Laura Bowman

From: official information
Sent: Monday, 24 January 2022 1:04 pm
To: [redacted]
Cc: official information; CEO
Subject: Final Response: LGOIMA 22001 - [redacted] - Notice of Liability for Vaccine Mandate
Attachments: Notice of Liability for vaccine mandate - Lance Vervoort.pdf; Finalised work - COVID-19 vaccination proposal - risk assessment - November 2021 (3).pdf; D-4013352 COVID-19 Vaccination Policy 031221.pdf

Kia Ora [redacted]

I am responding on behalf of our Chief Executive, Lance Vervoort.

In response to your email I have attached a copy of Council's Staff Vaccination Policy and the risk assessment approach undertaken to support the policy, which contains the information you have requested.

Our decision was based on risk assessments of the work our staff undertake, the nature of the services and legal guidance. The risk assessments showed us that all services present a risk of COVID-19 transmission. It also highlighted the need to protect Council's essential workers to keep our city's infrastructure and services running.

Our overriding consideration is and will continue to be the safety of our workforce, volunteers, and the community (many of whom are more vulnerable to potential COVID-19 transmission) who use our services.

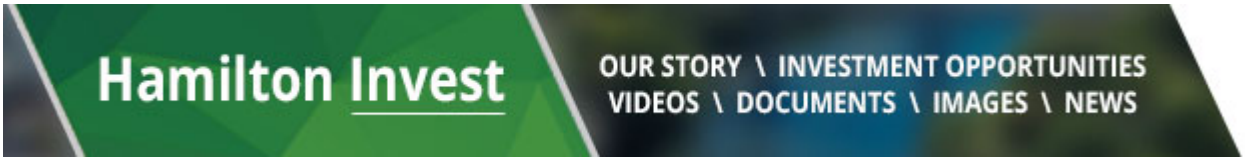
You have the right to seek an investigation and review by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Kind Regards,

Official Information Team
Legal Services & Risk | People and Organisational Performance
Email: officialinformation@hcc.govt.nz

Hamilton City Council
Te kaunihera o Kirikiriroa

Hamilton City Council | **Private Bag 3010** | **Hamilton 3240** | **www.hamilton.govt.nz**
Like us on Facebook Follow us on Twitter



From: [redacted]
Sent: Monday, 10 January 2022 9:57 am
To: CEO <CEO@hcc.govt.nz>
Subject: Attn Lance Vervoort

Please find attached a Notice for Lance Vervoort

[redacted]

Sent with ProtonMail Secure Email.

To: 7/1/22
Lance Vervoort in his private capacity
acting as Chief Executive Officer for Hamilton City Council
260 Anglesea St, Hamilton

NOTICE OF LIABILITY

in relation to mandating vaccination

Date served: 10 January 2022

I understand that Hamilton City Council is mandating the Pfizer Covid-19 vaccine for employees, and that you as Chief Executive Officer have responsibility for determining and implementing this policy.

As you will be aware, this vaccine carries with it the risk of adverse effects.

As you may not be aware, these are not limited to minor and temporary effects; adverse effects can be serious and are NOT rare as claimed.

Many people are experiencing significant health difficulties after vaccination, and documented adverse effects include a wide range of serious and potentially long-term and life-threatening conditions, and even death (Appendices 1-6).

Research conducted by Harvard University suggests that only a fraction of adverse effects are likely to be identified and reported, meaning that the number of people being adversely affected is likely to be much higher than is captured by official data.

New Zealand government officials recently issued a letter to health professionals alerting them to the risk of myocarditis/pericarditis from the Pfizer vaccine (Appendix 4). This is a serious and life-threatening condition, and the recent death of 26-year old Rory Nairn has now been confirmed by his coroner to have been caused by myocarditis from the Pfizer vaccine.

Do you feel comfortable about forcing people to be vaccinated when it could cause them to suffer serious health consequences?

On what basis can you reasonably require vaccination, in light of these risks?

Do you consider that you've adequately weighed up the risks vs alleged benefits of the vaccine in your health and safety policy?

Do you consider it's acceptable to put people at risk against their will in order for them to be able to provide for themselves and their families?

Have you considered the libaility risk to your company as a result of implementing this policy?

This is an experimental vaccine with no long-term data to confirm its safety or efficacy, and current data from hospitals indicates that it is NOT protecting vaccinated people from severe outcomes, as it was claimed it would. Any claimed efficacy has rapidly waned and there is no evidence of it providing significant protection against current variants. Omicron is proving to be of negligible risk to most people, in any case with around half the risk of hospitalisation of Delta (Appendix 7).

Any employees who have not yet been vaccinated clearly do not want to be. Requiring them to be vaccinated in order to keep their jobs is unjustified, unreasonable and completely unacceptable in

my view.
If you choose to implement this policy, please know that there may be consequences for you personally, not just your employees. You will have been complict in coercion, and this could even be considered a breach of the Nuremberg Code (Appendix 8).

In serving this notice, I am warning you that you may be held personally liable for any harm caused by implementing this policy. This is not something to take lightly, and given the information I have provided in this Notice and accompanying documentation, you would have no basis on which to claim that you were not aware of the possible if not likely serious harm you might cause to others by implementing this policy.

Please choose your actions wisely, in light of the possible consequences to yourself and others.

WHERE THERE IS RISK, THERE MUST BE CHOICE.

Sincerely,

[redacted]

Appendix 1

Health Forum NZ Deaths database of deaths occurring soon after vaccination

"The information on this Citizens Database is a community effort intended to provide general information to the public about Covid-19 Vaccine related deaths in New Zealand."

https://docs.google.com/spreadsheets/d/1EXQRRGGzzcxqFL6txrXgGC_Xp7Gb0LbCE3LLyszFBAs/edit#gid=1713619946

Total reported deaths following vaccination = 303 (4/1/21)

Appendix 2

A sample of adverse effects of Pfizer vaccine on the nervous system

(source: Medicines & Healthcare products Regulatory Agency, UK)

PFIZER - Sample of Nervous System Disorders Reported After Covid-19 Injections per MHRA -6th Oct 2021

Nervous system disorders	Total	Nervous system disorders	Total	Nervous system disorders	Total	Nervous system disorders	Total
Headache	22539	Parosmia	220	Coordination abnormal	47	Petit mal epilepsy	22
Dizziness	8558	Cluster headache	193	Generalised tonic-clonic seizure	45	Psychomotor hyperactivity	21
Paraesthesia	3518	Migraine with aura	167	Mental impairment	44	Drooling	21
Hypoaesthesia	2570	Dysarthria	165	Facial spasm	43	Carpal tunnel syndrome	20
Migraine	2565	Memory impairment	162	Cerebral haemorrhage	42	Nerve compression	20
Lethargy	1919	Amnesia	152	Cerebral venous sinus thrombosis	42	Multiple sclerosis relapse	20
Syncope	1806	Epilepsy	143	Hemiparesis	42	Cold-stimulus headache	19
Tremor	1444	Transient ischaemic attack	131	Depressed level of consciousness	41	Aura	19
Dysgeusia	1041	Restless legs syndrome	118	Neurological symptom	40	Bradykinesia	18
Somnolence	875	Paralysis	115	Status epilepticus	40	Vestibular migraine	18
Dizziness postural	635	Hypersomnia	101	Trigeminal neuralgia	40	Clumsiness	17
Presyncope	553	Neuropathy peripheral	95	Ischaemic stroke	39	Migraine without aura	17
Loss of consciousness	542	Sensory disturbance	92	Dizziness exertional	39	Tunnel vision	17
Seizure	516	Facial paresis	84	Unresponsive to stimuli	39	Muscle contractions involuntary	17
Tension headache	488	Hyperaesthesia	79	Hemiplegia	37	Partial seizures	17
Burning sensation	464	Cognitive disorder	74	Electric shock sensation	35	Slow speech	17
Neuralgia	458	Sciatica	73	Retinal migraine	30	Hyposmia	16
Ageusia	457	Aphasia	72	Hemiplegic migraine	29	Facial neuralgia	16
Bell's palsy	432	Monoplegia	67	Multiple sclerosis	28	Dystonia	15
Facial paralysis	336	Sensory loss	66	Myelitis transverse	26	Subarachnoid haemorrhage	14
Cerebrovascular accident	334	Hypokinesia	61	Optic neuritis	26	Dementia	14
Balance disorder	322	Speech disorder	59	Cerebral infarction	25	Vascular headache	14
Sinus headache	310	Dyskinesia	57	Hypotonia	25	Peroneal nerve palsy	14
Head discomfort	299	Guillain-Barre syndrome	55	Myoclonus	25	Nervous system disorder	14
Disturbance in attention	277	Dysstasia	51	Tonic convulsion	24	Febrile convulsion	14
Taste disorder	230	Movement disorder	49	Allodynia	24	Post herpetic neuralgia	14
Anosmia	227	Monoparesis	48	Sleep paralysis	23	Cerebral thrombosis	12

A total of 58,668 Pfizer nervous system injuries and 55 Pfizer nervous system related deaths have so far been reported in the UK at the time of publication

Appendix 3

Pfizer vaccine and myocarditis

A Report on Myocarditis Adverse Events in the U.S. Vaccine Adverse Events Reporting System (VAERS) in Association with COVID-19 Injectable Biological Products

Jessica Rose, PhD, MSc, BSc[1,*] and Peter A. McCullough, MD, MPH[1]

Abstract

"Following the global rollout and administration of the Pfizer Inc./BioNTech BNT162b2 and Moderna mRNA-1273 vaccines on December 17, 2020, in the United States, and of the Janssen Ad26.COV2.S product on April 1st, 2021, in an unprecedented manner, hundreds of thousands of individuals have reported adverse events (AEs) using the Vaccine Adverse Events Reports System (VAERS). We used VAERS data to examine cardiac AEs, primarily myocarditis, reported following injection of the first or second dose of the COVID-19 injectable products. Myocarditis rates reported in VAERS were significantly higher in youths between the ages of 13 to 23 ($p<0.0001$) with ~80% occurring in males. Within 8 weeks of the public offering of COVID-19 products to the 12-15-year-old age group, we found 19 times the expected number of myocarditis cases in the vaccination volunteers over background myocarditis rates for this age group. In addition, a 5-fold increase in myocarditis rate was observed subsequent to dose 2 as opposed to dose 1 in 15-year-old males. A total of 67% of all cases occurred with BNT162b2. Of the total myocarditis AE reports, 6 individuals died (1.1%) and of these, 2 were under 20 years of age - 1 was 13. These findings suggest a markedly higher risk for myocarditis subsequent to COVID-19 injectable product use than for other known vaccines, and this is well above known background rates for myocarditis. COVID-19 injectable products are novel and have a genetic, pathogenic mechanism of action causing uncontrolled expression of SARS-CoV-2 spike protein within human cells. When you combine this fact with the temporal relationship of AE occurrence and reporting, biological plausibility of cause and effect, and the fact that these data are internally and externally consistent with emerging sources of clinical data, it supports a conclusion that the COVID-19 biological products are deterministic for the myocarditis cases observed after injection."

