

Christchurch City Council COVID-19 Risk Assessment

January 2022

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Purpose of this Report

1. This report provides a summary of the COVID-19 risk/benefit assessment undertaken by Christchurch City Council.
2. The purpose of the Risk Assessment process was:
 - 2.1. To determine the risks associated with COVID-19 for Council workers, elected members and members of the public accessing Council's workplaces; and
 - 2.2. To assess the effectiveness of control mechanisms, including vaccination requirements, on reducing risks to a level that is deemed acceptable, or as low as reasonably practicable.

Executive Summary

3. As a Council, the health and safety of our residents, workers, and elected members is our top priority. While we want our services and facilities to be accessible to as many people as possible, we must ensure we can do this safely.
4. COVID-19 is a disease caused by the coronavirus SARS-CoV-2 which affects the lungs, airways and other organs. The virus has undergone genetic mutations over time and some of these mutations can spread more easily than the original virus.
5. COVID-19 affects different people in different ways. Most infected people develop mild to moderate illness and recover without hospitalisation. However, some infected people suffer a serious illness that: requires hospitalisation to get well; results in "long – COVID" illness for an elongated and unknown period of time; or results in death.
6. As of 29 December 2021, the World Health Organization reported over 281,808,270 cases and over 5,411,759 deaths globally.
7. An infected person has a very high chance of infecting others with COVID-19. Public health and social measures (controls) have proven critical to limiting transmission of COVID-19 and reducing mortality and morbidity. Public health and social measures and vaccinations act in concert, and a combination of measures is required to ensure adequate control.¹
8. Based on the risk assessment, the Council has determined that to minimise the risk of harm from COVID-19, anyone eligible to be vaccinated entering a Christchurch City Council workplace will require the My Vaccine Pass. This requirement includes all workers, elected members, contractors and other third parties.
9. We did not make the decision to implement the vaccine pass requirement lightly. We know that for a small number of workers and others, this decision will pose a hard choice. However,

¹ World Health Organization. (2021). Considerations for implementing and adjusting public health and social measures in the context of COVID-19. WHO reference number: WHO/2019-nCoV/Adjusting_PH_measures/2021.1

controlling and reducing the spread of COVID-19 is so important to our city, region and country that, based on our health and safety assessment, we concluded that adopting this approach is the responsible decision to make.

10. With the loosening of restrictions and the introduction of the new B.1.1.529 variant (Omicron) and potentially other variants, there will be a degree of ongoing transmission and it is more likely that COVID-19 will become endemic.
11. Vaccination is the primary way we can protect ourselves and the community from the spread of COVID-19. Vaccination is the only control currently known to reduce both likelihood of infection and the consequences of infections (**See Vaccination as a Key Control, page 33**).
12. Christchurch City Council has an obligation to provide a safe and healthy working environment under the Health and Safety at Work Act 2015. This obligation extends to our workers, elected members, contractors, and other people visiting our workplaces, including our customers, visitors, and the wider community (**See Obligations under the Health & Safety at Work Act, page 14**).
13. We undertook a comprehensive systematic health and safety risk assessment to determine whether, and to what level, vaccination is required in the workplace (**See Council's Risk Assessment, page 15**).
14. Our risk assessment process drew on the guidance provided by WorkSafe, the COVID-19 Local Government Response Unit, the Public Service Guidance provided by Te Kawa Mataaho Public Service Commission, and other information provided by government departments. We also drew on the available research and literature on COVID-19.
15. We sought expert advice from:
 - 15.1. Dr Alistair Humphrey, Public Health Physician
 - 15.2. Professor Michael Plank, Professor in the School of Mathematics and Statistics at the University of Canterbury who undertakes modelling to support New Zealand's all-of-government response to COVID-19.
16. The risk assessment identified that the nature of our roles is such that all roles, which carry out work in our offices, facilities, or other workplaces, involve an unacceptable level of risk of contracting COVID-19 and transmitting the virus to others, in the absence of a vaccination requirement (**See Findings for our Risk Assessment, page 19**).
17. Our services and workplaces are borderless and flexible, meaning Council operations require significant numbers of workers, elected members, customers, contractors, other third parties and members of the public to have frequent interactions within, across and beyond our facilities and work settings. This means, as a result of Council's operations, there is increased risk of infection and transmission.
18. The Council's risk assessment identified that there is a significant risk reduction associated with the use of vaccination alongside other controls. Without vaccine pass requirements we would be reliant on existing control measures that may not be sustainable or realistic over time (**See Controls, page 28**).

19. A fully vaccinated environment would:
 - 19.1. Reduce the likelihood of infection;
 - 19.2. Reduce the likelihood of transmission if infected;
 - 19.3. Provide for a reduction in the seriousness of consequences if infected; and
 - 19.4. Offer the best mitigation of the risks presented by COVID-19 when combined with all other current controls in place.

20. Expert public health advice received in December 2021 confirmed there is a risk of transmission across all Council roles and that vaccination provides the best protection against COVID-19:

“It is also important to acknowledge that office-based staff and public-facing staff are not mutually exclusive, either in the way they work or in their personal roles. Transmission across a council is a riskVaccination remains the mainstay of our public health measures to control COVID. Hand hygiene, masks and social distancing are additional and important measures. All these measures are important, and we are not yet at the stage where we can afford to forego one in place of another.”

Dr Alistair Humphrey, Public Health Physician (2021)

21. Advice received from an expert modeller highlights that vaccination against COVID-19 protects individuals and the health system from the impact of severe disease. It is effective at reducing transmission and infection, illness, and mortality:

“With 1500 people working in an open plan office, if 5% of the workforce are unvaccinated there would be a significantly higher risk of mortality, sickness, and workplace absences due to COVID-19 than if everyone was fully vaccinated. This is because the vaccine, although not perfect, greatly reduces the risk of catching the virus and spreading it to others. An unvaccinated person poses around 8 times the risk to people around them than a fully vaccinated person does. Because the virus is airborne, open plan spaces mean that everyone in the office is put at elevated risk if there are unvaccinated people working there.”

Professor Michael Plank Te Kura Pāngarau University of Canterbury (2021)

22. The COVID-19 pandemic remains a rapidly evolving situation worldwide, the level of uncertainty remains high:
 - 22.1. We do not know if the coronavirus will become endemic (meaning that it will continue to circulate in pockets of the global population for years to come) and, if so, what the impact will be on morbidity and mortality. One scenario is that SARS-CoV-2 infection will inevitably become endemic, and will be relatively benign once population immunity is widespread, as was eventually seen following the 1918 H1N1 influenza pandemic. However, key experts have argued that there is evidence that this may be overly optimistic.²
 - 22.2. Long-COVID is still poorly understood. The post-acute effects of SARS-CoV-2 infection (so called “long-COVID”) appear to be far more common and severe than for influenza. For example, there is the possibility of life-course impacts in the child

²Baker, M et al. (2021). The next phase in Aotearoa New Zealand’s COVID-19 response: a tight suppression strategy may be the best option. NZMJ 26 November 2021, Vol 134 No 1546. <https://journal.nzma.org.nz/journal-articles/the-next-phase-in-aotearoa-new-zealands-covid-19-response-tight-suppression-may-be-optimal-for-health-equity-and-wellbeing-in-the-months-ahead>

population through effects on the developing brain. Despite multiple reports of neurological deficits in patients with COVID-19 from across the world, the precise incidence of these manifestations has remained unknown.³

- 22.3. One of the biggest unknowns is the future evolution of “variants of concern” which may be more infectious, more lethal and/or vaccine resistant.
- 22.4. We do not know the impact of the emergence of the Omicron variant and if it poses a greater threat to the health and wellbeing of our workers and the people we serve.⁴
23. Because of the level of uncertainty, our risk assessment has taken a precautionary approach. The precautionary principle stresses the need to take a cautious approach in situations of high uncertainty where decisions have significant impacts.
24. Vaccination is the best way to slow the spread of COVID-19 and to prevent infection by Delta, Omicron or other known variants. COVID-19 vaccines are effective at reducing the risks of infection, serious illness, and death. Not introducing vaccination entry requirements could lead to increased morbidity and mortality.
25. Vaccination has a high level of acceptability in the local population. In Christchurch, 93% of the eligible population is fully vaccinated and 97% of the eligible population has had at least one dose. For the small number of people unvaccinated, we will continue to look for opportunities to provide alternative means of access to the services. We will work with any unvaccinated worker to explore alternative options.

