return to School and Kindergarten Plan*, which is currently being finalised.

#### COVIDSafe plans and sector operating guidelines

36. Under the *Pandemic (Workplace) Order 2022 (No. 3)*, Victorian workplaces are required to have a COVIDSafe Plan that demonstrates:

- i. the actions that an operator will take to help prevent the introduction of COVID-19 to their workplace;
- ii. how they will respond to suspected and confirmed COVID-19 cases; and
- iii. how they will meet orders set out by the Victorian Government.

37. The vital COVIDSafe measures will include:

- i. reinforcing the mask requirements outlined in paragraph 40;
- ii. separating of students and children according to classroom or year level wherever practicable to reduce mixing;
- iii. encouraging parents to keep symptomatic children at home;
- iv. handwashing and good hygiene measures;
- v. physical distancing, and
- vi. conducting activities in ways that avoid unnecessary congregation or in outdoor settings wherever possible where there is better ventilation.

38. To support each the education provider's COVIDSafe Plan, the Department of Education and Training (DET) have, and should continue to, develop, update and distribute the internal *Operating Guidelines for School* to reflect current and consistent public health information to the sector.



### Ventilation

39. Schools and ECEC have been, and should continue to be, provided with guidance regarding the importance of ventilation in indoor settings, in recognition that aerosols spread further than droplets and may linger in the air for some time, resulting in increased transmission, especially where ventilation is poor, and people are in close contact.<sup>15</sup> The WHO recommends improving indoor ventilation to decrease the risk of viral transmission.**Error! Bookmark not defined.**
40. Following formal ventilation assessments in schools and ECEC settings, strong ventilation measures should be put in place and prioritised considering the intercurrent Omicron wave. Consideration of additional ventilation strategies for classroom settings should be urgently prioritised - and any additional strategies provided to education operators - to help mitigate the risk of viral transmission.
41. I understand that, as part of the *Return to School and Kindergarten Plan*, there will be provision of air purifiers to schools, based on risk stratification and need.

### Face masks

42. As part of the *Pandemic (Open Premises) Order 2022 (No. 3)*, face masks must be worn in all indoor settings by those aged 8 years and above. Current evidence indicates that the use of masks contributes to a risk of SARS-CoV-2 infection and are more effective when combined with other preventative measures such as social distancing and improved ventilation.<sup>16,17, 18,19</sup> There are exceptions to the face mask requirements in the Orders which include persons for whom the nature of their work means that clear enunciation or visibility of their mouth is essential, such as educators. In the context of high community transmission and particularly in relation to the risky interactions identified in paragraph 32, I urge educators to use these exceptions only where clearly necessary.
43. Although mask wearing is a widely accepted and low-impost measure, compliance can fluctuate over time and is not appropriate universally across all age groups. Notably, classrooms are likely to be difficult settings to maintain this intervention especially in the youngest cohorts of children and students and hence those under 8 years of age or in primary school grade 2 or below are currently exempted. Therefore, face masks have some clear limitations in these settings and do not provide continuous protection against COVID-19.

### Rapid Antigen Testing

44. RA testing is a useful point of care testing modality that does not rely on healthcare staff or laboratory processing and produces prompt results which provide a good indication of a person's COVID-19 status. It is less sensitive than PCR testing, but its reliability improves with repeated administration over time.
45. Doherty Institute modelling<sup>20</sup> (which predated emergence of the Omicron variant) suggested that surveillance testing in ECEC and school settings could help substantially reduce the risk that incursions will lead to outbreaks and may be an appropriate strategy in areas with high levels of ongoing transmission.