(https://web.archive.org/web/20211002192421/https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8483988/)

Appendix 4

Letter from government officials warning of myocarditis, 15 Dec 2021

https://thebuzz.nz/bloomfield-issues-warning-of-vax-related-heart-issues/

pdf: https://thebuzz.nz/wp-content/uploads/2021/12/vaccine-associated-myocarditis-and-pericarditis_MOH-151221.pdf

Appendix 5

Brownstone Institute – Myocarditis in under 40 year olds

https://brownstone.org/articles/myocarditis-under-age-40-an-update

Appendix 6

Post marketing surveillance for Pfizer vaccine (released under court order)

Adverse effects "of special interest" reported within the first 90 days of public use

APPENDIX 1. LIST OF ADVERSE EVENTS OF SPECIAL INTEREST
1p36 deletion syndrome;2-Hydroxyglutaric aciduria;5'nucleotidase increased;Acoustic neuritis;Acquired C1 inhibitor deficiency;Acquired epidermolysis bullosa;Acquired epileptic aphasia;Acute cutaneous lupus erythematosus;Acute disseminated encephalomyelitis;Acute encephalitis with refractory, repetitive partial seizures;Acute febrile neutrophilic dermatosis;Acute flaccid myelitis;Acute haemorrhagic leukoencephalitis;Acute haemorrhagic oedema of infancy;Acute kidney injury;Acute macular outer retinopathy;Acute motor axonal neuropathy;Acute motor-sensory axonal neuropathy;Acute myocardial infarction;Acute respiratory distress syndrome;Acute respiratory failure;Addison's disease;Administration site thrombosis;Administration site vasculitis;Adrenal thrombosis;Adverse event following immunisation;Ageusia;Agranulocytosis;Air embolism;Alanine aminotransferase abnormal;Alanine aminotransferase increased;Alcoholic seizure;Allergic bronchopulmonary mycosis;Allergic oedema;Alloimmune hepatitis;Alopecia areata;Alpers disease;Alveolar proteinosis;Ammonia abnormal;Ammonia increased;Amniotic cavity infection;Amygdalohippocampectomy;Amyloid arthropathy;Amyloidosis;Amyloidosis senile;Anaphylactic reaction;Anaphylactic shock;Anaphylactic transfusion reaction;Anaphylactoid reaction;Anaphylactoid shock;Anaphylactoid syndrome of pregnancy;Angioedema;Angiopathic neuropathy;Ankylosing spondylitis;Anosmia;Antiacetylcholine receptor antibody positive;Anti-actin antibody positive;Anti-aquaporin-4 antibody positive;Anti-basal ganglia antibody positive;Anti-cyclic citrullinated peptide antibody positive;Anti-epithelial antibody positive;Anti-erythrocyte antibody positive;Anti-exosome complex antibody positive;AntiGAD antibody negative;Anti-GAD antibody positive;Anti-ganglioside antibody positive;Antigliadin antibody positive;Anti-glomerular basement membrane antibody positive;Anti-glomerular basement membrane disease;Anti-glycyl-tRNA synthetase antibody positive;Anti-HLA antibody test positive;Anti-IA2 antibody positive;Anti-insulin antibody increased;Anti-insulin antibody positive;Anti-insulin receptor antibody increased;Antiinsulin receptor antibody positive;Anti-interferon antibody negative;Anti-interferon antibody positive;Anti-islet cell antibody positive;Antimitochondrial antibody positive;Anti-muscle specific kinase antibody positive;Anti-myelin-associated glycoprotein antibodies positive;Anti-myelin-associated glycoprotein associated polyneuropathy;Antimyocardial antibody positive;Anti-neuronal antibody positive;Antineutrophil cytoplasmic antibody increased;Antineutrophil cytoplasmic antibody positive;Anti-neutrophil cytoplasmic antibody positive vasculitis;Anti-NMDA antibody positive;Antinuclear antibody increased;Antinuclear antibody positive;Antiphospholipid antibodies positive;Antiphospholipid syndrome;Anti-platelet antibody positive;Anti-prothrombin antibody positive;Antiribosomal P antibody positive;Anti-RNA polymerase III antibody positive;Anti-saccharomyces cerevisiae antibody test positive;Anti-sperm antibody positive;Anti-SRP antibody positive;Antisynthetase syndrome;Anti-thyroid antibody positive;Anti-transglutaminase antibody increased;Anti-VGCC antibody positive;AntiVGKC antibody positive;Anti-vimentin antibody positive;Antiviral prophylaxis;Antiviral treatment;Anti-zinc transporter 8 antibody positive;Aortic embolus;Aortic thrombosis;Aortitis;Aplasia pure red cell;Aplastic anaemia;Application site thrombosis;Application site vasculitis;Arrhythmia;Arterial bypass occlusion;Arterial bypass thrombosis;Arterial thrombosis;Arteriovenous fistula thrombosis;Arteriovenous graft site stenosis;Arteriovenous graft thrombosis;Arteritis;Arteritis coronary;Arthralgia;Arthritis;Arthritis enteropathic;Ascites;Aseptic cavernous sinus thrombosis;Aspartate aminotransferase abnormal;Aspartate aminotransferase increased;Aspartate-glutamate-transporter deficiency;AST to platelet ratio index increased;AST/ALT ratio abnormal;Asthma;Asymptomatic COVID19;Ataxia;Atheroembolism;Atonic seizures;Atrial thrombosis;Atrophic thyroiditis;Atypical benign partial epilepsy;Atypical pneumonia;Aura;Autoantibody positive;Autoimmune anaemia;Autoimmune aplastic anaemia;Autoimmune arthritis;Autoimmune blistering disease;Autoimmune cholangitis;Autoimmune colitis;Autoimmune

demyelinating disease;Autoimmune dermatitis;Autoimmune disorder;Autoimmune encephalopathy;Autoimmune endocrine disorder;Autoimmune enteropathy;Autoimmune eye disorder;Autoimmune haemolytic anaemia;Autoimmune heparin-induced thrombocytopenia;Autoimmune hepatitis;Autoimmune hyperlipidaemia;Autoimmune hypothyroidism;Autoimmune inner ear disease;Autoimmune lung disease;Autoimmune lymphoproliferative syndrome;Autoimmune myocarditis;Autoimmune myositis;Autoimmune nephritis;Autoimmune neuropathy;Autoimmune neutropenia;Autoimmune pancreatitis;Autoimmune pancytopenia;Autoimmune pericarditis;Autoimmune retinopathy;Autoimmune thyroid disorder;Autoimmune thyroiditis;Autoimmune uveitis;Autoinflammation with infantile enterocolitis;Autoinflammatory disease;Automatism epileptic;Autonomic nervous system imbalance;Autonomic seizure;Axial spondyloarthritis;Axillary vein thrombosis;Axonal and demyelinating polyneuropathy;Axonal neuropathy;Bacterascites;Baltic myoclonic epilepsy;Band sensation;Basedow's disease;Basilar artery thrombosis;Basophilopenia;B-cell aplasia;Behcet's syndrome;Benign ethnic neutropenia;Benign familial neonatal convulsions;Benign familial pemphigus;Benign rolandic epilepsy;Beta-2 glycoprotein antibody positive;Bickerstaff's encephalitis;Bile output abnormal;Bile output decreased;Biliary ascites;Bilirubin conjugated abnormal;Bilirubin conjugated increased;Bilirubin urine present;Biopsy liver abnormal;Biotinidase deficiency;Birdshot chorioretinopathy;Blood alkaline phosphatase abnormal;Blood alkaline phosphatase increased;Blood bilirubin abnormal;Blood bilirubin increased;Blood bilirubin unconjugated increased;Blood cholinesterase abnormal;Blood cholinesterase decreased;Blood pressure decreased;Blood pressure diastolic decreased;Blood pressure systolic decreased;Blue toe syndrome;Brachiocephalic vein thrombosis;Brain stem embolism;Brain stem thrombosis;Bromosulphthalein test abnormal;Bronchial oedema;Bronchitis;Bronchitis mycoplasmal;Bronchitis viral;Bronchopulmonary aspergillosis allergic;Bronchospasm;BuddChiari syndrome;Bulbar palsy;Butterfly rash;C1q nephropathy;Caesarean section;Calcium embolism;Capillaritis;Caplan's syndrome;Cardiac amyloidosis;Cardiac arrest;Cardiac failure;Cardiac failure acute;Cardiac sarcoidosis;Cardiac ventricular thrombosis;Cardiogenic shock;Cardiolipin antibody positive;Cardiopulmonary failure;Cardio-respiratory arrest;Cardio-respiratory distress;Cardiovascular insufficiency;Carotid arterial embolus;Carotid artery thrombosis;Cataplexy;Catheter site thrombosis;Catheter site vasculitis;Cavernous sinus thrombosis;CDKL5 deficiency disorder;CEC syndrome;Cement embolism;Central nervous system lupus;Central nervous system vasculitis;Cerebellar artery thrombosis;Cerebellar embolism;Cerebral amyloid angiopathy;Cerebral arteritis;Cerebral artery embolism;Cerebral artery thrombosis;Cerebral gas embolism;Cerebral microembolism;Cerebral septic infarct;Cerebral thrombosis;Cerebral venous sinus thrombosis;Cerebral venous thrombosis;Cerebrospinal thrombotic tamponade;Cerebrovascular accident;Change in seizure presentation;Chest discomfort;ChildPugh-Turcotte score abnormal;Child-Pugh-Turcotte score increased;Chillblains;Choking;Choking sensation;Cholangitis sclerosing;Chronic autoimmune glomerulonephritis;Chronic cutaneous lupus erythematosus;Chronic fatigue syndrome;Chronic gastritis;Chronic inflammatory demyelinating polyradiculoneuropathy;Chronic lymphocytic inflammation with pontine perivascular enhancement responsive to steroids;Chronic recurrent multifocal osteomyelitis;Chronic respiratory failure;Chronic spontaneous urticaria;Circulatory collapse;Circumoral oedema;Circumoral swelling;Clinically isolated syndrome;Clonic convulsion;Coeliac disease;Cogan's syndrome;Cold agglutinins positive;Cold type haemolytic anaemia;Colitis;Colitis erosive;Colitis herpes;Colitis microscopic;Colitis ulcerative;Collagen disorder;Collagen-vascular disease;Complement factor abnormal;Complement factor C1 decreased;Complement factor C2 decreased;Complement factor C3 decreased;Complement factor C4 decreased;Complement factor decreased;Computerised tomogram liver abnormal;Concentric sclerosis;Congenital anomaly;Congenital bilateral perisylvian syndrome;Congenital herpes simplex infection;Congenital myasthenic syndrome;Congenital varicella infection;Congestive hepatopathy;Convulsion in childhood;Convulsions local;Convulsive threshold lowered;Coombs positive haemolytic anaemia;Coronary artery disease;Coronary artery embolism;Coronary artery thrombosis;Coronary bypass thrombosis;Coronavirus infection;Coronavirus test;Coronavirus test negative;Coronavirus test positive;Corpus callosotomy;Cough;Cough variant asthma;COVID-19;COVID-19 immunisation;COVID-19 pneumonia;COVID-19 prophylaxis;COVID-19 treatment;Cranial nerve disorder;Cranial nerve palsies multiple;Cranial nerve paralysis;CREST syndrome;Crohn's disease;Cryofibrinogenaemia;Cryoglobulinaemia;CSF oligoclonal band present;CSWS syndrome;Cutaneous amyloidosis;Cutaneous lupus erythematosus;Cutaneous sarcoidosis;Cutaneous vasculitis;Cyanosis;Cyclic neutropenia;Cystitis interstitial;Cytokine release syndrome;Cytokine storm;De novo purine synthesis inhibitors associated acute inflammatory syndrome;Death neonatal;Deep vein thrombosis;Deep vein thrombosis postoperative;Deficiency of bile secretion;Deja vu;Demyelinating polyneuropathy;Demyelination;Dermatitis;Dermatitis bullous;Dermatitis herpetiformis;Dermatomyositis;Device embolisation;Device related thrombosis;Diabetes mellitus;Diabetic ketoacidosis;Diabetic mastopathy;Dialysis amyloidosis;Dialysis membrane reaction;Diastolic hypotension;Diffuse vasculitis;Digital pitting scar;Disseminated intravascular