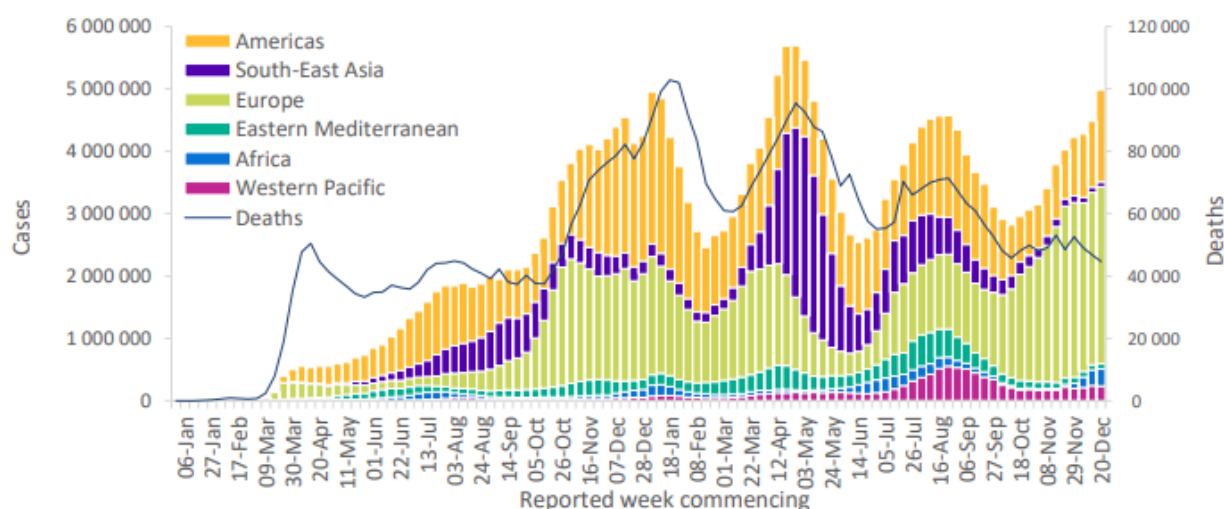
³ Baig, A. M. (2021). Counting the neurological cost of COVID-19. *Nat Rev Neurol*. 2021. doi: 10.1038/ s41582-021-00593-7. <https://www.nature.com/articles/s41582-021-00593-7>

⁴ Kins, S. (2021). We Know Enough about Omicron to Know That We’re in Trouble” *The Atlantic*. 12 December 2021. <https://www.theatlantic.com/science/archive/2021/12/covid-cases-omicron-highly-contagious/621038/>

The Global Pandemic

26. On 31 December 2019, the Wuhan Municipal Health Commission in Wuhan City, Hubei province, China reported a cluster of pneumonia cases of unknown aetiology, with a common reported link to Wuhan's Huanan Seafood Wholesale Market (a wholesale fish and live animal market selling different animal species)⁵. On 9 January 2020, the Chinese Center for Disease Control and Prevention (CDC) reported that a novel coronavirus (2019-nCoV) was detected as the causative agent and the genome sequence was made publicly available.⁶
27. On 30 January 2020, the Director General of the World Health Organization declared that the novel coronavirus outbreak constituted a Public Health Emergency of International Concern.⁷ This was followed by the confirmation on 11 March 2020 of the COVID-19 outbreak as a global pandemic.⁸ On 11 February 2020, the WHO confirmed that the disease caused by this novel coronavirus was to be called COVID-19 and the International Committee on Taxonomy of Viruses designated the official name for the causative virus to be SARS-CoV-2.⁹
28. Since its outbreak, COVID-19 has spread rapidly, with a sharp rise in the accumulative number of infections worldwide.

Figure 1: COVID-19 cases reported weekly by WHO Region, and global deaths, as of 28 December 2021



Source: World Health Organization. (2021). COVID-19 Weekly Epidemiological Update. Edition 72, published 28 December 2021.¹⁰

⁵ Wuhan City Health Committee. (2019). Wuhan Municipal Health and Health Commission's briefing on the current pneumonia epidemic situation in our city 2019 [updated 14 January 2020] <http://wjw.wuhan.gov.cn/front/web/showDetail/2019123108989>

⁶ Wuhan City Health Committee. (2020). Wuhan Municipal Health Committee's report on unexplained viral pneumonia 2020 [14 January 2020]. <http://wjw.wuhan.gov.cn/front/web/showDetail/2020010509020>

⁷ World Health Organization. (2020). Statement on the second meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel coronavirus (2019-nCoV) [30 January 2020]. [https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-healthregulations-\(2005\)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-\(2019-ncov\)](https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-healthregulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov))

⁸ World Health Organization. (2020). WHO announces COVID19 outbreak a pandemic. <http://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/news/news/2020/3/who-announces-covid-19-outbreak-a-pandemic>

⁹ [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it)

¹⁰ World Health Organization. (2021). COVID-19 Weekly Epidemiological Update. Edition 72, published 28 December 2021. file:///ccity.biz/Users/HD04/RichardsonM/Downloads/20211228_Weekly_Epi_Update_72.pdf

29. As of 29 December 2021, the World Health Organization reported over 281,808,270 cases and over 5,411,759 deaths globally.¹¹
30. Health care systems and societies worldwide have been challenged by emerging variants of the virus. Five variants have been defined as variants of interest (VOI) as they have been associated with one or more of the following changes at a degree of global public health significance:
 - 30.1. Increase in transmissibility or detrimental change in COVID-19 epidemiology; or
 - 30.2. Increase in virulence or change in clinical disease presentation; or
 - 30.3. Decrease in effectiveness of public health and social measures or available diagnostics, vaccines, therapeutics.¹²
31. The current global epidemiology is currently characterised by a predominance of the Delta variant; a declining trend in the proportion of Alpha, Beta and Gamma variants, which have been circulating at a very low prevalence for several weeks; and the emergence of the Omicron variant.

Omicron Variant

32. The Omicron variant was first detected in Botswana on 11 November 2021, and South Africa on 14 November 2021. On 26 November 2021, the variant was designated a variant of concern (VOC) and assigned the label Omicron by the World Health Organization.^{13,14} On 30 November 2021, the U.S. SARS-CoV-2 Interagency Group (SIG), which includes the Centers for Disease Control and Prevention (CDC), the National Institutes of Health, the Food and Drug Administration, the Biomedical Advanced Research and Development Authority, and the Departments of Defense, Agriculture, and Health and Human Services, classified the Omicron variant as a Variant of Concern.¹⁵
33. By 1 December 2021, the Omicron variant had been detected in at least 20 countries in addition to those in Southern Africa, including the United States, Israel, Hong Kong, Nigeria, Saudi Arabia, South Korea, Australia, Canada, the United Kingdom, and several European countries. As of 22 December 2021, the Omicron variant had been identified in 110 countries across all six World Health Organization Regions.¹⁶

¹¹ World Health Organization. (2021). COVID-19 Weekly Epidemiological Update <https://www.who.int/publications/m/item/weekly-epidemiological-update-on-covid-19---21-december-2021>

¹² World Health Organization. (2021). Tracking SARS-CoV-2 variants [last updated on 31 December 2021] <https://www.who.int/en/activities/tracking-SARS-CoV-2-variants/>

¹³ European Centre for Disease Prevention and Control. (2021). Implications of the emergence and spread of the SARS-CoV-2 B.1.1.529 variant of concern (Omicron), for the EU/EEA. 26 November 2021. ECDC: Stockholm; 2021. <https://www.ecdc.europa.eu/en/publications-data/threat-assessment-brief-emergence-sars-cov-2-variant-b.1.1.529>

¹⁴ Centers for Disease Control and Prevention. (2021). New SARS-CoV-2 Variant of Concern Identified: Omicron (B.1.1.529) Variant. https://emergency.cdc.gov/han/2021/han00459.asp?ACSTrackingID=USCDC_511-DM71221&ACSTrackingLabel=HAN%20459%20-%20General%20Public&deliveryName=USCDC_511-DM71221

¹⁵ Centers for Disease Control and Prevention. (2021). New SARS-CoV-2 Variant of Concern Identified: Omicron (B.1.1.529) Variant. https://emergency.cdc.gov/han/2021/han00459.asp?ACSTrackingID=USCDC_511-DM71221&ACSTrackingLabel=HAN%20459%20-%20General%20Public&deliveryName=USCDC_511-DM71221

¹⁶ World Health Organization. (2021). Enhancing Readiness for Omicron (B.1.1.529): Technical Brief and Priority Actions for Member States [https://www.who.int/publications/m/item/enhancing-readiness-for-omicron-\(b.1.1.529\)-technical-brief-and-priority-actions-for-member-states](https://www.who.int/publications/m/item/enhancing-readiness-for-omicron-(b.1.1.529)-technical-brief-and-priority-actions-for-member-states)

34. In Australia, case numbers of Omicron have continued to increase sharply. As of 22 December 2021, 547 confirmed cases due to the Omicron variant have been reported in Australia, but a substantial number of suspected unconfirmed cases are also likely to be due to the Omicron variant (awaiting confirmation via sequencing). At the time of writing this report, the Omicron variant is thought to be dominant in all regions of New South Wales, and community transmission of the Omicron variant is occurring in all jurisdictions apart from Western Australia.¹⁷
35. Emerging data on the clinical impact of Omicron are preliminary and limited but suggest that Omicron has a replication advantage over the Delta variant and evades infection and vaccine-induced humoral immunity to a greater extent than prior variants.
36. The World Health Organization (2021) reported that the overall risk related to Omicron is very high. It identified that consistent evidence shows that the Omicron variant has a growth advantage over the Delta variant with a doubling time of 2-3 days and rapid increases in the incidence of cases seen in a number of countries, including those where the Omicron variant has become the dominant variant, such as the United Kingdom and the United States of America. However, a decline in the incidence of cases has now been observed in South Africa.¹⁸
37. The World Health Organization suggests that the rapid growth rate is likely to be a combination of both immune evasion and intrinsic increased transmissibility of the Omicron variant.
38. The risk of severe disease with the Omicron variant is more uncertain.¹⁹ Data on clinical severity in patients infected with Omicron is growing but is still limited.
39. The Ministry of Health report that Omicron has similar hospitalisation rates, however more information is required to determine disease severity.²⁰
40. The World Health Organization has reported that it is not yet clear whether infection with Omicron causes more or less severe disease compared to infections with other variants, including Delta.²¹ It reports that early data from the United Kingdom, South Africa and Denmark suggests there is a reduced risk of hospitalisation for the Omicron variant compared to the Delta variant, however, further data are needed to understand the clinical markers of