46. A core component of the *Return to School and Kindergarten Plan* for Victoria will be surveillance testing. Eligible children, students and staff will be strongly recommended to undergo twice weekly surveillance through RA testing, contingent on adequate supply. This program is planned to be operational for four weeks from the commencement of Term 1 to correspond with the anticipated peak number of infections in Victoria and will be reviewed in February 2022 to determine if it will continue based on the epidemiology and evidence at the time.
47. However, RA tests only provide a point-in-time assessment of a person's infection status. People may become infectious in the period between tests, especially if tests are carried out less frequently than daily. There is also the risk of false negative results which may inadvertently lead to an infectious case attending the education setting. In addition, there have been widespread global shortages in supply that are a limiting operational factor. RA tests on their own do not confer absolute protection.

#### Vaccination of students

48. Promoting high rates of vaccination among students will continue to be an important public health strategy, and I strongly recommend that all efforts be made to engage, educate and incentivise parents and guardians to encourage uptake of vaccination amongst this age group.
49. Vaccination will have a slightly different role due to Omicron. As outlined in paragraph 19, emerging evidence on Omicron highlights that vaccination will likely remain effective against severe illness, especially following a booster dose. Vaccination is, however, less impactful against transmission.
50. Further, as stated in paragraphs 28 to 29, primary school aged children will not have achieved vaccine-induced immunity against COVID-19 before commencing the academic year, given that the vaccine rollout for this age group commenced from 10 January 2022 and ATAGI currently recommends an 8 week interval between primary course doses.<sup>12</sup> I note that measures are planned to increase coverage rates, including at least 30 school pop-up vaccination clinics.
51. In addition, children under the age of 5 remain ineligible for vaccination and therefore ECEC settings in particular therefore remain a substantial risk for outbreaks.
52. Based on these considerations, although measures to strengthen vaccine uptake in both eligible workers and students remain necessary, other public health measures remain essential.

#### Vaccination of education facility workers

53. While vaccine coverage among primary school and secondary school children will increase, there will be a continued risk of onward viral transmission, particularly for primary school and ECEC staff who are working alongside a largely unvaccinated population in predominantly indoor settings where there are innate challenges in maintaining mask compliance and physical distancing.
54. As part of the *COVID-19 Mandatory Vaccination (Specified Facilities) Order 2022 (No. 2)*, workers at educational facilities are required to have received two doses of a TGA approved COVID-19 vaccination, unless medically exempt. The second dose deadline for education facility

workers was 29 November 2021, and as such some workers may be due for a booster dose and may be experiencing waning immunity from the effects of vaccination.

### **Mandatory COVID-19 vaccination booster dose for education workers**

55. In the context of high community transmission, a suite of public health measures that nevertheless leave some residual risk and a new academic year, it is open to the Acting Minister to consider mandating that education workers receive a vaccination booster dose. My advice on this issue is set out below and should be understood in the context of the analysis that is set out above.

56. For clarity, this advice relates to public health measures that supplement or alter the public health measures proposed in my advice to the Minister made on 12 December 2021 and 23 December 2021, as well as the Acting Chief Health Officer's advice to the Minister made on 12 January 2022 (**previous advice**). This advice supplements and updates the previous advice, which I have read. To the extent that there is no inconsistency between this advice and the previous advice, I still consider the public health measures set out in the previous advice to be necessary and appropriate.

### Risk Assessment

57. Given the discussion above, the primary risk to which a vaccination mandate responds is the risk of education workers developing illness, particularly severe illness (since vaccination is less effective against transmission). Vaccination remains an evidence-based intervention that research has shown protects individuals who contract COVID-19 from severe illness, even in the context of Omicron.

58. A mandate would also partially respond to the consequential risk of a reduction in face-to-face learning, due to large numbers of education workers quarantining or being unable to attend school. Due to the fact that vaccination against Omicron is less effective against symptomatic illness and further transmission, such consequences can only be partly mitigated. In the presence of widespread community transmission, the likelihood of such absences is high. Disruption to face-to-face learning and education can have significant negative effects on the health and wellbeing of students and children, especially during critical years of growth and development. There are also significant impacts on parents and guardians who support these children through changing requirements and the downstream impacts on the overall Victorian workforce.