coagulation;Disseminated intravascular coagulation in newborn;Disseminated neonatal herpes simplex;Disseminated varicella;Disseminated varicella zoster vaccine virus infection;Disseminated varicella zoster virus infection;DNA antibody positive;Double cortex syndrome;Double stranded DNA antibody positive;Dreamy state;Dressler's syndrome;Drop attacks;Drug withdrawal convulsions;Dyspnoea;Early infantile epileptic encephalopathy with burst-suppression;Eclampsia;Eczema herpeticum;Embolia cutis medicamentosa;Embolic cerebellar infarction;Embolic cerebral infarction;Embolic pneumonia;Embolic stroke;Embolism;Embolism arterial;Embolism venous;Encephalitis;Encephalitis allergic;Encephalitis autoimmune;Encephalitis brain stem;Encephalitis haemorrhagic;Encephalitis periaxialis diffusa;Encephalitis post immunisation;Encephalomyelitis;Encephalopathy;Endocrine disorder;Endocrine ophthalmopathy;Endotracheal intubation;Enteritis;Enteritis leukopenic;Enterobacter pneumonia;Enterocolitis;Enteropathic spondylitis;Eosinopenia;Eosinophilic fasciitis;Eosinophilic granulomatosis with polyangiitis;Eosinophilic oesophagitis;Epidermolysis;Epilepsy;Epilepsy surgery;Epilepsy with myoclonic-atonic seizures;Epileptic aura;Epileptic psychosis;Erythema;Erythema induratum;Erythema multiforme;Erythema nodosum;Evans syndrome;Exanthema subitum;Expanded disability status scale score decreased;Expanded disability status scale score increased;Exposure to communicable disease;Exposure to SARS-CoV-2;Eye oedema;Eye pruritus;Eye swelling;Eyelid oedema;Face oedema;Facial paralysis;Facial paresis;Faciobrachial dystonic seizure;Fat embolism;Febrile convulsion;Febrile infection-related epilepsy syndrome;Febrile neutropenia;Felty's syndrome;Femoral artery embolism;Fibrillary glomerulonephritis;Fibromyalgia;Flushing;Foaming at mouth;Focal cortical resection;Focal dyscognitive seizures;Foetal distress syndrome;Foetal placental thrombosis;Foetor hepaticus;Foreign body embolism;Frontal lobe epilepsy;Fulminant type 1 diabetes mellitus;Galactose elimination capacity test abnormal;Galactose elimination capacity test decreased;Gamma-glutamyltransferase abnormal;Gamma-glutamyltransferase increased;Gastritis herpes;Gastrointestinal amyloidosis;Gelastic seizure;Generalised onset non-motor seizure;Generalised tonic-clonic seizure;Genital herpes;Genital herpes simplex;Genital herpes zoster;Giant cell arteritis;Glomerulonephritis;Glomerulonephritis membranoproliferative;Glomerulonephritis membranous;Glomerulonephritis rapidly progressive;Glossopharyngeal nerve paralysis;Glucose transporter type 1 deficiency syndrome;Glutamate dehydrogenase increased;Glycocholic acid increased;GM2 gangliosidosis;Goodpasture's syndrome;Graft thrombosis;Granulocytopenia;Granulocytopenia neonatal;Granulomatosis with polyangiitis;Granulomatous dermatitis;Grey matter heterotopia;Guanase increased;GuillainBarre syndrome;Haemolytic anaemia;Haemophagocytic lymphohistiocytosis;Haemorrhage;Haemorrhagic ascites;Haemorrhagic disorder;Haemorrhagic pneumonia;Haemorrhagic varicella syndrome;Haemorrhagic vasculitis;Hantavirus pulmonary infection;Hashimoto's encephalopathy;Hashitoxicosis;Hemimegalencephaly;Henoch-Schonlein purpura;HenochSchonlein purpura nephritis;Hepaplastin abnormal;Hepaplastin decreased;Heparin-induced thrombocytopenia;Hepatic amyloidosis;Hepatic artery embolism;Hepatic artery flow decreased;Hepatic artery thrombosis;Hepatic enzyme abnormal;Hepatic enzyme decreased;Hepatic enzyme increased;Hepatic fibrosis marker abnormal;Hepatic fibrosis marker increased;Hepatic function abnormal;Hepatic hydrothorax;Hepatic hypertrophy;Hepatic hypoperfusion;Hepatic lymphocytic infiltration;Hepatic mass;Hepatic pain;Hepatic sequestration;Hepatic vascular resistance increased;Hepatic vascular thrombosis;Hepatic vein embolism;Hepatic vein thrombosis;Hepatic venous pressure gradient abnormal;Hepatic venous pressure gradient increased;Hepatitis;Hepatobiliary scan abnormal;Hepatomegaly;Hepatosplenomegaly;Hereditary angioedema with C1 esterase inhibitor deficiency;Herpes dermatitis;Herpes gestationis;Herpes oesophagitis;Herpes ophthalmic;Herpes pharyngitis;Herpes sepsis;Herpes simplex;Herpes simplex cervicitis;Herpes simplex colitis;Herpes simplex encephalitis;Herpes simplex gastritis;Herpes simplex hepatitis;Herpes simplex meningitis;Herpes simplex meningoencephalitis;Herpes simplex meningomyelitis;Herpes simplex necrotising retinopathy;Herpes simplex oesophagitis;Herpes simplex otitis externa;Herpes simplex pharyngitis;Herpes simplex pneumonia;Herpes simplex reactivation;Herpes simplex sepsis;Herpes simplex viraemia;Herpes simplex virus conjunctivitis neonatal;Herpes simplex visceral;Herpes virus infection;Herpes zoster;Herpes zoster cutaneous disseminated;Herpes zoster infection neurological;Herpes zoster meningitis;Herpes zoster meningoencephalitis;Herpes zoster meningomyelitis;Herpes zoster meningoradiculitis;Herpes zoster necrotising retinopathy;Herpes zoster oticus;Herpes zoster pharyngitis;Herpes zoster reactivation;Herpetic radiculopathy;Histone antibody positive;Hoigne's syndrome;Human herpesvirus 6 encephalitis;Human herpesvirus 6 infection;Human herpesvirus 6 infection reactivation;Human herpesvirus 7 infection;Human herpesvirus 8 infection;Hyperammonaemia;Hyperbilirubinaemia;Hypercholia;Hypergammaglobulinaemia benign monoclonal;Hyperglycaemic seizure;Hypersensitivity;Hypersensitivity vasculitis;Hyperthyroidism;Hypertransaminasaemia;Hyperventilation;Hypoalbuminaemia;H ypocalcaemic seizure;Hypogammaglobulinaemia;Hypoglossal nerve paralysis;Hypoglossal nerve paresis;Hypoglycaemic

seizure;Hyponatraemic seizure;Hypotension;Hypotensive crisis;Hypothenar hammer syndrome;Hypothyroidism;Hypoxia;Idiopathic CD4 lymphocytopenia;Idiopathic generalised epilepsy;Idiopathic interstitial pneumonia;Idiopathic neutropenia;Idiopathic pulmonary fibrosis;IgA nephropathy;IgM nephropathy;IIIrd nerve paralysis;IIIrd nerve paresis;Iliac artery embolism;Immune thrombocytopenia;Immunemediated adverse reaction;Immune-mediated cholangitis;Immune-mediated cholestasis;Immune-mediated cytopenia;Immune-mediated encephalitis;Immune-mediated encephalopathy;Immune-mediated endocrinopathy;Immune-mediated enterocolitis;Immunemediated gastritis;Immune-mediated hepatic disorder;Immune-mediated hepatitis;Immunemediated hyperthyroidism;Immune-mediated hypothyroidism;Immune-mediated myocarditis;Immune-mediated myositis;Immune-mediated nephritis;Immune-mediated neuropathy;Immune-mediated pancreatitis;Immune-mediated pneumonitis;Immune-mediated renal disorder;Immune-mediated thyroiditis;Immune-mediated uveitis;Immunoglobulin G4 related disease;Immunoglobulins abnormal;Implant site thrombosis;Inclusion body myositis;Infantile genetic agranulocytosis;Infantile spasms;Infected vasculitis;Infective thrombosis;Inflammation;Inflammatory bowel disease;Infusion site thrombosis;Infusion site vasculitis;Injection site thrombosis;Injection site urticaria;Injection site vasculitis;Instillation site thrombosis;Insulin autoimmune syndrome;Interstitial granulomatous dermatitis;Interstitial lung disease;Intracardiac mass;Intracardiac thrombus;Intracranial pressure increased;Intrapericardial thrombosis;Intrinsic factor antibody abnormal;Intrinsic factor antibody positive;IPEX syndrome;Irregular breathing;IRVAN syndrome;IVth nerve paralysis;IVth nerve paresis;JC polyomavirus test positive;JC virus CSF test positive;Jeavons syndrome;Jugular vein embolism;Jugular vein thrombosis;Juvenile idiopathic arthritis;Juvenile myoclonic epilepsy;Juvenile polymyositis;Juvenile psoriatic arthritis;Juvenile spondyloarthritis;Kaposi sarcoma inflammatory cytokine syndrome;Kawasaki's disease;Kayser-Fleischer ring;Keratoderma blenorrhagica;Ketosisprone diabetes mellitus;Kounis syndrome;Lafora's myoclonic epilepsy;Lambl's excrescences;Laryngeal dyspnoea;Laryngeal oedema;Laryngeal rheumatoid arthritis;Laryngospasm;Laryngotracheal oedema;Latent autoimmune diabetes in adults;LE cells present;Lemierre syndrome;Lennox-Gastaut syndrome;Leucine aminopeptidase increased;Leukoencephalomyelitis;Leukoencephalopathy;Leukopenia;Leukopenia neonatal;Lewis-Sumner syndrome;Lhermitte's sign;Lichen planopilaris;Lichen planus;Lichen sclerosus;Limbic encephalitis;Linear IgA disease;Lip oedema;Lip swelling;Liver function test abnormal;Liver function test decreased;Liver function test increased;Liver induration;Liver injury;Liver iron concentration abnormal;Liver iron concentration
increased;Liver opacity;Liver palpable;Liver sarcoidosis;Liver scan abnormal;Liver tenderness;Low birth weight baby;Lower respiratory tract herpes infection;Lower respiratory tract infection;Lower respiratory tract infection viral;Lung abscess;Lupoid hepatic cirrhosis;Lupus cystitis;Lupus encephalitis;Lupus endocarditis;Lupus enteritis;Lupus hepatitis;Lupus myocarditis;Lupus myositis;Lupus nephritis;Lupus pancreatitis;Lupus pleurisy;Lupus pneumonitis;Lupus vasculitis;Lupus-like syndrome;Lymphocytic hypophysitis;Lymphocytopenia neonatal;Lymphopenia;MAGIC syndrome;Magnetic resonance imaging liver abnormal;Magnetic resonance proton density fat fraction measurement;Mahler sign;Manufacturing laboratory analytical testing issue;Manufacturing materials issue;Manufacturing production issue;Marburg's variant multiple sclerosis;Marchiafava-Bignami disease;Marine Lenhart syndrome;Mastocytic enterocolitis;Maternal exposure during pregnancy;Medical device site thrombosis;Medical device site vasculitis;MELAS syndrome;Meningitis;Meningitis aseptic;Meningitis herpes;Meningoencephalitis herpes simplex neonatal;Meningoencephalitis herpetic;Meningomyelitis herpes;MERS-CoV test;MERS-CoV test negative;MERS-CoV test positive;Mesangioproliferative glomerulonephritis;Mesenteric artery embolism;Mesenteric artery thrombosis;Mesenteric vein thrombosis;Metapneumovirus infection;Metastatic cutaneous Crohn's disease;Metastatic pulmonary embolism;Microangiopathy;Microembolism;Microscopic polyangiitis;Middle East respiratory syndrome;Migraine-triggered seizure;Miliary pneumonia;Miller Fisher syndrome;Mitochondrial aspartate aminotransferase increased;Mixed connective tissue disease;Model for end stage liver disease score abnormal;Model for end stage liver disease score increased;Molar ratio of total branched-chain amino acid to tyrosine;Molybdenum cofactor deficiency;Monocytopenia;Mononeuritis;Mononeuropathy multiplex;Morphoea;Morvan syndrome;Mouth swelling;Moyamoya disease;Multifocal motor neuropathy;Multiple organ dysfunction syndrome;Multiple sclerosis;Multiple sclerosis relapse;Multiple sclerosis relapse prophylaxis;Multiple subpial transection;Multisystem inflammatory syndrome in children;Muscular sarcoidosis;Myasthenia gravis;Myasthenia gravis crisis;Myasthenia gravis neonatal;Myasthenic syndrome;Myelitis;Myelitis transverse;Myocardial infarction;Myocarditis;Myocarditis post infection;Myoclonic epilepsy;Myoclonic epilepsy and ragged-red fibres;Myokymia;Myositis;Narcolepsy;Nasal herpes;Nasal obstruction;Necrotising herpetic retinopathy;Neonatal Crohn's disease;Neonatal epileptic seizure;Neonatal lupus erythematosus;Neonatal mucocutaneous herpes simplex;Neonatal pneumonia;Neonatal seizure;Nephritis;Nephrogenic systemic fibrosis;Neuralgic amyotrophy;Neuritis;Neuritis