¹⁷Australian Technical Advisory Group on Immunisation (ATAGI). (2021). ATAGI Statement on the Omicron variant and the timing of COVID-19 booster vaccination. 24 December 2021. <https://www.health.gov.au/news/atagi-statement-on-the-omicron-variant-and-the-timing-of-covid-19-booster-vaccination>

¹⁸ World Health Organization. (2021). COVID-19 Weekly Epidemiological Update. Edition 72, published 28 December 2021. file:///ccity.biz/Users/HD04/RichardsonM/Downloads/20211228_Weekly_Epi_Update_72.pdf

¹⁹ World Health Organization. (2021). Enhancing Readiness for Omicron (B.1.1.529): Technical Brief and Priority Actions for Member States. December 10, 2021. [https://www.who.int/publications/m/item/enhancing-readiness-for-omicron-\(b.1.1.529\)-technical-brief-and-priority-actions-for-member-states](https://www.who.int/publications/m/item/enhancing-readiness-for-omicron-(b.1.1.529)-technical-brief-and-priority-actions-for-member-states)

²⁰ Ministry of Health. (2021). <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-health-advice-public/about-covid-19/covid-19-about-omicron-variant>.

²¹ World Health Organization. (2021). <https://www.who.int/news/item/28-11-2021-update-on-omicron>

severity including the use of oxygen, mechanical ventilation and death, and how severity may be impacted by vaccination and/or prior SARSCoV-2 infection.²²

41. Other reports stress that any reductions in severity need to be weighed against the fact Omicron appears to spread much faster than Delta and is more able to evade vaccines. Sheer numbers of infections could still overwhelm hospitals.
42. A technical report from the UK Health Security Agency (31 December 2021) identified that the risk of being admitted to hospital for Omicron cases was lower for those who had received two doses of a vaccine compared to those who had not received any vaccination. The risk of being admitted to hospital for Omicron cases was even lower among those who had received three doses of vaccine.²³ It also indicated that vaccine effectiveness against symptomatic disease with the Omicron variant is lower than compared to the Delta variant and wanes rapidly. Nevertheless, protection against hospitalisation is much greater than that against symptomatic disease, in particular after a booster dose, where vaccine effectiveness against hospitalisation is close to 90%.²⁴
43. Making conclusions based on small, early reports is premature and the number of confirmed cases is too low to understand if the disease clinical spectrum of Omicron differs from that of previously detected variants.
44. The relative mildness of disease may reflect the younger age of individuals impacted at this stage of the surge (or a higher proportion of reinfections). There is often a delay between symptom onset and respiratory complications, the scope of clinical severity may not be evident for several weeks.²⁵
45. It is also still unclear to what extent the observed reduction in risk of hospitalisation can be attributed to immunity from previous infections or vaccination and to what extent Omicron may be less virulent i.e. it is due to the virus itself or existing immunity.
46. It is reasonable to expect that Omicron will have an impact on community transmission in Christchurch and across New Zealand.

“Delta has an Ro of 5-6. Omicron has an Ro of 10. It is for this reason that it has spread so rapidly throughout Europe. At the time of writing, our border controls had prevented Omicron from entering the country, but we know that a case will eventually leak.” (Dr Alistair Humphrey, 2021)

²² World Health Organization. (2021). Enhancing Readiness for Omicron (B.1.1.529): Technical Brief and Priority Actions for Member States. 23 December 2021. [https://www.who.int/publications/m/item/enhancing-readiness-for-omicron-\(b.1.1.529\)-technical-brief-and-priority-actions-for-member-states](https://www.who.int/publications/m/item/enhancing-readiness-for-omicron-(b.1.1.529)-technical-brief-and-priority-actions-for-member-states)

²³ UK Health Security Agency. (2021). SARS-CoV-2 variants of concern and variants under investigation in England Technical briefing: Update on hospitalisation and vaccine effectiveness for Omicron VOC-21NOV-01 (B.1.1.529) 31 December 2021. <https://www.gov.uk/government/publications/investigation-of-sars-cov-2-variants-technical-briefings>

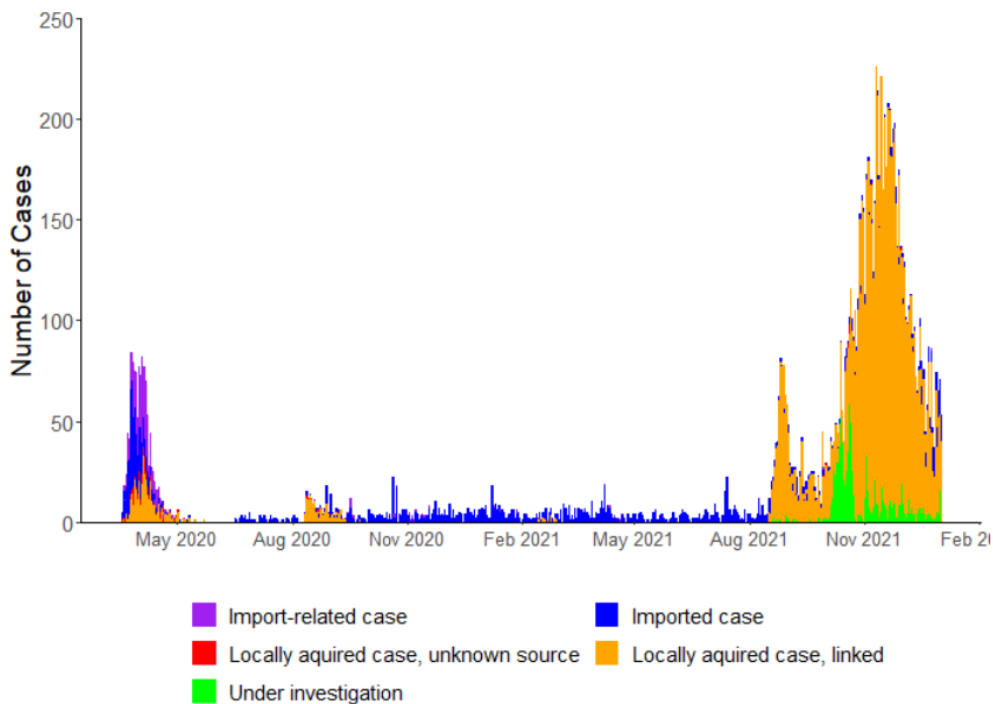
²⁴ UK Health Security Agency. (2021). SARS-CoV-2 variants of concern and variants under investigation in England Technical briefing: Update on hospitalisation and vaccine effectiveness for Omicron VOC-21NOV-01 (B.1.1.529) 31 December 2021. <https://www.gov.uk/government/publications/investigation-of-sars-cov-2-variants-technical-briefings>

²⁵ McIntosh, K. et al. (2021). COVID-19: Epidemiology, virology, and prevention. <https://www.uptodate.com/contents/covid-19-epidemiology-virology-and-prevention>

COVID-19 in New Zealand

47. The first COVID-19 case was identified in New Zealand in late February 2020, and case numbers rose rapidly in the following month. New Zealand initially followed a mitigation strategy. In late March 2020, the country switched to an elimination strategy. The initial national COVID-19 wave was successfully eliminated by May 2020 and subsequent outbreaks in Auckland were managed in a similar way.²⁶
48. New Zealand continued to follow an elimination strategy to keep the country free from COVID-19 while the population was vulnerable and unvaccinated.
49. New Zealand's elimination strategy response to COVID-19 produced the best mortality protection outcomes in the OECD. New Zealand had the lowest cumulative COVID-19 death rate in the OECD at 242 times lower than the 38-OECD-country average: 5.2 vs 1256 per million population. In economic terms it also performed better than the OECD average in terms of adverse impacts on GDP and employment.²⁷
50. As of 26 December 2021, there have been 13,855 cases reported in New Zealand.