59. In addition, existing policies that apply to the education sector can also carry risk of incursion and transmission. Most recently, the class exemption to quarantine requirements of close contacts (set out in the *Quarantine Isolation and Testing Order*) for the purpose of work was enacted to include education facility workers from 18 January. These class exemptions are intended to be enacted as a last resort to preserve the operations of essential services and sectors that benefit the Victorian community, such as schools and ECECs, but can unintentionally propagate outbreaks as the risk mitigating conditions are not as strong as for strict quarantine.

60. Vaccines, once administered, have the additional advantage over situational public health measures that rely on user implementation and practice, such as face mask wearing, physical

distancing and hygiene practices, by producing a more consistent and enduring protection against the harms of COVID-19. No other mitigation than vaccination applies continuously and universally in all settings and circumstances.

The benefits of encouragement and facilitation

61. The peak of the current Omicron wave is anticipated to occur in late January 2022, coinciding with the return of preschools and schools from the summer holiday period. This peak will occur before any implemented vaccine mandate is likely to be fully effective. This is in part due to the fact that a reasonable 'grace period' needs to be given to individuals and because approximately one week is needed before substantial additional immune protection from a third dose occurs. Additionally, vaccine mandates can reduce some undecided individuals' willingness to undergo vaccination, thereby deferring uptake by some days or weeks.
62. It is therefore appropriate to consider what alternate measures might be utilised first to encourage or facilitate a more immediate take-up of vaccines.
63. I understand that DET, as part of its announcement of the *Return to School and Kindergarten Plan*, plans to include information on booster dose vaccinations in its communications with school and ECEC workers ahead of the commencement of Term 1. Additional information will be included as part of regular DET newsletters as well as through staff participating in the Vaccine Champions Program to promote booster dose uptake within education settings and broader community.
64. I also understand that DET plans to reintroduce the steps that it took in 2021 to encourage and facilitate eligible workers to receive their booster dose. These steps include providing paid time off to attend vaccine appointments, allowing staff to book at school-based vaccine pop-up clinics and encouraging principals to maximise the opportunity for all staff to be vaccinated through these arrangements as well as offering vaccine communication packs. In ECEC settings, similar provision of paid leave, notifications through direct send emails and communication packs and peak bodies communication to members are to be made available. I recommend that these strategies be introduced as soon as possible to empower workers and promote earlier, increased uptake of booster doses.
65. I acknowledge the potential effect that a mandate might have on community goodwill and the compliance that flows from such goodwill. I note that extensive consultation has taken place within the education sector through DET and stakeholder responses have been predominantly supportive from education and childcare peak bodies while workers unions have not opposed this potential measure. I also note that the current workforce is operating under an existing mandate, reflecting a willingness to be vaccinated with COVID-19 vaccines, albeit as a condition of attending work in the education sector.
66. Should a third dose mandate be considered, education workers who have direct interactions with students and children and are integral to providing education, learning and supportive services should be included in scope.

**Conclusion**

67. On the basis of the analysis set out above, I consider that it is open to the Acting Minister to mandate third doses of COVID-19 vaccination for school and ECEC workers, in particular to help ensure continued protection for this workforce, most notably individuals with significant underlying health conditions. To a lesser degree, a mandate may help to mitigate against the risk of outbreaks in these settings. The absence of sector-specific data makes an assessment of the benefit of any mandate challenging at this time. I advise that this conclusion would be particularly available if the Acting Minister was of the view that less restrictive public health measures, including (but not limited to) individual counselling and support; sector-wide engagement and communication; incentivisation and/or compensation for work absence; and facilitation of access had already been enacted or adopted and given the opportunity to take full effect, supported by current data. I nevertheless acknowledge that the Acting Minister has the ultimate discretion and authority on this issue.

**Adjunct Clinical Professor Brett Sutton**

Victorian Chief Health Officer

Dated this 21st day of January 2022

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