cranial;Neuromyelitis optica pseudo relapse;Neuromyelitis optica spectrum disorder;Neuromyotonia;Neuronal neuropathy;Neuropathy peripheral;Neuropathy, ataxia, retinitis pigmentosa syndrome;Neuropsychiatric lupus;Neurosarcoidosis;Neutropenia;Neutropenia neonatal;Neutropenic colitis;Neutropenic infection;Neutropenic sepsis;Nodular rash;Nodular vasculitis;Noninfectious myelitis;Noninfective encephalitis;Noninfective encephalomyelitis;Noninfective oophoritis;Obstetrical pulmonary embolism;Occupational exposure to communicable disease;Occupational exposure to SARS-CoV-2;Ocular hyperaemia;Ocular myasthenia;Ocular pemphigoid;Ocular sarcoidosis;Ocular vasculitis;Oculofacial paralysis;Oedema;Oedema blister;Oedema due to hepatic disease;Oedema mouth;Oesophageal achalasia;Ophthalmic artery thrombosis;Ophthalmic herpes simplex;Ophthalmic herpes zoster;Ophthalmic vein thrombosis;Optic neuritis;Optic neuropathy;Optic perineuritis;Oral herpes;Oral lichen planus;Oropharyngeal oedema;Oropharyngeal spasm;Oropharyngeal swelling;Osmotic demyelination syndrome;Ovarian vein thrombosis;Overlap syndrome;Paediatric autoimmune neuropsychiatric disorders associated with streptococcal infection;Paget-Schroetter syndrome;Palindromic rheumatism;Palisaded neutrophilic granulomatous dermatitis;Palmoplantar keratoderma;Palpable purpura;Pancreatitis;Panencephalitis;Papillophlebitis;Paracancerous pneumonia;Paradoxical embolism;Parainfluenzae viral laryngotracheobronchitis;Paraneoplastic dermatomyositis;Paraneoplastic pemphigus;Paraneoplastic thrombosis;Paresis cranial nerve;Parietal cell antibody positive;Paroxysmal nocturnal haemoglobinuria;Partial seizures;Partial seizures with secondary generalisation;Patient isolation;Pelvic venous thrombosis;Pemphigoid;Pemphigus;Penile vein thrombosis;Pericarditis;Pericarditis lupus;Perihepatic discomfort;Periorbital oedema;Periorbital swelling;Peripheral artery thrombosis;Peripheral embolism;Peripheral ischaemia;Peripheral vein thrombus extension;Periportal oedema;Peritoneal fluid protein abnormal;Peritoneal fluid protein decreased;Peritoneal fluid protein increased;Peritonitis lupus;Pernicious anaemia;Petit mal epilepsy;Pharyngeal oedema;Pharyngeal swelling;Pityriasis lichenoides et varioliformis acuta;Placenta praevia;Pleuroparenchymal fibroelastosis;Pneumobilia;Pneumonia;Pneumonia adenoviral;Pneumonia cytomegaloviral;Pneumonia herpes viral;Pneumonia influenzal;Pneumonia measles;Pneumonia mycoplasmal;Pneumonia necrotising;Pneumonia parainfluenzae viral;Pneumonia respiratory syncytial viral;Pneumonia viral;POEMS syndrome;Polyarteritis nodosa;Polyarthritis;Polychondritis;Polyglandular autoimmune syndrome type I;Polyglandular autoimmune syndrome type II;Polyglandular autoimmune syndrome type III;Polyglandular disorder;Polymicrogyria;Polymyalgia rheumatica;Polymyositis;Polyneuropathy;Polyneuropathy idiopathic progressive;Portal pyaemia;Portal vein embolism;Portal vein flow decreased;Portal vein pressure increased;Portal vein thrombosis;Portosplenomesenteric venous thrombosis;Post procedural hypotension;Post procedural pneumonia;Post procedural pulmonary embolism;Post stroke epilepsy;Post stroke seizure;Post thrombotic retinopathy;Post thrombotic syndrome;Post viral fatigue syndrome;Postictal headache;Postictal paralysis;Postictal psychosis;Postictal state;Postoperative respiratory distress;Postoperative respiratory failure;Postoperative thrombosis;Postpartum thrombosis;Postpartum venous thrombosis;Postpericardiotomy syndrome;Post-traumatic epilepsy;Postural orthostatic tachycardia syndrome;Precerebral artery thrombosis;Pre-eclampsia;Preictal state;Premature labour;Premature menopause;Primary amyloidosis;Primary biliary cholangitis;Primary progressive multiple sclerosis;Procedural shock;Proctitis herpes;Proctitis ulcerative;Product availability issue;Product distribution issue;Product supply issue;Progressive facial hemiatrophy;Progressive multifocal leukoencephalopathy;Progressive multiple sclerosis;Progressive relapsing multiple sclerosis;Prosthetic cardiac valve thrombosis;Pruritus;Pruritus allergic;Pseudovasculitis;Psoriasis;Psoriatic arthropathy;Pulmonary amyloidosis;Pulmonary artery thrombosis;Pulmonary embolism;Pulmonary fibrosis;Pulmonary haemorrhage;Pulmonary microemboli;Pulmonary oil microembolism;Pulmonary renal syndrome;Pulmonary sarcoidosis;Pulmonary sepsis;Pulmonary thrombosis;Pulmonary tumour thrombotic microangiopathy;Pulmonary vasculitis;Pulmonary veno-occlusive disease;Pulmonary venous thrombosis;Pyoderma gangrenosum;Pyostomatitis vegetans;Pyrexia;Quarantine;Radiation leukopenia;Radiculitis brachial;Radiologically isolated syndrome;Rash;Rash erythematous;Rash pruritic;Rasmussen encephalitis;Raynaud's phenomenon;Reactive capillary endothelial proliferation;Relapsing multiple sclerosis;Relapsing-remitting multiple sclerosis;Renal amyloidosis;Renal arteritis;Renal artery thrombosis;Renal embolism;Renal failure;Renal vascular thrombosis;Renal vasculitis;Renal vein embolism;Renal vein thrombosis;Respiratory arrest;Respiratory disorder;Respiratory distress;Respiratory failure;Respiratory paralysis;Respiratory syncytial virus bronchiolitis;Respiratory syncytial virus bronchitis;Retinal artery embolism;Retinal artery occlusion;Retinal artery thrombosis;Retinal vascular thrombosis;Retinal vasculitis;Retinal vein occlusion;Retinal vein thrombosis;Retinol binding protein decreased;Retinopathy;Retrograde portal vein flow;Retroperitoneal fibrosis;Reversible airways obstruction;Reynold's syndrome;Rheumatic brain disease;Rheumatic disorder;Rheumatoid arthritis;Rheumatoid factor increased;Rheumatoid factor positive;Rheumatoid factor quantitative

increased;Rheumatoid lung;Rheumatoid neutrophilic dermatosis;Rheumatoid nodule;Rheumatoid nodule removal;Rheumatoid scleritis;Rheumatoid vasculitis;Saccadic eye movement;SAPHO syndrome;Sarcoidosis;SARS-CoV-1 test;SARS-CoV-1 test negative;SARS-CoV-1 test positive;SARS-CoV-2 antibody test;SARS-CoV-2 antibody test negative;SARS-CoV-2 antibody test positive;SARS-CoV-2 carrier;SARS-CoV-2 sepsis;SARS-CoV-2 test;SARSCoV-2 test false negative;SARS-CoV-2 test false positive;SARS-CoV-2 test negative;SARSCoV-2 test positive;SARS-CoV-2 viraemia;Satoyoshi syndrome;Schizencephaly;Scleritis;Sclerodactylia;Scleroderma;Scleroderma associated digital ulcer;Scleroderma renal crisis;Scleroderma-like reaction;Secondary amyloidosis;Secondary cerebellar degeneration;Secondary progressive multiple sclerosis;Segmented hyalinising vasculitis;Seizure;Seizure anoxic;Seizure cluster;Seizure like phenomena;Seizure prophylaxis;Sensation of foreign body;Septic embolus;Septic pulmonary embolism;Severe acute respiratory syndrome;Severe myoclonic epilepsy of infancy;Shock;Shock symptom;Shrinking lung syndrome;Shunt thrombosis;Silent thyroiditis;Simple partial seizures;Sjogren's syndrome;Skin swelling;SLE arthritis;Smooth muscle antibody positive;Sneezing;Spinal artery embolism;Spinal artery thrombosis;Splenic artery thrombosis;Splenic embolism;Splenic thrombosis;Splenic vein thrombosis;Spondylitis;Spondyloarthropathy;Spontaneous heparin-induced thrombocytopenia syndrome;Status epilepticus;Stevens-Johnson syndrome;Stiff leg syndrome;Stiff person syndrome;Stillbirth;Still's disease;Stoma site thrombosis;Stoma site vasculitis;Stress cardiomyopathy;Stridor;Subacute cutaneous lupus erythematosus;Subacute endocarditis;Subacute inflammatory demyelinating polyneuropathy;Subclavian artery embolism;Subclavian artery thrombosis;Subclavian vein thrombosis;Sudden unexplained death in epilepsy;Superior sagittal sinus thrombosis;Susac's syndrome;Suspected COVID19;Swelling;Swelling face;Swelling of eyelid;Swollen tongue;Sympathetic ophthalmia;Systemic lupus erythematosus;Systemic lupus erythematosus disease activity index abnormal;Systemic lupus erythematosus disease activity index decreased;Systemic lupus erythematosus disease activity index increased;Systemic lupus erythematosus rash;Systemic scleroderma;Systemic sclerosis pulmonary;Tachycardia;Tachypnoea;Takayasu's arteritis;Temporal lobe epilepsy;Terminal ileitis;Testicular autoimmunity;Throat tightness;Thromboangiitis obliterans;Thrombocytopenia;Thrombocytopenic purpura;Thrombophlebitis;Thrombophlebitis migrans;Thrombophlebitis Page 37 090177e196ea1800\Approved\Approved On: 30-A pr-2021 09:26 (GMT) FD
neonatal;Thrombophlebitis septic;Thrombophlebitis superficial;Thromboplastin antibody positive;Thrombosis;Thrombosis corpora cavernosa;Thrombosis in device;Thrombosis mesenteric vessel;Thrombotic cerebral infarction;Thrombotic microangiopathy;Thrombotic stroke;Thrombotic thrombocytopenic purpura;Thyroid disorder;Thyroid stimulating immunoglobulin increased;Thyroiditis;Tongue amyloidosis;Tongue biting;Tongue oedema;Tonic clonic movements;Tonic convulsion;Tonic posturing;Topectomy;Total bile acids increased;Toxic epidermal necrolysis;Toxic leukoencephalopathy;Toxic oil syndrome;Tracheal obstruction;Tracheal oedema;Tracheobronchitis;Tracheobronchitis mycoplasmal;Tracheobronchitis viral;Transaminases abnormal;Transaminases increased;Transfusion-related alloimmune neutropenia;Transient epileptic amnesia;Transverse sinus thrombosis;Trigeminal nerve paresis;Trigeminal neuralgia;Trigeminal palsy;Truncus coeliacus thrombosis;Tuberous sclerosis complex;Tubulointerstitial nephritis and uveitis syndrome;Tumefactive multiple sclerosis;Tumour embolism;Tumour thrombosis;Type 1 diabetes mellitus;Type I hypersensitivity;Type III immune complex mediated reaction;Uhthoff's phenomenon;Ulcerative keratitis;Ultrasound liver abnormal;Umbilical cord thrombosis;Uncinate fits;Undifferentiated connective tissue disease;Upper airway obstruction;Urine bilirubin increased;Urobilinogen urine decreased;Urobilinogen urine increased;Urticaria;Urticaria papular;Urticarial vasculitis;Uterine rupture;Uveitis;Vaccination site thrombosis;Vaccination site vasculitis;Vagus nerve paralysis;Varicella;Varicella keratitis;Varicella post vaccine;Varicella zoster gastritis;Varicella zoster oesophagitis;Varicella zoster pneumonia;Varicella zoster sepsis;Varicella zoster virus infection;Vasa praevia;Vascular graft thrombosis;Vascular pseudoaneurysm thrombosis;Vascular purpura;Vascular stent thrombosis;Vasculitic rash;Vasculitic ulcer;Vasculitis;Vasculitis gastrointestinal;Vasculitis necrotising;Vena cava embolism;Vena cava thrombosis;Venous intravasation;Venous recanalisation;Venous thrombosis;Venous thrombosis in pregnancy;Venous thrombosis limb;Venous thrombosis neonatal;Vertebral artery thrombosis;Vessel puncture site thrombosis;Visceral venous thrombosis;VIth nerve paralysis;VIth nerve paresis;Vitiligo;Vocal cord paralysis;Vocal cord paresis;Vogt-Koyanagi-Harada disease;Warm type haemolytic anaemia;Wheezing;White nipple sign;XIth nerve paralysis;X-ray hepatobiliary abnormal;Young's syndrome;Zika virus associated Guillain Barre syndrome