Figure 2: Daily confirmed and probable cases by source New Zealand (Updated 02 January 2022)



Source: Ministry of Health. (2021). COVID-19: Source of cases.²⁸

²⁶ Editorial. New Zealand Medical Journal. (2021). The next phase in Aotearoa New Zealand's COVID-19 response: a tight suppression strategy may be the best option. <https://journal.nzma.org.nz/journal-articles/the-next-phase-in-aotearoa-new-zealands-covid-19-response-tight-suppression-may-be-optimal-for-health-equity-and-wellbeing-in-the-months-ahead>

²⁷ Wilson, N. et al. (2021). Use of the Elimination Strategy in Response to the COVID-19 Pandemic: Health and Economic Impacts for New Zealand Relative to Other OECD Countries <https://doi.org/10.1101/2021.06.25.21259556>

²⁸ Ministry of Health. (2021). COVID-19: Source of cases. <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-data-and-statistics/covid-19-source-cases>

Figure 3: How COVID-19 has spread (Updated 02 January 2022)

	Number of cases	Percentage (%) of all NZ cases
Imported case ¹	2159	15%
Import-related case ²	497	3%
Locally acquired, linked ³	10478	74%
Locally acquired, unknown source ⁴	112	1%
Under investigation	1009	7%
Total	14255	100%

1. International passengers and crew entering the country who caught COVID-19 overseas or during the journey
2. People exposed to international returnees - includes close contacts, other returnees in managed isolation or quarantine, and staff working at the border or in managed facilities
3. Caught COVID-19 from someone locally
4. Caught COVID-19 within New Zealand (hadn't travelled overseas recently or been in close contact with someone who travelled recently) but source is unknown

Figure 4: COVID-19 cases by source and ethnicity (Updated 02 January 2022)

	Māori	Pacific peoples	Asian	Middle Eastern/ Latin American/ African	European/ Other	Unknown
Import-related case	67	14	57	12	346	1
Imported case	71	67	709	146	1122	44
Locally acquired case, unknown source	11	16	16	5	64	0
Locally acquired, epidemiologically linked	4528	3161	745	186	1841	17

Source: Ministry of Health. (2021). COVID-19: Source of cases.²⁹

New Zealand's Transition to a Minimise and Protect Strategy

51. New Zealand has moved 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.
 - 51.1. On 4 October 2021, the Prime Minister indicated that New Zealand would transition away from the elimination strategy. This change was precipitated by a Delta variant outbreak first detected on 17 August 2021 in Auckland. This outbreak proved too difficult to stamp out using the methods that effectively eliminated previous outbreaks arising from border control failures.
 - 51.2. On 18 October 2021, Cabinet agreed to shift away from an elimination strategy for responding to COVID-19 to a “minimisation and protection” approach based on the protection vaccines provide and the challenges of containing the Delta variant.
 - 51.3. On 2 December 2021, the COVID-19 Public Health Response (Protection Framework) Order 2021 came into effect.
52. This new framework is expected to result in a degree of ongoing community transmission as restrictions start to ease and we move away from lockdowns under the alert level system. With loosening of restrictions people will be at a higher risk of contracting (and therefore of transmitting) COVID-19. The Ministry of Health (2021) has stated that:

“Importantly, minimisation means that we are aiming to keep the spread of COVID-19 as low as possible so while there will be some level of cases in the community on an ongoing basis, we will work to contain and control any outbreaks, and if practical to do so, stamp them out... We will

²⁹ Ministry of Health. (2021). COVID-19: Source of cases. <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-data-and-statistics/covid-19-source-cases>

*protect people from it with vaccination, active public health measures including testing, isolation and contact tracing, and a response that focusses on minimising the significant health impacts we know it can have.*³⁰

53. The likelihood of infection, transmission and the health impact and outcomes of any infection will be mitigated somewhat through the use of vaccinations and other risk mitigations in the COVID-19 Protection Framework.
54. Vaccination rollout using Pfizer vaccine is currently underway across New Zealand, with 94% of the eligible population having received their first dose and 90% their second dose (97% and 93% respectively in Christchurch).

³⁰Ministry of Health. (2021). COVID-19: Minimisation and protection strategy for Aotearoa New Zealand. (7 December 2021). <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-response-planning/covid-19-minimisation-and-protection-strategy-aotearoa-new-zealand>

Obligations under the Health & Safety at Work Act 2015

55. Christchurch City Council has an obligation to provide a safe and healthy working environment under the Health and Safety at Work Act 2015. This obligation extends to our workers, elected members, contractors, and those people visiting our workplaces, including our customers, visitors, and wider communities.
56. Under the Health and Safety at Work Act 2015, a Person Conducting a Business or Undertaking (PCBU) must identify whether there is a risk to the health of their workers from exposure to COVID-19 at their workplace. PCBUs must ensure, so far as is reasonably practicable:
 - 56.1. The health and safety of their workers while they are carrying out their work;
 - 56.2. The health and safety of other persons is not put at risk from work carried out as part of the conduct of the business or undertaking;
 - 56.3. The provision of a work environment that is without risks to health and safety;
 - 56.4. The provision and maintenance of safe systems of work;
 - 56.5. The provision of any information, training, instruction, or supervision that is necessary to protect all persons from risks to their health and safety arising from work carried out as part of the conduct of the business or undertaking.
57. A PCBU who manages or controls a workplace, has a duty under the Act to ensure, so far as is reasonably practicable, that the workplace, the means of entering and exiting the workplace and anything arising from the workplace, are without risks to the health and safety of any person (public and workers included).
58. Where a risk is identified, PCBUs must eliminate the risk, so far as is reasonably practicable. When elimination is not possible, they must reduce the risk so far as is reasonably practicable.

Wider legislative context

59. It is also important to take into consideration that decisions made within the COVID-19 and health and safety legislative frameworks do not sit in a vacuum.
60. There are tensions between legislation to enact the COVID-19 Protection Framework, the rights of individuals (for example, under the New Zealand Bill of Rights Act 1990), health and safety and employment law, and the nature of the Council's role in providing services to the community under the Local Government Act 2002 and other legislation.
61. While balancing these considerations is not an easy process, the overriding consideration should be the health and safety of workers, elected members and our community in the context of the significant risk that COVID-19 presents.

Council's Risk Assessment

62. In consultation with staff, the Council has conducted an assessment of exposure and transmission risks across the organisation. We also considered the range of controls available and how those may be applied.

Purpose of our Risk Assessment

63. The purpose of our risk assessment was to:
- 63.1. Assess the risks associated with COVID-19;
 - 63.2. Identify who is at risk of exposure (the likelihood of coming into direct, indirect or close contact with a person infected with the virus), including which Council roles are at risk and/or creating a risk;
 - 63.3. Identify if, and what kind of, control measures should be implemented to reduce risks to a level that is deemed acceptable, or as low as reasonably practicable;
 - 63.4. Assess the use of vaccination as a workplace control.
64. The scope of our assessment included:
- 64.1. The risk to any of Council's workers, elected members, contractors and other workers.
 - 64.2. The risk that our workers may pose to members of the community – particularly for those who are under 12 or otherwise vulnerable.³¹
65. There is an acknowledgement that where the Council places a risk on an individual of infection that risk is then carried forward to pose a risk to that person's colleagues, whanau and social networks.

Methodology – Our Risk Assessment Process

66. Our COVID-19 risk assessment process drew on the guidance provided by:
- 66.1. WorkSafe³²
 - 66.2. Public Service Guidance provide by Te Kawa Mataaho Public Service.³³
 - 66.3. COVID-19 Local Government Response Unit³⁴

³¹ Vulnerable populations include people aged ≥60 years and/or with comorbidities that increase risk of serious COVID-19 disease; disadvantaged groups such as marginalized populations, and those in low resource settings and lower income groups. Maori experience higher rates of infectious diseases than other New Zealanders. Maori 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 Maori.

³² WorkSafe Mahi Haumarū Aotearoa. (2021). How to decide what work requires a vaccinated employee. <https://www.worksafe.govt.nz/managing-health-and-safety/novel-coronavirus-covid/how-to-decide-what-work-requires-a-vaccinated-employee/>

³³ Te Kawa Mataaho Public Service. (2021). Public-Service-workforce-guidance-for-the-COVID-19-Protection-Framework.pdf <https://www.publicservice.govt.nz/resources/public-service-workforce-guidance-for-the-covid-19-protection-framework/>

³⁴ The Department of Internal Affairs hosts a COVID-19 Local Government Response Unit. This dedicated working group comprises senior leadership from DIA's Local Government Branch, from the Taituarā — Local Government Professionals Aotearoa, Local Government New Zealand (LGNZ), and the National Emergency Management Agency (NEMA): <https://www.dia.govt.nz/Local-Government-COVID-19-Response>

67. We also drew on the available research and literature on COVID-19 and the information provided by government departments.
68. We sought advice from:
 - 68.1. Dr Alistair Humphrey, Public Health Physician.
 - 68.2. Professor Michael Plank, Professor in the School of Mathematics and Statistics at the University of Canterbury who undertakes modelling to support New Zealand's all-of-government response to COVID-19.
69. We reviewed the policies and risk assessments of other Councils, including Auckland City Council, Hamilton City Council, Porirua City Council and our neighbouring councils. We are grateful to these councils for sharing their information with us.