Appendix 7

Denmark health chief says Omicron is bringing about the END of the pandemic and 'we will have our normal lives back in two months'

- **Tyra Grove Krause is the chief epidemiologist at Denmark's State Serum Institute**
- **Speaking Monday, she said Omicron's hospitalisation risk was half that of Delta**
- **This, she said, could spell the end of the pandemic in around two months**

By Chris Jewers For Mailonline

Published: 23:46 AEDT, 3 January 2022 | Updated: 03:06 AEDT, 4 January 2022

A Danish health chief has said the Covid-19 **Omicron** variant is bringing about the end of the pandemic, saying 'we will have our normal lives back in two months'.

Speaking to Danish TV 2,Tyra Grove Krause - the chief epidemiologist at Denmark's State Serum Institute - said a new study from the organisation found that the risk of hospitalisation from Omicron is half that seen with the Delta variant.

This, she said, has given Danish authorities hope that the **Covid-19** pandemic in Denmark could be over in two months.

Despite early fears that Omicron could prolong the pandemic due to its increased level of infection, Ms Krause said it actually could spell the end of the pandemic.

According to the study: 'Omicron is here to stay, and it will provide some massive spread of infection in the coming month. When it's over, we're in a better place than we were before.'

But while infection numbers in countries with the variant are soaring, the expert said that the highly infectious Omicron appears milder than the Delta variant, and therefore more people will be infected without having serious symptoms.

As a result, she said, this will provide a good level of immunity in the population.

Denmark has seen a spike in new cases in recent weeks, and on Sunday recorded its highest ever seven-day average infections, recording an average of 20,886 across the previous week, or 3,592.74 per million people - one of Europe's highest rates.

It reported its highest ever new infections on December 27 (41,035).

By comparison, the UK's seven-day average daily new confirmed Covid-19 cases per million people sits at 2,823.31 as on Monday, while in the United States, that number is 1,215.76 - lower than many countries in Europe.

Ms Krause stressed that there was still work to be done to beat the pandemic in the coming months, however.

'Omicron will peak at the end of January, and in February we will see declining infection pressure and a decreasing pressure on the health care system,' she said.

'But we have to make an effort in January, because it will be hard to get through.'

The epidemiologist said Danes should continue to follow the now well-known measures to help slow the spread, such as good hygiene, social distancing where possible, and staying at home when symptoms present themselves.

Omicron's increasing spread will continue to put pressure on Denmark's healthcare system, she said. 'This is definitely what will be the challenge in the future.'

Professor Lars Østergaard, chief physician at the Department of Infectious Diseases at Aarhus University Hospital, also looked towards the end of the pandemic in comments made on January 1.

He said that while the coronavirus will not be characterised as a pandemic forever, it will likely never fully disappear.

I never think we'll ever wave goodbye to the corona,' he said.

'But we want such a good immunity in the population - partly because of new vaccines, partly because people have been infected - that we can handle it as another of the infections we know that come especially in the winter month.'

Ms Krause agreed, saying: 'In the long run, we are in a place where coronavirus is here, but where we have restrained it, and only the particularly vulnerable need to be vaccinated up to the next winter season.'

Ms Krause's optimistic comments came three days after the World Health Organisation made a similarly hopeful statement about Omicron.

'If we put an end to inequality, we will put an end to the pandemic and the global nightmare that we have all gone through,' WHO chief Tedro's Adhanom Ghebreyesus said in a speech on New Years Eve.

But the WHO also warned warned of trying times ahead, saying Omicron could lead to 'a tsunami of cases'.

'This... will continue to put immense pressure on exhausted health workers, and health systems on the brink of collapse,' Ghebreyesus said.

Many Western leaders have been hesitant to reimpose strict controls seen in 2020, for fear of sparking a new economic downturn.

But on-again-off-again restrictions have still prompted frequent, vocal and occasionally violent anti-lockdown, anti-vaccine and anti-government protests.

Experts and non-experts alike hope that 2022 may be remembered as a new, less deadly phase of the pandemic.

https://www.dailymail.co.uk/news/article-10364503/Denmark-health-chief-says-Omicron-bringing-END-pandemic.html

Appendix 8

The Nuremberg Code

"The judgment by the war crimes tribunal at Nuremberg laid down 10 standards to which physicians must conform when carrying out experiments on human subjects in a new code that is now accepted worldwide.

This judgment established a new standard of ethical medical behavior for the post World War II human rights era. Amongst other requirements, this document enunciates the requirement of *voluntary informed consent* of the human subject. The principle of voluntary informed consent protects the right of the individual to control his own body.

This code also recognizes that the risk must be weighed against the expected benefit, and that unnecessary pain and suffering must be avoided.

This code recognizes that doctors should avoid actions that injure human patients.

The principles established by this code for medical practice now have been extended into general codes of medical ethics"

(**BRITISH MEDICAL JOURNAL** No 7070 Volume 313: Page 1448, 7 December 1996, http://www.cirp.org/library/ethics/nuremberg/)

---

1. The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved, as to enable him to make an understanding and enlightened decision. This latter element requires that, before the acceptance of an affirmative decision by the experimental subject, there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person, which may possibly come from his participation in the experiment. The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.

2. The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.

3. The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study, that the anticipated results will justify the performance of the experiment.

4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.

5. No experiment should be conducted, where there is an a priori reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.

6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.

7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.

8. The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.

9. During the course of the experiment, the human subject should be at liberty to bring the experiment to an end, if he has reached the physical or mental state, where continuation of the experiment seemed to him to be impossible.

10. During the course of the experiment, the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill and careful judgement required of him, that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.

["**Trials of War Criminals before the Nuremberg Military Tribunals under Control Council Law, No. 10**", Vol. 2, pp. 181-182. Washington, D.C.: U.S. Government Printing Office, 1949.]

Date Approved by ELT:	3 December 2021
Next review date:	3 June 2022
Document number:	D-4013352
Associated documents:	N/A
Sponsor/Group:	People and Organisational Performance
Policy Owner:	People, Safety and Wellness

Management Policy – COVID-19 Vaccination Policy

Te Puutake - Purpose

1. The purpose of this Policy is to outline Hamilton City Council's ('Council') position and requirements in relation to COVID-19 vaccinations to reduce the risk of contracting or transmitting Covid-19 for all Employees, Contractors and Volunteers.

2. In consultation with employees, Council has conducted a risk assessment examining exposure and transmission risks across most roles within the organisation. We also looked at the range of other controls available and how those may be applied across the organisation.

3. Council has an obligation to provide a safe and healthy working environment for all our workers under the Health and Safety at Work Act 2015, which extends to others that we engage, including our customers, visitors and wider communities and iwi. This commitment is reinforced through our organisational purpose, to 'Improve the wellbeing of Hamiltonians' and places front and centre our non-negotiable ethos: Safety first in all we do.

4. Under the Health and Safety at Work Act 2015 we have a duty to take all reasonably practicable steps to eliminate, or otherwise minimise, any risks to our people. Council continually assesses risks within our workplaces, including the risk that is introduced by having COVID-19 in the community.

5. Vaccinations play a key role in managing the risk of COVID-19 in the workplace as they provide an effective way to mitigate the risk to business continuity arising from workplace infection and support the continuing provision of our services and job security for our people. More importantly, they are crucial in reducing the likelihood of our people and the community accessing our workplaces and becoming infected with COVID-19 in the course of the work that we do and reducing the severity of the illness if anybody is infected despite best efforts being made to avoid that happening.

Overview

6. Council recognises that vaccination against COVID-19 represents an important risk mitigation to assist in bringing the spread and impact of the disease under control. Vaccines help protect people by reducing their likelihood of becoming infected and by

either preventing or reducing symptoms of COVID- 19 which is helpful in reducing the risk of COVID-19 spreading in the workplace.

Ngaa Tikanga Whakahaere - Principles of Policy

7. The guiding principles for this policy are:

    - To effectively manage the health and safety of all people in the workplace through our risk management process
    - Support the Governments vaccination programme and the ethos behind the COVID-19 Protection Framework
    - Adhere to all Public Health Orders issued by Government to manage COVID-19, which takes precedence over this Policy and any other Council issued instructions

Te Whaanuitanga – Scope

8. This Policy applies to all Employees, Contractors and Volunteers of the Council, regardless of whether they work full time, part time or on a casual basis and irrespective of location.

9. This policy also extends to any contractors and temporary staff performing work for Council or who are present in the workplace or engaging with our employees through the course of their work.

10. All Council Business Units are required to comply with this Policy in its entirety.

11. COVID-19 vaccination requirements applicable to independent contractors and suppliers will be set out in the Supplier Requirements.

12. This Policy has been drafted based on the advice and information provided by government departments at the time. However, given the changing nature of matters relating to COVID-19, this Policy will be reviewed in 6 months' time, or earlier if required, and changes made where necessary. Staff will be advised of any further updates to this Policy.

Aahurutanga – Guidelines

Accessing our workplaces

13. While vaccination greatly reduces a person's chance of infection with COVID-19 as well as likelihood of severe illness resulting from infection, transmission can still occur. For this reason, it is important that staff remain vigilant and take appropriate alternative precautions and protections.

    Symptoms of COVID-19 include:

    - Fever
    - Cough
    - Fatigue/tiredness
    - Loss of taste and/or smell
    - Sore throat
    - Headache
    - Aches and pain

14. If you experience any of the above symptoms, or any other cold or flu-like symptoms, you should not come to work. You should notify your People Leader as per the usual process for sick leave. Symptomatic staff should be tested for COVID-19 as soon as possible in accordance with the Ministry of Health's guidelines. Council may require evidence of a negative COVID-19 test returning to work.

15. More information about COVID-19 symptoms and what to do if symptoms develop can be found here COVID-19-like symptoms

16. All Council employees shall be given reasonable, paid, time off work to enable a COVID-19 test to be taken and to isolate until the result is known if they are displaying COVID-19 symptoms, or if they have returned a positive test result.

17. If a Council employee contracts COVID-19, they must follow all Ministry of Health instructions, notify their People Leader, and may not return to a Council workplace until they return a negative COVID-19 test and are asymptomatic.

18. Council will provide paid special leave to accommodate short-term absences from work relating to COVID-19. If time off is prolonged (longer than three weeks), then we will work with the employee on a case-by-case basis to assist in determining further ongoing support.

19. Vaccination is a key measure for Council to minimise the risk of COVID-19 in the workplace and from the date the COVID-19 Protection Framework comes into force on 3 December 2021:

    a. Every Council Employee, Contractor or Volunteer who is required to enter one of Council's workplaces to perform their duties must be vaccinated. Council appreciates that not all staff are currently vaccinated and so this requirement will be phased in as follows:

       From 13 December 2021: only people who have had at least one COVID-19 vaccination will be allowed on our sites.

       From 17 January 2022: only people who are fully vaccinated will be allowed on our sites.

    b. Every Council Employee, Contractor or Volunteer who enters any of our customer or supplier sites must be fully vaccinated.

20. ‘Fully vaccinated’ means having received two doses of the Pfizer COVID-19 vaccine or an equivalent approved by the Ministry of Health. Additional booster vaccinations will also be required to maintain a person’s ‘fully vaccinated’ status as those become applicable.

21. In circumstances where a member of staff has not been vaccinated (due to medical, religious, or personal choice reasons), or provided proof of vaccination by the above date(s), Council will work with those individuals and consider any redeployment options or alternative duties that may be available, including any remote working arrangements. The Chief Executive, the General Manager - People and Organisational Performance, the relevant General Manager of the staff member and the People, Safety and Wellness Manager, will oversee and approve these arrangements on a case-by-case basis.

22. Due to the nature of the work that we do, these options are likely to be very limited. If an alternative is not able to be found, we may be left with no option but to terminate employment.

23. To help us manage our vaccination requirements:

    a. Every Council Employee, Contractor and Volunteer will be asked to disclose their vaccination status, and to update that status as and when it changes (e.g., they receive a booster vaccination).

    b. Council acknowledges that someone’s vaccine status is personal and private information and employees are not obliged to disclose their vaccination status to anyone beyond their People Leader and/or a nominated representative from People, Safety and Wellness for record purposes.

    c. All vaccination information will be held in a secure, confidential system with restricted access, and in accordance with the Privacy Act 2020. If you choose not to disclose your vaccination status, we will assume you are not vaccinated for the purpose of this Policy.

    d. All employees have Council’s full support in getting vaccinated. For those not vaccinated, reasonable time off on pay will be given (up to one day) to speak to a medical professional regarding the vaccine, and/or to receive the vaccine.

    e. If an employee has any concerns regarding this Policy, or wishes to discuss their individual circumstances, they are encouraged to talk to their People Leader, a member of the People, Safety and Wellness Team, Health & Safety Representative, or an independent advisor.

Public Facilities

24. Council will require proof of vaccination (My Vaccine Pass) from the public as a condition of entry into Council facilities e.g., H3 Sites (FMG Stadium, Claudelands and Seddon Park), Hamilton Park Cemetery (crematorium, chapel and other building accesses by the public) our Aquatic Centres, the Hamilton Zoo, Waikato Museum, ArtsPost and i-site, Hamilton Gardens (pavilion, information centre/shop and enclosed gardens), our Libraries, the Municipal Building and Council Chambers, to protect the public and our people from contracting or transmitting COVID-19.

25. As a public service we have an obligation to our community to operate as effectively and efficiently as is possible under the COVID-19 Protection Framework (traffic light system).

26. By implementing the requirements to provide proof of vaccination (or exemption) to gain entry into Council venues and facilities, it logically follows that public will expect that all Employees, Contractors and Volunteers are also vaccinated. For staff working in sectors or business units described as being "higher risk" under the traffic light system (including events, hospitality, close contact services etc.), staff will be legally required to be vaccinated under the Government mandate (Vaccine Pass Mandate).

Risk Assessment

27. The purpose of our risk assessment was to determine the current risk associated with COVID-19, and to assess the effectiveness of control mechanisms, including the use of vaccination as a workplace control, to reduce risk to a level that is deemed acceptable, or as low as reasonably practicable.

28. Using WorkSafe's risk assessment approach we worked with relevant people leaders and staff who perform the work to understand the risk for each role. For completeness, we have performed a risk assessment for roles that are already subject to a Government mandate and those working in higher-risk environments subject to a Vaccine Pass mandate under the traffic light system.

29. At Council we have over 1,300 employees undertaking approximately 655 different roles. For the purpose of the risk assessment, each role was placed into the following broad categories:

A.	**PHO Roles**	Positions that fall under the COVID-19 Public Health Response (Vaccinations) Order 2021
B.	**Higher Risk Roles**	Positions working in environments or services specified as being higher risk under the COVID-19 Protection Framework (traffic light system)
C.	**Vulnerable Contact Roles**	Positions that work with children under 12, or other vulnerable members of the community
D.	**Office Based Roles**	Positions predominately based indoors with little or no interaction with general public

E.	**Public Facing Roles**	Positions that are public facing and/or involve a high level of interaction with the general public (including community-based events)
F.	**Physical Works Role**	Positions predominately based outdoors with little to no interaction with general public
G.	**Essential Service Roles**	Positions that are essential in providing key services to support the running of the city

Risk Assessment Summary

30. For all role types A to G above, the risk assessment process demonstrated that there is a significant risk reduction with the use of vaccination, alongside other controls. Without vaccination in each category, our reliance is on our existing control measures (e.g., Lockdowns) that may not be sustainable or realistic over time.

31. People in positions at the lower risk end, even those workers in outdoor settings or in office environments, still present with risk due to the contact with other staff in our workplace and the consequences associated with COVID-19. Vaccinated workers provide for a reduction in those consequences, and a further reduction in likelihood of infection, when combined with all other current controls in place.

Risk Assessment Outcomes

32. Through our assessment of all information available it became evident that the best way to protect our people and the community we serve, was that including vaccinations as a requirement of employment (existing and new), provided the best chance of reducing the risk and ensured that we are meeting our obligations as a good employer.

Record Keeping

33. Vaccination information that is collected will be kept confidential and secure and handled in accordance with all applicable privacy laws.

34. Proof of vaccination status will be required to ensure compliance with this Policy. As your vaccination status is your personal information, you are under no obligation to share it. However, if you do not disclose your vaccination status or provide proof that you are fully vaccinated (or have received your first dose), we must assume that you are not fully vaccinated (or have not received your first dose) for the purposes of this Policy.

35. It may be necessary to share your vaccination information with third parties (to satisfy site entry requirements etc). You will be provided with further details and asked for consent to share your information with any third-party before any disclosure is made.

36. Proof should be provided in the form of a government issued vaccine certificate or "My Vaccine Pass". You can download your vaccine certificate/pass through My Covid Record: https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-vaccines/my-covid-record-proof-vaccination-status

Monitoring & Surveillance

37. Rapid antigen screening is another tool to support the pandemic response but does not replace the usual mask-wearing, hand hygiene and distancing rules that need to remain in place, as well as the need for vaccination. Council will consider adopting this tool in the future if practicable and may conduct 'Rapid Antigen Testing' to promote early detection of COVID-19 cases in the workplace.

New Employees

38. All new Employees, Contractors and Volunteers must be fully vaccinated (two doses) with an Approved COVID-19 Vaccine and provide Evidence of Vaccination before they commence employment.

39. It will be made clear to all applicants that all staff at Council must be fully vaccinated. Candidates who are not fully vaccinated or do not hold a MOH exemption will not be offered employment.

40. All new offers of employment/engagement will be subject to the successful candidate providing proof that they are fully vaccinated against COVID-19, or hold a MOH exemption, *before* they begin work.

41. Where a person offered employment/engagement with Council is not able to provide proof that they are fully vaccinated (or a MOH exemption) within the required timeframe, the offer will lapse.

Ngaa Hononga - *Legislation and HCC Documents*

The following legislation and documents are related or should be read in conjunction with this Policy:

- Code of Conduct Management Policy
- Health and Safety Policy
- Employment Agreement
- Human Rights Act 1993
- Bill of Rights Act 1990
- Employment Relations Act 2000
- Privacy Act 2020
- Health and Safety at Work Act 2015
- COVID-19 Public Health Response Act 2000
- COVID-19 Response (Vaccinations) Legislation Act 2021
- COVID-19 Public Health Response (Vaccinations) Order 2021
- COVID-19 Public Health Response (Protection Framework) Order 2021

COVID-19 Vaccination Proposal

RISK ASSESSMENT

Amohia ake te ora o te iwi, ka puta ki te wheiao.

To protect the wellbeing of our people is paramount.
King Tuuheitia Pootatau Te Wherowhero VII

Hamilton City Council
Te kaunihera o Kirikiriroa

APPROACH

This risk assessment was undertaken in line with guidance issued by WorkSafe New Zealand[1] and incorporates that advice into the approach taken.

The approach includes an assessment of the level of risk associated with COVID-19 based on the role (including the work being done and the location from which the work is being done) rather than the individual performing the role to determine the effectiveness of existing controls and their impact, and the potential risk impact from the use of vaccines.

Indigenous ethnic inequities in infectious diseases are clear. Maaori experience higher rates of infectious diseases than other New Zealanders. Maaori generally have higher rates of chronic conditions and comorbidities and, following international trends, are likely to have an increased risk of infection should a community outbreak occur. The unequal distribution and exposure to the determinants of health further increases the risk for Maaori. This requires equity to be a central feature to the COVID-19 response, ensuring the active protection of the health and wellbeing of our Maaori staff.

CONTEXT OF RISK ASSESSMENT

Hamilton City Council has an obligation to provide a safe and healthy working environment for all of our workers, which extends to contractors and others that we engage as well as our employee, and those people visiting our workplaces, including our customers, visitors, and wider communities. This commitment is reinforced through our orgainsational purpose, to 'Improve the Wellbeing of Hamiltonians' and places front and center our Non-Negotiable: 'Safety first in all we do'.

Demonstrating a commitment to Te Tiriti o Waitangi and the achievement of Maaori health equity is a critical component of this Plan. Meeting these obligations requires collective effort across the organisation and the application of Te Tiriti articles and principles at every level of the response. Equity considerations should continue to be integrated across the response.

We have a duty of care under the Health and Safety at Work Act 2015[2] to take all reasonably practicable steps to eliminate, or otherwise minimise, any risks to our people. Hamilton City Council continually assesses these risks, which also includes the risk presented by having COVID-19 in the workplace as well as the community.

New Zealand has moved away from an elimination strategy, towards one of minimisation and protection. This will result in a degree of ongoing community transmission as restrictions start to ease as we move away from lockdowns under the alert level system and into the new framework. It is

reasonable to expect that with loosening of restrictions, and a strategy of "minimise and protect", people will be at a higher risk of contracting (and therefore or transmitting) COVID-19 in the coming weeks/months, with the likelihood of infection, transmission and the health impact and outcomes of any infection being mitigated somewhat through the use of vaccinations[3] and other risk mitigations that make up the COVID-19 Protection Framework.

Vaccination rollout using Pfizer vaccine is currently underway across New Zealand with the Government working towards a vaccination target rate of 90% of the eligible population within each local District Health Board to be fully vaccinated (having received first and second doses). The Government has announced that we will move to the new Covid-19 Protection Framework on 3 December 2021.

The purpose of this risk assessment undertaken by Council is to determine the current risk associated with COVID-19, and to assess the effectiveness of control mechanisms, including the potential use of vaccination as a workplace control, on reducing risk to a level that is deemed acceptable, or as low as reasonably practicable.