How we assessed the Risk of Exposure

70. The degree to which a person is exposed to COVID-19 is the determining factor as to whether they will become infected, and therefore be prone to the consequences associated with the virus. The risk factors in the WorkSafe guidance on risk assessments relate specifically to whether a person will be exposed, and if exposed, how quickly might the contact tracing identify that they have been exposed.
71. We carried out health and safety risk assessments for each role at the Council. We worked with relevant Heads of Units, Managers and other workers who perform the work to understand the exposure risk for each role.
72. For completeness, we undertook a risk assessment for roles that were already subject to a Government mandate and those working in higher-risk environments subject to a Vaccine Pass mandate under the COVID-19 Protection Framework traffic light system.
73. We had previously undertaken an assessment to determine the Council facilities that require a vaccination passport to enter the premises under the new framework. To ensure consistency, we reviewed the risk assessment for roles that are already subject to vaccine pass requirements in our facilities.
74. The Council's duties under the Health and Safety at Work Act 2015 extend to others in our workplaces, or those who are impacted by our operations. Therefore, when considering exposure, it was important to consider both the degree to which our workers may be exposed to COVID-19, and the degree to which our workers expose others to the virus.
75. We considered:
 - 75.1. Risks of workers becoming infected with COVID-19 while at work;
 - 75.2. Risks of workers transmitting COVID-19 to others during work;
 - 75.3. Risks being carried forward to pose a risk to that person's colleagues, whanau and social networks.
76. The role assessments considered:
 - 76.1. Inherent risk of to a worker in the role and to others if no controls are in place;

- 76.2. Residual risk with current controls, such as barriers, masks, handwashing, social distancing, and remote working.
- 77. We used a tool to capture the Heads', Managers' and other workers' assessment of risks. This tool included a series of questions assessing awareness of COVID-19 controls, including:
 - 77.1. Access to information on COVID-19
 - 77.2. Awareness of COVID-19 symptoms
 - 77.3. Awareness of what to do if unwell or have been exposed to a COVID-19 case
 - 77.4. Whether good cleaning regime and hygiene measures are in place
 - 77.5. Whether QR Codes are displayed and Manual Sign-In is available
 - 77.6. Whether the role requires entry to a site that may only be accessed by a vaccinated worker
- 78. The tool also captured workers' assessment of the exposure risk associated with the role. Based on the WorkSafe guidance the tool used a series of questions relating to exposure:
 - 78.1. How many people a worker in the role comes into close contact with;
 - 78.2. How easy it would be to identify the people who a worker in the role comes into contact with;
 - 78.3. How close a worker carrying out the role is in proximity to other people;
 - 78.4. How long the worker is required to be in proximity to other people;
 - 78.5. Whether the work involves regular interaction with people considered at higher risk of severe illness from COVID-19, such as people with underlying health conditions, or unvaccinated children;
 - 78.6. The risks in the work environment compared to the risk outside work.
- 79. These were rated as from 'low risk' to 'high risk', depending on the level of exposure.
- 80. The Council has approximately 2,680 workers undertaking a variety of roles and activities.³⁵ We assessed each role's exposure risk individually. We then consolidated the individual roles into the following broad categories/role profiles³⁶ to allow us to describe the level and type of risks associated with the variety of roles:
 - 80.1. Office-based workers without public-facing roles
 - 80.2. Workers who work in our public facilities
 - 80.3. Workers who have other public-facing roles
 - 80.4. Workers with roles that mean they spend most of their time outside
 - 80.5. Workers who work with children under 12 years, or other vulnerable members of the community
 - 80.6. Workers who provide essential services.

³⁵ At balance date 2021, the Council employed 2,684 staff members. These comprised 1,756 full time employees with the balance of employees representing 391 full-time equivalent employees. Christchurch City Council (2021) Annual Report 2021.

³⁶ We used similar categories to other councils to enable comparison.

81. The summarised exposure risks within these categories are outlined in Section: **Risk of Exposure on page 19** below.

How we assessed the Risk of Infection

82. The assessment considered the risks of infection. We considered risks to our workers of:
- 82.1. an unvaccinated person transmitting infection during work to an unvaccinated worker;
 - 82.2. an unvaccinated person transmitting infection during work to a vaccinated worker;
 - 82.3. a vaccinated person transmitting infection during work to an unvaccinated worker;
 - 82.4. a vaccinated person transmitting infection during work to a vaccinated worker.
83. We also considered risks of transmission by our workers to others during work, including:
- 83.1. an unvaccinated worker transmitting to an unvaccinated person;
 - 83.2. an unvaccinated worker transmitting to a vaccinated person;
 - 83.3. a vaccinated worker transmitting to an unvaccinated person;
 - 83.4. a vaccinated worker transmitting to a vaccinated person.
84. Our assessment drew on available research. We also sought expert advice on the risks of infection if there were unvaccinated people in the workplace compared to if all people at the workplace were vaccinated.

Findings from our Risk Assessment

85. The report summarises the findings from our assessment of risks, including:
 - 85.1. Risk of Exposure;
 - 85.2. Risk of Infection;
 - 85.3. Risk of Community Transmission.
86. The report then describes our assessments of the consequences:
 - 86.1. Consequences of Infection;
 - 86.2. Consequences of Business Failure.

Risk of Exposure

87. Our risk assessment concluded that it is reasonably foreseeable that, our people will be regularly exposed to COVID-19 as part of their regular work. There is a **high likelihood** of exposure from the many types of interactions our workers undertake.

Initial Assessment of Exposure Risk

88. We assessed each role's exposure risk individually. Exposure risk was rated as either 'low', 'moderate' or 'high'.
89. We initially assessed the individual role's exposure without allowing for transmission across roles.
90. These assessments are summarised in the following role profiles/categories (as discussed in paragraph 80):
 - 90.1. Office-based roles without public-facing roles;
 - 90.2. Roles that work in our public facilities;
 - 90.3. Roles that provide other public-facing services;
 - 90.4. Roles that spend most of their time outside;
 - 90.5. Roles who work with children <12yr, or other vulnerable people;
 - 90.6. Roles that deliver essential services.

Figure 5: Initial Exposure Risk by Role Categories

	Number of people	Proximity	Interaction with people not known	Risk transmission compare to outside work	Exposure Risk
Office-based roles without public-facing roles.	Moderate	High	Low	Moderate	Moderate
Roles that work in our public facilities	High	High	High	High	High
Roles that provide other public-facing services.	High	Moderate/High	High	High	High
Roles that spend most of their time outside.	Low	Low	Moderate	Moderate	Low / Moderate
Roles that work with children <12yr, or other vulnerable people	High	High	Moderate	Moderate	High
Roles that operate essential services	Low	High	Low	Low	Low

Reassessment of Exposure Risk based on Expert Advice

91. We subsequently received expert advice regarding the risk of exposure / transmission across Council roles:

“It is also important to acknowledge that office-based staff and public-facing staff are not mutually exclusive, either in the way they work or in their personal roles. Transmission across a council is a risk.”

Dr Alistair Humphrey, Public Health Physician

“With 1500 people working in an open plan office, if 5% of the workforce are unvaccinated there would be a significantly higher risk of mortality, sickness, and workplace absences due to Covid-19 than if everyone was fully vaccinated. This is because the vaccine, although not perfect, greatly reduces the risk of catching the virus and spreading it to others. An unvaccinated person poses around 8 times the risk to people around them than a fully vaccinated person does. Because the virus is airborne, open plan spaces mean that everyone in the office is put at elevated risk if there are unvaccinated people working there.”

(Professor Michael Plank, Te Kura Pāngarau University of Canterbury)

92. The context in which the Council operates means that significant numbers of workers, elected members, customers, contractors and members of the public have frequent interactions within, across and beyond our facilities and work settings.
93. The nature of the work in the Council workplace is interactive. Our workers and elected members need to be present on the workplace and this requires close interaction. Team members share working spaces – kitchens, toilets, meeting rooms, lifts, offices.
94. This means our services and workplaces are borderless and flexible, which results in increased risk of transmission and infection.
- 94.1. Our workers interact with each other regularly, both within each office/facility and across locations (for example, facilities based workers frequently coming in to the Civic offices for meetings).
- 94.2. In the Civic building there are approximately 1,500 people working across six open plan floors. Most workers will encounter many other staff members in their working

day – many of whom they will not know. These interactions would be difficult to trace.

94.3. Most workers work indoors, in confined and enclosed spaces. Even our field workers, such as Parks staff, regulatory officers and parking officers spend time indoors, in confined enclosed spaces.

94.4. Our community facing roles interact with thousands of people daily, in our community facilities such as libraries, gyms, pools, the Art Gallery, Akaroa museum, customer services and other settings. Our Regulatory staff also interact daily with customers. Other roles also interact with the public and even office-based roles engage with external people directly.

95. Based on the expert advice we reassessed the individual role assessment. Our revised summary of role categories is in Figure 6 below.

Figure 6: Revised Exposure Risk by Role Categories

	Number of people	Proximity	Interaction with people not known	Risk transmission compare to outside work	Exposure Risk
Office-based roles without public-facing roles.	Moderate	High	Moderate	High	High
Roles that work in our public facilities	High	High	High	High	High
Roles who have other public-facing roles.	High	Moderate/High	High	High	High
Roles that spend most of their time outside.	Moderate	Low	Low	High	High
Roles that work with children <12yr, or other vulnerable people	High	High	High	High	High
Roles that operate essential services	Low	High	Low	Low	Low

Description of Role Profiles/Categories

96. As reported above, the Council has approximately 2,680 workers undertaking a variety of roles and activities.³⁷ The roles have been grouped into the following role profiles/categories for this report.³⁸

Figure 7: Description of Role Profile

Role Profile	Description
Office-based roles	<ul style="list-style-type: none"> Office-based roles work for long periods in indoor environments where there is limited interaction with the public. Team members share spaces (communal) including open plan offices, lifts, kitchens, meeting rooms, common equipment, and toilets. 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

³⁷ Over 330 separate role assessments were completed, with a number of assessments group similar roles into a single assessment.

³⁸ We used similar categories to other metropolitan councils to enable comparison.