ASSESSMENT OF PROBABILITY

The Delta variant of COVID-19 is described by the New Zealand Ministry of Health as being a more infectious mutation of the virus. It is predicted that without any controls, the R0-value would be between 5 and 6 – meaning that one infected person may infect up to 5 to 6 others. It has been described as "highly transmissible".

The probability of infection taking hold when directly exposed to COVID-19 viral particles can vary from person to person, but there is enough anecdotal evidence to show that in the absence of other controls e.g., mask wearing, social distancing, and hygiene practices, there is a high probability of becoming infected when directly exposed to COVID-19. This is seen in the number of household infections that occur when those household members share a space with a COVID-19 positive person. There is also increasing evidence of infection occurring due to incidental exposure outside the home, as seen in MIQ facilities between rooms when doors have been opened.

The infectiousness has also been identified in the challenges associated with connecting some cases epidemiologically due to the transient nature of some of the exposure events. An example of this is the way in which the initial infection in this outbreak occurred, with no known direct exposure link, and the possibility of unidentified chains of infection.

On this basis, it is reasonably foreseeable that if a person is exposed to COVID-19 without any controls in place there is a **high probability** of infection as a result.

ASSESSMENT OF CONSEQUENCE

The range of consequences for a person infected with COVID-19 is extremely broad and will depend on a myriad of factors. While some people may be completely asymptomatic for the duration of the infection, others may lose their life to the infection or its associate complications.

As at November 2021 here have been over 5.15 million deaths associated with COVID-19 globally, with 40 in New Zealand.

While some individuals may recover from all COVID-19 symptoms within a few days (or not experience any at all), others will continue to struggle with lingering, and sometimes debilitating, effects for significant time after the infection has cleared.

As well as potentially serious consequences in respect of mortality and health (both long term and short term), which must be a primary consideration, there are also consequences of infection related to business continuity and the provision of important services to the community. Widespread infection of staff, or infection of people holding key or highly skilled roles could have a serious impact in this regard.

ASSESSMENT OF EXPOSURE

The degree to which a person is exposed to COVID-19 is the determining factor as to whether a person might become infected, and therefore be prone to the consequences associated with the virus. When examining WorkSafe New Zealand guidance on risk assessments[4], the risk factors described by the regulator relate specifically to whether a person will be exposed, and if exposed, how quickly might the contact tracing identify that they have been exposed.

For the purposes of this assessment, exposure will be rated as either 'lower risk' or 'higher risk' and/or determined by the Central Government Health Order mandating specific areas and roles that will be required to be vaccinated[5]. There is also a further undertaking to determine those Council Facilities that will require a vaccination passport to enter the premises under the new framework and therefore both the public and employees will be required to be vaccinated under the legislation expected to be introduced shortly.

New Zealand is currently moving from an elimination strategy, to one of minimisation and protection, which attempts to slow the spread of COVID-19 rather than removing community transmission completely. There is an understanding within a suppression strategy that COVID-19 will still circulate within the community to varying degrees (depending on a number of factors, including vaccination rates and other controls in place). With community transmission remaining for the foreseeable future, we will soon be faced with

a higher degree of exposure while carrying out our work than we previously have been.

When considering exposure, it is important to consider the degree to which our workers may be exposed to COVID-19, and the degree to which our workers could expose others to the virus. As our duties under the Health and Safety at Work Act 2015[6] extend to others in our workplaces, or those who are impacted by our operations, it is appropriate to consider the level of risk to those communities as well as to our workers.

The WorkSafe guidance refers to a number of example questions relating to exposure, where the risk is seen to be framed around:

- The number of people the employee comes into contact with when carrying out the work .
- The degree to which employees carrying out the tasks are in proximity to other people, and for how long.
- Whether there is a higher risk of infection and transmission within the work environment, compared to the non-work environment.
- The level of interaction with people who are not known to the employee.

Hamilton City Council has a significant number of roles and activities, with **1341** staff undertaking **655** role types, however the majority of roles can be placed into one or more of the following broad categories. We have undertaken to assess each role individually, working with our team leaders to examine each role specifically against the WorkSafe guidelines. It is also reasonably practicable to assess the risk of these categories to determine exposure as a proxy for a role-by-role based assessment and subsequently, the level of risk posed to those workers. The following points outline these broad categories:

- Roles subject to **Covid-19 Public Health Response (Vaccinations) Order 2021**
- Roles in environments specified as "higher risk" under the protection framework
- Roles that work with children under 12, or other vulnerable members of the community
- **Office Based Roles** - predominately indoor based with little to no public interaction
- **Public Facing Roles** – public facing roles and/or roles with a high level of public interaction (including community-based events)
- **Physical Works Role** - predominately outdoor based with little to no public interaction
- **Essential Service Roles** – positions that are essential in providing and maintaining critical services and functions to support the running of the city

The Ministry of Health has since announced the **Covid-19 Public Health Response (Vaccinations) Amendment Order (No 3) Schedule 2**[7] which requires:

- Education and health and disability staff to have receive one dose of the Covid-19 vaccine by 15 November 2021 and be fully vaccinated by 1 January 2022, and
- Corrections workers to be fully vaccinated by 8 December 2021.

This amendment came into effect on 25 October 2021 and applies to the health and disability sector, education services and prisons. There are 25 role types filled by 65 employees within Council, which are associated to the Health Order affecting education workers, and a separate process is already being undertaken to work with those employees who must be vaccinated per the Government mandate in order to carry out their duties.

In October, the Government announced the COVID-19 Protection Framework (the traffic light system) and the new legislation to be introduced alongside it. Under the new framework, businesses or operators offering services in various environments regarded as being higher risk (events, hospitality close personal services, funerals, weddings etc.) can restrict services/entry to only vaccinated patrons. Businesses/services which require vaccination will be able to operate with greater freedoms under the various traffic light settings than those who don't. The Government also announced that businesses requiring vaccination certificates from public would also, under the legislation to be introduced, need to operate with a fully vaccinated staff.

We are working with our community leaders to understand the approach to be taken with our business units and worksites falling into the higher risk categories under the new Framework. Decisions made in respect of public access could have a direct impact on vaccination requirements for the staff working in those environments. A separate process may need to be undertaken with those employees who must be vaccinated under the new legislation to be introduced as we move into the COVID-19 Protection Framework, to the extent that it is relevant to the specific workplaces.

STAFF WORKING WITH CHILDREN UNDER 12, OR OTHER VULNERABLE MEMBERS OF THE COMMUNITY

For staff working with children under 12, or other vulnerable members of the community, there is potential for harmful exposure in both directions, and the consequences may be more direct for these persons. Staff working with children will be working in close proximity to a part of the population in which there is no current option for vaccination – meaning that there is a higher degree of exposure to people infected with COVID-19. There is also a risk of exposure for those children, and to others who may be vulnerable, where a staff member may have a COVID-19 infection.

Number of people the workers will come into contact with: Moderate to High.

Proximity to other people: Moderate to High. Distancing can be challenging due to nature of the work.

Risk of transmission compared to non-work environment: Higher risk where restrictions are being eased regionally.

Level of interaction with people who are not known: Moderate to High .

The level of exposure for these workers is **HIGHER**. In addition, the risk tolerance is very low because of the impacts of transmitting COVID-19 to children under 12, or other vulnerable members of the community.

OFFICE-BASED STAFF

Office-based staff who do not have public-facing roles work for long periods in indoor environments where there is limited interaction with the public, however there is regular and prolonged interaction expected within the office between a potentially large number of other co-workers and teams, including individuals or teams who are undertaking work outside of the office and need to undertake certain tasks within the office. There is a potential for any of these workers to be infected outside the workplace, and arrive at work prior to a test and diagnosis, and then transmit the virus to others.

Number of people the workers will come into contact with: Low to Moderate.

Proximity to other people: Low to Moderate. Distancing is mostly achievable within the office environment. Difficult to achieve in shared spaces such as entry points, stairways, elevators and communal areas.

Risk of transmission compared to non-work environment: Low. Similar risk where restrictions are being eased regionally.

Level of interaction with people who are not known: Low.

For these workers, there is a **LOWER** level of exposure.

PUBLIC-FACING STAFF

Public-facing staff undertake a range of tasks in environments that may be either indoor or outdoor, some within the control of Hamilton City Council, and some that are not. There are a number of activities which may require our workers to interact in close proximity with others from across every community within Hamilton. Wherever there is interaction with the public, there is opportunity for COVID-19 to spread to our staff, or from our staff into the community. There have already been a number of exposure events within a number of public facing roles and activities already at alert Levels 4 and 3 of the current outbreak.

Number of people the workers will come into contact with: Moderate to High.

Proximity to other people: Moderate to High. Distancing is sometimes achievable within the workplace. Difficult to achieve in shared spaces in the work environment and in some public facing roles.

Risk of transmission compared to non-work environment: Higher risk where restrictions are being eased regionally.

Level of interaction with people who are not known: Moderate to High.

For these workers, the level of exposure is **HIGHER**.

STAFF WORKING OUTDOORS

Staff working outdoors undertake work where the environment is generally not conducive to the spread of COVID-19 due to the impact of wind and sunlight. Workers performing these duties may be required to interact with team members, as well as some interactions with members of public and contractors. These workers will also spend time indoors with others from time-to-time, for example in break rooms, offices and vehicles.

Number of people the workers will come into contact with: Low.

Proximity to other people: Low to Moderate. Distancing is mostly achievable within the workplace. Difficult to achieve in shared spaces although limited time in these spaces.

Risk of transmission compared to non-work environment: Low. Similar risk where restrictions are being eased regionally.

Level of interaction with people who are not known: Low to Moderate.

The exposure level for these workers is deemed to be **LOWER**.

ESSENTIAL WORKERS

Essential workers undertake a range of important tasks required to operate essential services across the city, such as water, wastewater, and roading. The tasks are performed in both indoor and outdoor environments. Workers performing these duties may be required to interact with team members, as well as some interactions with members of public and contractors. Essential workers are critical to the safety of the community and any risk of contracting COVID-19 within these work groups could have an extremely detrimental impact on our ability to provide core services. The risk rating takes into consideration the significance of the potential consequences for the community if essential workers were to be infected with COVID-19.

Number of people the workers will come into contact with: Low.

Proximity to other people: Low to Moderate. Distancing is mostly achievable within the workplace. Difficult to achieve in shared spaces although limited time in these spaces.

Risk of transmission compared to non-work environment: Low. Similar risk where restrictions are being eased regionally.

Level of interaction with people who are not known: Low to Moderate.

The exposure level for these workers is deemed to be **LOW** however the impact on the Community should these workers become infected is much HIGHER.

RISK ASSESSMENT TOOL

The WorkSafe Risk Assessment tool has been adapted and designed to assess current roles within Hamilton City Council. The tool is based on a questionnaire and consists of seven questions, which are individually rated as either 'lower risk' or 'higher risk', depending on the level of exposure.

Using the risk assessment tool 1276 positions were assessed across HCC, using a desk top approach, and involved people leaders and those who performed the roles. 145 positions rated all 7 questions as having 'higher risk' at one end of the scale, with 169 positions rating at least 1 question as having 'higher risk'. There were 0 positions that assessed all 7 questions as having a 'lower risk' and therefore all roles that were assessed had a level of 'higher risk' exposure in at least one aspect within the role.

Sum of Staff Employed in Role	Total Higher Risk							
Business Portfolio	1	2	3	4	5	6	7	Grand Total
Community	54	49	70	73	18	125	144	533
Infrastructure Operations	47	11	29	52	20	42	1	202
People and Organisational Performance	49	46	72	10	9			186
Growth				101	24			125
Venue, Tourism & Major Events			23		68	27		118
Development	19	10	17	15	6			67
Strategy and communication		27	3	12	3			45
Grand Total	**169**	**143**	**214**	**263**	**148**	**194**	**145**	**1276**

HCC initial risk of exposure to COVID -19 for roles across the business

The reason for this risk assessment is to identify where there is risk of exposure for staff at Hamilton City Council and if a vaccination is required to ensure their safety. Please complete all three steps outlined below before returning to hands@hcc.govt.nz

Step one:	
Business Unit:	
Unit Manager:	
Safety and Wellbeing Business Partner:	
Person completing the risk assessment:	
Role assessed e.g., zoo keeper:	
Number of staff employed in this role e.g., 20:	

Step two:

Please identify which of the five categories listed below the role being assessed falls into. If there are two or more it aligns with, pick the category it most aligns with:

1. **Office Based Roles** - staff who are predominately based in the office with no or very little interaction with others outside the office environment
2. **Physical Works Roles** - staff engaged in physical work that requires use of equipment, work indoors and/or outdoors
3. **Office Based Roles & Physical Works** – staff who may work in an office environment and be required to work or attend work indoors/outdoors as part of their role
4. **Public Facing Roles** – staff who are involved with public or client facing roles e.g.: library, museum, zoo, pools
5. **Essential Workers** – staff who are who are essential to maintain critical services and functions within Council

	Select from the drop down box:
Please identify the category this role most aligns with:	

Step three:

Description	**Risk Rating**	**Please select risk rating from d**
How many people does the employee carrying out that work come into contact with?	**Lower risk** = Very few **Higher risk** = Many	
How easy will it be to identify the people who the employee comes into contact with?	**Lower risk** = Easy to identify, such as co-workers **Higher risk** = difficult to identify, such as unknown members of public	
How close is the employee carrying out the tasks in proximity to other people?	**Lower risk** = 2 metres or more in an outdoor space **Higher risk** = Close physical contact in	
How long does the work require the employee to be in that proximity to other people?	**Lower risk** = brief contact **Higher risk** = lengthy contact	
Does the work involve regular interaction with people considered at higher risk of severe illness from COVID-19, such as people with underlying	**Lower risk** = little to none **Higher risk** = whole time	
What is the risk of COVID-19 infection and transmission in the work environment when compared to the risk outside work?	**Lower risk** = equal to outside work **Higher risk** = higher than outside work	
Will the work continue to involve regular interaction with unknown people if the region is at	**Lower risk** = no **Higher risk** = yes	
	Total Lower risk:	**0**
	Total Higher risk:	**0**

Thank you for helping us gather information to help provide Hamilton City Council with information on the roles within the business that present a higher level of risk to being exposed to COVID -19. The information will now be collated between all business units to help inform senior leadership of the potential risk in the business. Consultation with the business units will then commence to ensure all interested parties have an opportunity to be involved in possible next steps.
Please return this completed risk assessment hands@hcc.govt.nz

RISK TOLERANCE

Hamilton City Council have in principle determined that a role presenting with any level of 'higher risk' exposure should be assessed in more detail with all possible mechanisms for reducing that risk being explored further, including implementing a requirement that staff performing those roles be vaccinated against COVID-19.

There is a higher risk tolerance in some roles then others. This is largely dependent on the consequences that could arise if a staff member were to be infected, or if a member of the public was to be infected as a result of their interaction with a staff member. For example, there are some highly skilled essential roles which very few people are able to perform. There could be a significant impact on service to the community if a person holding one of these roles were to become infected. There are some roles that interact with particularly vulnerable people in the community who would either be more likely to contract the virus if exposed, and/or more likely to be seriously affected by an infection.

Based on this risk assessment HCC is proposing that ALL positions required to perform their substantive duties at work should be fully vaccinated in order to mitigate the risk of contracting or transmitting COVID-19 in the workplace as far as is reasonably practicable.

It is also important to note that other risk mitigants would also need to be present and that vaccination is not the only risk control present or required to reduce the risk to an acceptable level, based on HCC's risk tolerance.

IMPACT OF EXISTING CONTROLS

There are a broad range of controls already in place to prevent infection, and these are associated with particular levels within the established hierarchy of control from the lowest level of effectiveness through to the highest:

PPE CONTROL: THE USE OF FACE COVERINGS

Effectiveness: partially effective

These work by reducing the spread of viral particles from person-to-person by capturing droplets that would normally be expelled through breathing, talking, coughing or sneezing. There are varying degrees of effectiveness, depending on the material being used, the fit, and whether these are worn correctly. N95 or surgical masks may be better than reusable cloth masks, but must be replaced more often and can become ineffective when they become moist (either from the environment or from the humidity of exhaled breath). While masks reduce the probability that viral particles will be passed from person-to-person, there has still been infection between persons who are masked and so are not to be considered infallible as a control measure.

ADMINISTRATIVE CONTROL: PHYSICAL DISTANCING.

Effectiveness: partially effective

Physical distancing of at least one metre within the workplace, and two metres between people in public works by reducing the opportunity for viral particles to pass from one person through the air to another, as the particles are expelled only so far into the airspace around the infected person and is effective for transmission by droplets. However, aerosol transmission of Delta has reduced the effectiveness of this control. It is heavily reliant on people "following the rules" and has been shown to be a challenging control to manage due to a number of factors (including incidental breaches and the lack of visual cues to remind people of what 2 metres looks like in different environments).

ADMINISTRATIVE CONTROL: HYGIENE

Effectiveness: partially effective

Practicing good personal hygiene and the regular use of handwashing and/or hand sanitiser helps to remove viral particles which people may have come into contact with through touching surfaces that have been contaminated with particles, which is particularly important when touching the face, eating, or adjusting masks. Regular cleaning of surfaces, particularly high-touch surfaces such as lift buttons, door handles etc. works in the same way, by removing any particles from the surfaces before they are touched. The effectiveness of these types of controls is highly dependent on a number of factors, including the type of soap or sanitiser being used, the method and duration of handwashing, and whether individuals remember to clean their hands prior to touching the face etc.

Rules have also been put in place in relation to staying home if sick, which works by reducing the potential for COVID particles to be deposited in the workplace by infected people and picked up by others. This relies on people following this requirement – however when applied correctly can reduce the potential exposure to COVID-19. This is not infallible even when applied correctly, as it is possible to be infected with COVID-19 but not show symptoms (this is known as being A-symptomatic).

This particular control relies heavily on behaviours which may be impacted subconsciously, so is not an effective control in isolation and requires a number of other controls to be in place to create defence in depth. The aerosol nature of virus transmission also limits the effectiveness of this control.

ENGINEERING CONTROL: WORKPLACE DESIGN

Effectiveness: partially effective

Design factors such as ventilation systems and air circulation can reduce the level of exposure if designed correctly with COVID-19 transmission in mind. Many buildings occupied or entered by Hamilton City Council staff will not have been designed in a way that provides adequate protection, however some buildings may have a level of air changes and ventilation which exceeds American Society of Heating, Refrigeration and Air-Conditioning Engineers (ASHRAE) standards. It is not financially feasible to upgrade ventilation systems in all of our facilities, nor do we have the time to undertake such substantial building works. This is reliant on other controls, such as physical distancing and hygiene being in place and only reduces exposure so far.

ISOLATION CONTROL: WORKING FROM HOME

Effectiveness: effective

This control is currently being used extensively to reduce the level of exposure to COVID-19. It works by removing people from situations and environments whereby they may be infected. It is effective for work-related exposure for those who are able to work from home during periods of lockdown, however it should be noted that there are potential exposure events that may occur inside the home. Exposure to COVID-19 at home while performing work is difficult to influence and control by Hamilton City Council so has not considered as part of this assessment.

Working from home is an effective control (it is used as part of lockdown measures to reduce exposure), however it may give rise to other potential wellbeing, cultural and productivity challenges associated with being isolated from work colleagues for extended periods or on a permanent basis. It is also not possible for all roles to perform their work from home, or for that to be sustainable long-term. While in a heightened alert level, many services have been halted which requires workers who are not undertaking essential services to be sheltering at home. Once alert level restrictions are e ased, most employees will be required to work onsite at some point or to some extent to effectively undertake their duties, connect with colleagues and therefore the control itself may be wholly unsuitable and unable to be applied for certain roles.

Each of these controls work by reducing the likelihood of infection, either by impacting the probability of infection, or by decreasing the level of exposure. Due to the way these controls work, they do not reduce the potential consequences of COVID-19 once infection has taken place.

While not a control, we note also the important role the testing plays in the fight against COVID-19. While testing is a vital tool in identifying infection, which can generate a reduction in exposure risk created by that infected

person through their immediate isolation following a positive result, it does not reduce the likelihood of becoming infected or the consequences of the infection. An infected person may also have created a risk of exposure during an infectious period prior to being tested, or receiving the result.

While our staff survey indicated that the majority of our people are or intend to be fully vaccinated (with this already being a requirement for some through the Public Health Order mandate) we have not considered this a "current control" as this has not been fully defined or implemented as a required control across our entire workplace setting at this point. This assessment considers the application of vaccinations as a "proposed" control only.

IMPACT OF VACCINATION

According to the Ministry of Health[8], being fully vaccinated (currently described as two doses of the Pfizer vaccine) provides protection in three ways. The first is by minimising the likelihood of infection, and the second is that it reduces the seriousness of illness if infected. The third way it provides protection is that it helps to reduce the likelihood of transmission.

The effectiveness of two doses of the Pfizer vaccine provides 64% to 95% protection against symptomatic illness.

Two doses of the vaccine provides 90-96% protection against hospitalisation or severe illness due to Delta infection.

To understand the long-term efficacy and safety of the vaccine, participants in the clinical trials are being tracked for another two years after their second dose of the Pfizer vaccine.

There is still potential for infection to occur regardless of vaccination, however it is much less likely for serious illness or hospitalisation to be required and very unlikely for an infected person to pass away as a result of their infection.

REFERENCES

1. worksafe.govt.nz/managing-health-and-safety/novel-coronavirus-covid/how-to-decide-what-work-requires-a-vaccinated-employee
2. worksafe.govt.nz/laws-and-regulations/acts/hswa
3. covid19.govt.nz/alert-levels-and-updates/covid-19-protection
4. worksafe.govt.nz/managing-health-and-safety/novel-coronavirus-covid/how-to-decide-what-work-requires-a-vaccinated-employee
5. covid19.govt.nz/alert-levels-and-updates/latest-updates/expanded-vaccination-order-for-health-and-disability-education-and-prison-workers
6. worksafe.govt.nz/laws-and-regulations/acts/hswa
7. legislation.govt.nz/regulation/public/2021/0325/latest/LMS579374.html
8. health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19- vaccines

SUMMARY

This risk assessment has determined that there is a significant impact on risk reduction for potential consequences associated with the use of vaccination alongside other controls. Without vaccination we are reliant on existing control measures that may not be sustainable or realistic over time, as seen by extended lock-downs and other alert level restrictions. Workers occupying roles at the lower end of the risk scale, even those workers in outdoor settings or in office environments with limited contact, still present with a level of risk due to the contact that they have with others and the shared facilities that they access. Due to the potentially serious consequences associated with COVID-19, HCC's view is that any level of risk, even low risk, needs to be addressed and reduced. A fully vaccinated workforce would provide for a reduction in the seriousness of consequences if infected, would reduce likelihood of infection and would reduce likelihood of transmission if infected. Vaccination would offer the best mitigation of the risks presented by COVID-19 when combined with all other current controls in place.

A LOWER level of risk is achievable using existing controls, including using isolation to restrict workers to their home to undertake work. In this way, it would be unlikely for that person to be infected during the course of their work – however this may not be a sustainable method of working in the long-term, and there are a large number of roles across Hamilton City Council where this is not impossible. We do however need to be mindful that working remotely is supported by our flexible working policy and often sought by job seekers in a tight labour market. For certain roles, working from home could provide a suitable alternative not requiring vaccination.

Hamilton City Council
Garden Place, Private Bag 3010, Hamilton

HamiltonCityCouncil
@hamilton_city_nz
07 838 6699

hamilton.govt.nz