Role Profile	Description
	<p>office and need to undertake certain tasks or attend meetings within the office.</p> <ul style="list-style-type: none"> • Exposure is more likely in enclosed spaces, or in locations where people eat or talk, such as kitchen spaces and lunch spaces. • Roles often use communal pool vehicles to travel and may not travel alone • Visitors, customers, suppliers, contractors, consultants, and other people visit these locations. • Roles con occasions attend Council and Community Board meetings and community or consultations meetings. • There is the potential for any of these workers to be infected outside the workplace, and then transmit the virus to others prior to a test and diagnosis.
Public-facing roles	<ul style="list-style-type: none"> • Public-facing roles undertake a range of tasks in environments that may be either indoor or outdoor. • There are a number of activities which may require our workers to interact in close proximity with others from across every community. • Wherever there is interaction with the public, there is opportunity for COVID-19 to spread to our workers, or from our workers into the community. • These roles frequently come to the Civic Offices, Community Board rooms or Service Centres to attend workplace meetings and formal Council, Committee and Community Board meetings. • Roles interact with suppliers and people from other organisations. • There is the potential for any of these workers to be infected outside the workplace, and then transmit the virus to others prior to a test and diagnosis.
Outdoor roles	<ul style="list-style-type: none"> • Roles operate at various locations • Roles working outdoors work in an environment that is not conducive to the spread of COVID-19, however there is a degree of exposure from working alongside others. • Workers share spaces with other team members and sometimes operate in relatively closed environments with another team member. • Team members share relatively closed spaces with other team members and other teams, including kitchens and toilets. • Roles often use communal pool vehicles to travel and may not travel alone. • These roles frequently come to the Civic Offices, Community Board rooms or Service Centres to attend workplace meetings and formal Council, Committee and Community Board meetings. • There is the potential for any of these workers to be infected outside the workplace, and then transmit the virus to others prior to a test and diagnosis.

Role Profile	Description
Roles working with vulnerable people	<ul style="list-style-type: none"> • Roles working with children under 12 years, 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. • Roles working with children tend to 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 risk of infection for these children. • There is also a risk of exposure for those children, and to others who may be vulnerable, where a worker may have a COVID-19 infection. • These roles frequently come to the Civic Offices or Service Centres to attend workplace meetings. • These roles tend to be captured by the Government mandate.
Essential Workers	<ul style="list-style-type: none"> • Essential workers undertake a range of tasks required to operate essential services across the city, such as water, wastewater, land drainage. • Team members share spaces, including kitchens, toilets, meeting rooms, and the workspace with others, and receive visits from Civic Office-based workers, or work in Civic themselves. • 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 contractors. • Any risk of contracting COVID-19 within these work groups could have an extremely detrimental impact on our ability to provide core services. • Section Business Failure on page 26 below discusses this risk in more detail.

Risks Associated with Community Transmission

97. New Zealand has moved 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 circulate within the community.
98. When there is community transmission in Christchurch, we anticipate increased risk of exposure while carrying out our work than previously. For example, there will be an increased risk from infected people without symptoms (asymptomatic) or before the onset of recognized symptoms (presymptomatic).
99. Changes to the Auckland boundary settings on Wednesday 15 December 2021 increased the risk of community transmission in Christchurch. Christchurch airport is the main entry point to Christchurch for North Island visitors.
 - 99.1. There were 206 flights scheduled on the Auckland – Christchurch route from 15 – 24 December 2021. This means that between 3000 – 4000 people a day may have flown

into Christchurch Airport from Auckland over this ten day period, or 35,000 – 40,000 over the full 10 day period.

- 99.2. There were 124 flights scheduled on the Christchurch to Auckland route from 20 – 24 December 2021. This means that as many as 21,200 Christchurch residents may have travelled to Auckland for the Christmas period.
 - 99.3. On 24 December 2021, Christchurch International Airport was identified as a location of interest. Subsequent Christchurch-based locations of interest have been added since 24 December 2021.
100. During the Christmas and summer holiday period, Christchurch residents are likely to be more mobile, heightening the risk of COVID-19 spreading in the community. Spending data for the previous two Decembers (2019 & 2020) shows that Auckland is a popular holiday location for Christchurch residents. Queenstown Lakes, Central Otago, other areas in Canterbury, and Nelson and Tasman are also popular for Christchurch and Auckland residents.
 101. There is also a risk of community transmission from overseas returnees. As of the week commencing 16 December 2021, there were 419 returnees in MIQ facilities in Christchurch, this was around 15% of all people in MIQ for this week (2955 people). The Elms Hotel was recently added to the MIQ facilities in Christchurch, bringing the total number of MIQ facilities in the city to seven. At the time of writing, across all MIQ facilities, there are 2,889 people who hold vouchers to arrive in New Zealand in the next week.
 102. The Government has announced that the date for New Zealanders and other eligible travellers to return to New Zealand and self-isolate at home will be pushed out from 16 January 2021 to late-February 2022 due to the growing risk that the Omicron variant poses.

Risk of Infection

103. The probability of infection when exposed to COVID-19 viral particles can vary from person to person, but there is evidence to indicate that in the absence of other controls, there is a **moderate to high** probability of becoming infected when directly exposed to someone who has COVID-19.³⁹
104. The Delta variant of COVID-19 is described as a “highly transmissible” mutation of the virus. It is believed to be more than twice as contagious as previous variants. It is estimated that on average, without vaccination, one person infected with Delta may infect 5 or 6 other people.⁴⁰ Studies have shown that it may be more likely than the original virus to put infected people in the hospital.⁴¹
105. The emergence of the Omicron variant of COVID-19 potentially poses a greater threat to the health and wellbeing of our workers and the wider community. Emerging data on the clinical impact of Omicron are preliminary and limited but suggest that Omicron has a replication advantage over the Delta variant.

³⁹ Ministry of Health. (2021). COVID-19: About Delta variant. <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-health-advice-public/about-covid-19/covid-19-about-delta-variant> (30 September 2021)

⁴⁰ Ministry of Health. (2021). COVID-19: About Delta variant. <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-health-advice-public/about-covid-19/covid-19-about-delta-variant> (30 September 2021)

⁴¹ Katella, K. (2021). Delta Variant. Yale Medicine. <https://www.yalemedicine.org/news/5-things-to-know-delta-variant-covid>

106. People who are not vaccinated are most at risk. Unvaccinated people are more likely to test positive than vaccinated people and more likely to be hospitalised and die from COVID-19 than fully vaccinated people. Professor Michael Plank from Te Kura Pāngarau University of Canterbury, stated that an unvaccinated person poses around eight times the risk to people around them than a fully vaccinated person does.
107. While breakthrough infections—infections in people who are vaccinated— do sometimes occur, vaccinated people are overall less likely to be infected. Vaccinated people clear the virus faster, with lower levels of virus overall, and have less time with very high levels of virus present.

Consequences of Infection

108. The range of consequences for a person infected with COVID-19 is extremely broad and will depend on a myriad of factors. COVID-19 affects different people in different ways:
 - 108.1. Most infected people develop mild to moderate illness and recover without hospitalisation.
 - 108.2. Some people may be completely asymptomatic for the duration of the infection.
 - 108.3. Some will continue to struggle with lingering, and sometimes debilitating, effects for elongated and unknown period of time (long-COVID).
 - 108.4. Some infected people suffer a serious illness that requires hospitalisation to get well.
 - 108.5. Some may lose their life to the infection or its associated complications.
109. As of 19 December 2021, the World Health Organization reported over 273 million cases and over 5.3 million deaths globally. In New Zealand there have been 13,932 COVID-19 cases since the first New Zealand case, and 50 deaths.
110. The ‘vaccinated vulnerable’ are at increased risk. The vaccinated vulnerable are those people that have received the vaccine but they have underlying conditions that make them more vulnerable to still getting an infection that may be severe. The ‘vaccinated vulnerable’ can include older people, immunocompromised people, such as those with cancer, people who have had transplants, those with rheumatological conditions, and also anyone taking immunosuppressants or long-term steroids. It also includes people with lung disease, like COPD and asthma, and heart disease.
111. If there is widespread community transmission, there could also be challenges associated with the health system’s capacity to:
 - 111.1. Detect and confirm cases of COVID-19.
 - 111.2. Identify and locate close contacts of an infected person in a timely manner to notify them of exposure, assess them for signs and symptoms of illness, and take other measures as needed to prevent further spread of disease.
 - 111.3. Monitor potentially exposed individuals for the duration of the incubation period to determine if they become symptomatic.
 - 111.4. Keep persons who might have been exposed to the virus away from others - quarantine persons known or suspected to have been exposed.

- 111.5. Treat COVID-19 patients.
112. If our health system was under strain this could have a negative impact on the consequences of infection.

Business Failure

113. The decision regarding the requirements that roles should be undertaken by vaccinated workers must be based on mitigating the risk of COVID-19 to workers' and visitors' health and safety.
114. However, we note that there are also 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.
115. The consequences associated with business interruption have been considered significant, but secondary, by most councils.
116. Our expert advice from a Public Health Physician is that the consequences associated with failure of essential services could have serious health, economic and environmental consequences and should not be considered as secondary.

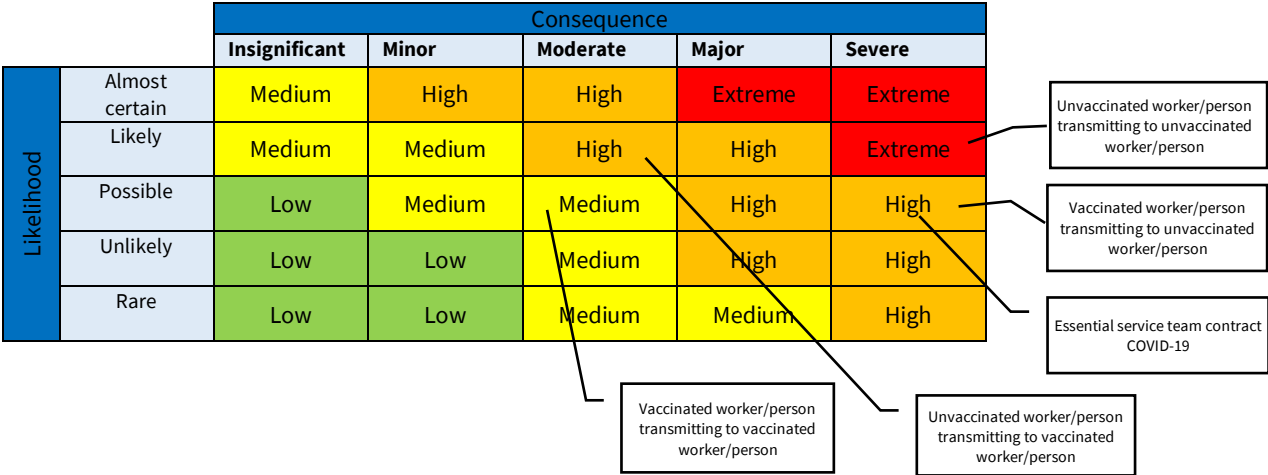
“Failure of continuity in any business whose purpose is to protect health (including the health service itself, of course) can have both morbidity and mortality consequences...The consequences of failure of Council services are severe and only marginally second to a failure in health services.”

Dr Alistair Humphrey, Public Health Physician 2021

117. Infection of people holding key or highly skilled roles could have a serious impact on the provision of important services to the community.
118. The risk of loss of key workers in teams providing essential services due to someone acquiring COVID-19 (at or outside of work) and bringing it into the workplace has been assessed. Our water services, land drainage, regulatory responsibilities, and public safety may all be impacted if a proportion of workers or an entire team was to be infected or be otherwise required to isolate.
119. The consequences have been assessed as catastrophic for four of our operational teams - network operations, shift engineers, electrical and treatment plant operations - and major for two teams - treatment plant maintenance, laboratory. These are our core network operations teams, largely based at the Christchurch Wastewater Treatment Plant in Bromley. They are responsible for ensuring day to day delivery of water services. We also rely on CityCare for maintenance and incident response.
120. The Council's Business Continuity Planning is actively managed and updated to ensure we can manage any major disruptions in the event of a community outbreak, enable the continuation of service delivery and minimise the impact on the Council and city.

Inherent Risk Score

- 121. With the roles and their likely exposure and transmission identified and the likelihood and consequences of infection considered, we then mapped these on a risk matrix.
- 122. This was initially mapped as the inherent risk. Inherent risk level is determined by looking at the likelihood and consequence of infection without any prevention or mitigation in place.



Controls

123. There is a range of controls already in place in the Council to prevent infection. Our key control is our consistent health messaging, including:
 - 123.1. Get vaccinated as soon as it's your turn and follow local guidance on vaccination.
 - 123.2. Keep physical distance of at least 1 metre from others, even if they don't appear to be sick. Avoid crowds and close contact.
 - 123.3. Wear a properly fitted mask when physical distancing is not possible and in poorly ventilated settings.
 - 123.4. Wash hands thoroughly with soap and water for 20-30 seconds. In the absence of soap and water use alcohol-based hand sanitizer ($\geq 60\%$ alcohol).
 - 123.5. Cover your mouth and nose with a bent elbow or tissue when you cough or sneeze. Dispose of used tissues immediately and clean hands regularly.
 - 123.6. Stay home if you have symptoms of illness. If you develop symptoms or test positive for COVID-19, self-isolate until you recover.
 - 123.7. Keep track of where you have been, turn on Bluetooth in the COVID-19 tracer app and scan QR codes.
124. Council has used regular email communication and signage to communicate key public health messages and critical procedures. As we continue to face unprecedented times it will be essential we communicate clearly with, and regularly inform, our workers, elected members, visitors, customers and other residents.
125. Other controls that the Council utilises include:
 - 125.1. Physical distancing requirements;
 - 125.2. Mask wearing requirements;
 - 125.3. Regular surface cleaning, particularly of any areas frequented by workers or others (for example, visitors) and frequently touched areas and surfaces, such as lift buttons, handrails, tables, counter tops, door knobs, sinks etc;
 - 125.4. Restriction of the number of people in meeting rooms and lifts;
126. Each of these controls works by reducing the likelihood of infection, either by impacting the probability of infection, or by decreasing the level of exposure. These measures are most effective when layered together and used alongside vaccination.
127. We have provided a brief summary of the effectiveness of these controls below.

Current Control Measures

Control	Use and effectiveness
Physical distancing requirements	<p>It is clear from available evidence and experience, that limiting close contact between infected people and others is central to breaking chains of transmission of the virus causing COVID-19. Emerging evidence suggests significant risk associated with close-contact transmission over short distances and in poorly ventilated spaces.</p> <p>Physical distancing of at least one metre within the workplace, and two metres between people in public works can reduce the opportunity for viral particles to pass from one person through the air to another</p> <p>However, aerosol transmission of Delta (and now Omicron) 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.</p>
Non-contact ways of greeting	<p>Some cultural practices involve physical contact between individuals (for example, handshakes, hugs) and may increase risk of transmission.</p> <p>Promoting alternate (non-contact) ways of greeting or congratulating one another can reduce this risk.</p>
Mask wearing	<p>Wearing a mask is an added layer of protection and can help prevent the spread of COVID-19. Fabric masks, if made and worn properly, can serve as a barrier to droplets expelled from the wearer into the air and environment. The efficacy of a non-medical mask depends on breathability, filtration efficiency, and of critical importance, fit.</p> <p>Where masks are not fitted properly, or worn in the correct way (covering the mouth and nose at all times) they are not an effective barrier for viruses.</p> <p>Masks must be used as part of a comprehensive package of preventive measures. However, lay-persons are infrequently trained in the correct use of personal protective equipment (PPE). In the current pandemic, people are frequently ill-equipped, wearing non-medical masks and fabric face coverings which are not PPE and, therefore, does not eliminate SARS-CoV-2 infection risk to the individual.</p> <p>This is heavily reliant on people “following the rules”.</p>
Regular surface cleaning	<p>Respiratory secretions or droplets expelled by infected individuals can contaminate surfaces and objects, creating fomites (contaminated surfaces). Viable SARS-CoV-2 virus can be found on those surfaces for periods ranging from hours to days, depending on the ambient environment (including temperature and humidity) and the type of surface.</p>

Control	Use and effectiveness
	<p>Increased frequency of cleaning and disinfection, particularly of shared areas (for example, toilets and kitchens), high touch surfaces (for example, faucet handles and doorknobs) and equipment (for example, recreational equipment and electronic equipment) is identified as a control.</p> <p>However, recent research has demonstrated comparatively low risk of contact transmission.⁴² The World Health Organization has noted that despite evidence of the survival of SARS-CoV-2 on certain surfaces, no reports have directly demonstrated fomite transmission.⁴³</p>
Personal hygiene	<p>Practicing good sneeze and cough hygiene and regular handwashing and/or the use of hand sanitiser helps to remove viral particles which may have been deposited on hands, which is particularly important when touching the face, eating, or adjusting masks.</p> <p>Frequent handwashing is encouraged. SARS-CoV-2 RNA has been detected in biological samples, including the urine and faeces of some patients, however, there have been no published reports of transmission of SARS-CoV-2 through faeces or urine.⁴⁴</p> <p>This is heavily reliant on people “following the rules”.</p>
Ensure good environmental ventilation in all closed settings	<p>Ventilation plays an important role in reducing the risk of COVID-19 and other illnesses in indoor settings. Good ventilation exchanges indoor air for outdoor air, helping to reduce potentially infectious respiratory particle build-up in the air indoors.</p> <p>Many buildings occupied or entered by Council workers 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 (ASHRAE) standards. Only some buildings allow the opening of doors and windows.</p> <p>It is not possible or financially viable to redesign all our indoor spaces, ventilation systems, and other infrastructure to sufficiently ameliorate the risk of pathogenic transmission. Nor do we have the time to undertake such substantial building works.</p> <p>This control is reliant on other controls, such as physical distancing and hygiene being in place and only reduces exposure risks.</p>

⁴² Mondelli, M.U. et al. (2021). Low risk of SARS-CoV-2 transmission by fomites in real-life conditions. *Lancet Infect Dis.* (2021) 21:e112. doi: 10.1016/S1473-3099(20)30678-2

⁴³ World Health Organization. (2021). Transmission of SARS-CoV-2: Implications for Infection Prevention Precautions. <https://www.who.int/news-room/commentaries/detail/transmission-of-sars-cov-2-implications-for-infection-prevention-precautions>

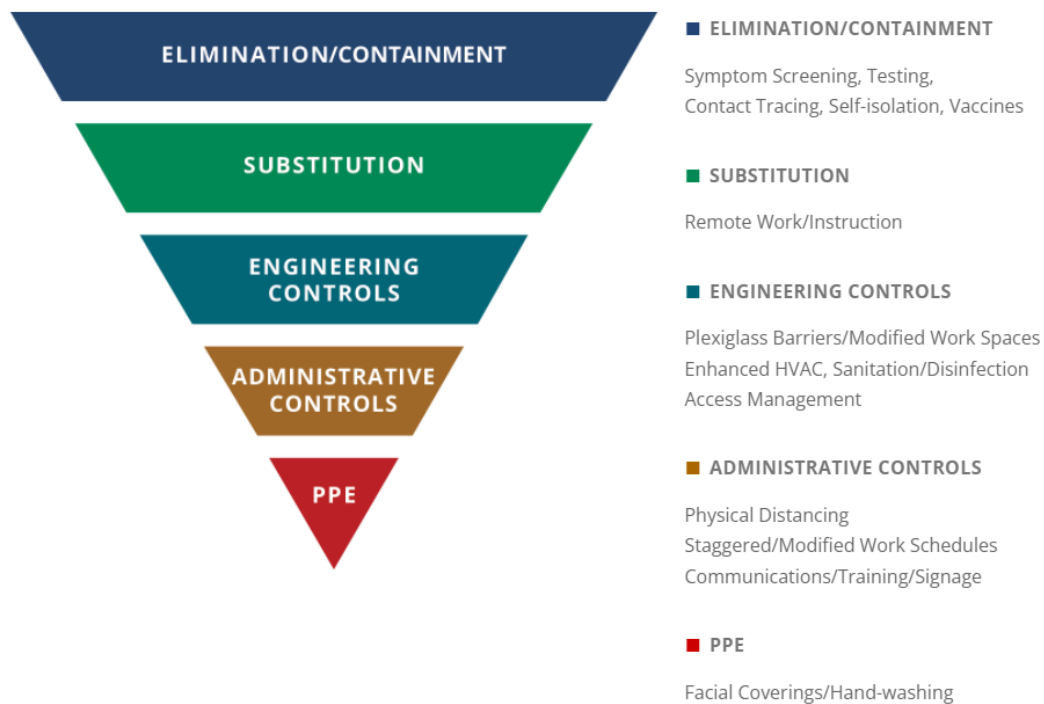
⁴⁴ World Health Organization. (2021). Transmission of SARS-CoV-2: Implications for Infection Prevention Precautions. <https://www.who.int/news-room/commentaries/detail/transmission-of-sars-cov-2-implications-for-infection-prevention-precautions>

Control	Use and effectiveness
Physical barriers	<p>Physical barriers separating individuals who must interact at close range are a now very common example of an engineering control.</p> <p>Engineering controls such barriers, partitions, ropes to separate employees from public or building occupants, for example, plexiglass screens, sneeze guards, theatre ropes and stanchions, hazard warning tape, etc.</p> <p>Do not eliminate hazards, but rather isolate individuals from them. Importantly engineering controls must be employed in concert with other controls.</p>
Working from Home	<p>Working from home is an effective control, however it may give rise to other potential wellbeing, cultural and productivity challenges.</p> <p>It is not possible for all roles to work from home. Most employees will be required to work on site at some point to effectively undertake their duties and connect with colleagues. Therefore the control itself may be unsuitable and unable to be applied for many roles or for this to be sustainable long-term.</p> <p>Where employees are working from home, their home is considered a workplace and we have a responsibility to eliminate or minimise the risks as much as reasonably practicable.</p>
Shift Change Procedures	<p>Change to shifts and work patterns, for example:</p> <ul style="list-style-type: none"> • Have people coming in half time or stagger the work hours. • Look at existing high-density areas and ask half of workers to work on site certain days with virtual meetings. • Stagger workdays and hours so only 1 out of 2 workspaces is occupied on any day or portion of day. • Stagger start times to avoid bottlenecks at the entrance. <p>May give rise to other potential wellbeing, cultural and productivity challenges.</p> <p>It is not possible for all roles to stagger. Some roles are required to work on site to effectively undertake their duties. Some roles need to connect with colleagues and wouldn't be as effective on split shifts. May require cleaning between shifts, etc.</p>
Discontinuing non-essential travel to locations with ongoing COVID-19 outbreaks.	<p>This control would only be effective until there is community transmission in Christchurch and/or it is possible to travel to Christchurch from areas with community transmission. Unlikely to be viable under the COVID-19 Protection Framework.</p>

Hierarchy of Controls

128. The application of the Hierarchy of Controls is a recognised approach to containment or mitigation of hazards and is fundamental to an occupational health and safety framework. The hierarchy of controls framework enables us to better understand the relative effectiveness of different strategies for risk reduction, and to help determine feasible and effective solutions.^{45,46} The model (illustrated in Figure 8 below) is represented as an upside-down pyramid, with five categories represented in descending order of effectiveness: elimination, substitution, engineering controls, administrative controls, and personal protective equipment.
129. The fundamental idea behind the hierarchy is that, while different controls are effective at minimising risk, those at the top of the model are more protective than those at the bottom. Employing the most effective methods first and most frequently can best minimize the risk of COVID-19 transmission.

Figure 8: Hierarchy of Controls



Source: Carnegie Mellon University (2022)⁴⁷

130. Elimination is the first and most effective control, and often involves physically removing a hazard. We can eradicate viruses by denying access to host cells so the virus is unable to

⁴⁵ The National Institute for Occupational Safety and Health. (2021). Hierarchy of Controls <https://www.cdc.gov/niosh/topics/hierarchy/default.html>

⁴⁶ Graham, T. (2020). The Hierarchy of Controls Is the Best Defense We Have Against COVID-19. April 22, 2020. <https://www.kpa.io/blog/the-hierarchy-of-controls-is-the-best-defense-we-have-against-covid-19>

⁴⁷ Carnegie Mellon University (2022) COVID-19 Updates <https://www.cmu.edu/coronavirus/return/mitigation2.html>

replicate. Denying access can be in the form of effective vaccinations and transmission prevention.^{48,49,50}

131. The vaccine programme has the ultimate goal of eliminating the virus from circulation within the community and have proven to be a very effective pharmacologic elimination strategy where available.⁵¹
132. Highly effective COVID-19 vaccines are available in New Zealand and there is high vaccination coverage.⁵² Enhancing vaccine effectiveness with a third dose (booster) will provide increased protection from COVID-19 due to the Omicron (B.1.1.529) variant.

Vaccination as a Key Control

133. When considering the role of vaccination in an overall COVID-19 control strategy, its impact and material benefit is significant. No other control currently available to us is as effective against reducing the effects of COVID-19 as vaccination.
134. Vaccination has been shown to significantly reduce the likelihood of getting infected, and also the likelihood of then transmitting the virus to others. It has also been shown to be materially effective in reducing the severity of the symptoms associated with the virus, including the incidence of hospitalisation and death.
135. Vaccine Pass requirements are key to reducing:
 - 135.1. Likelihood of our workers becoming infected with COVID-19 in the course of their work;
 - 135.2. Likelihood of our workers infecting someone else with COVID-19 in the course of their work; and
 - 135.3. Severity of the illness if anybody is infected despite best efforts being made to avoid that happening.
136. Clinical trials have found that the Pfizer vaccine gave 95% protection against the symptoms of COVID-19.⁵³

“A consistently high efficacy (between 90 and 100 percent) was observed in the clinical trials across age groups, sex, race, ethnicity and people with underlying medical conditions.

⁴⁸ Spigarelli, C. (2020). Understanding the Hierarchy of Controls Through A Pandemic.

⁴⁹ Ontario Agency for Health Protection and Promotion (Public health Ontario). (2021). Interim IPAC recommendations for use of personal protective equipment for care of individuals with suspect or confirmed COVID-19. Toronto, ON: Queens’s Printer for Ontario; 15 December 2021.

⁵⁰ Graham, T. (2020). The Hierarchy of Controls Is the Best Defense We Have Against COVID-19. April 22, 2020.

<https://www.kpa.io/blog/the-hierarchy-of-controls-is-the-best-defense-we-have-against-covid-19>

⁵¹ Neil J. S. and Donald K. M. (2021). Applying the Hierarchy of Controls: What Occupational Safety Can Teach us About Safely Navigating the Next Phase of the Global COVID-19 Pandemic. *Frontiers Public Health*. 2021; 9: 747894.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8602064/>

⁵² Vaccines can also be interpreted as an Administrative control and not rated as effective because compliance is necessary for administrative controls to be effective. In New Zealand 94% of the eligible population have had their first dose and 91% have had their second dose.

⁵³ Ministry of Health. (2021). COVID-19: Vaccine effectiveness and protection. (9 December 2021).

<https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-vaccines/covid-19-vaccine-effectiveness-and-protection#:~:text=The%20clinical%20trials%20performed%20on,effective%20after%20only%20one%20dose.>

*This means after getting two doses of the Pfizer vaccine, more than 9 out of 10 people are protected against COVID-19 regardless of their age, health status or ethnic group.*⁵⁴

137. While the data is clear that vaccines protect people from the effects of COVID-19, research is ongoing to determine whether a vaccinated person could still transmit the virus to someone else. The Ministry of Health has identified that we must assume there is still a risk of transmission. However, reducing the number of people with symptoms will help to control the spread of the virus because fewer people will be producing large quantities of virus and spreading it, for example by coughing.
138. A number of international studies have shown that vaccination leads to a significant reduction in the rate of transmission of SARS-CoV-2.⁵⁵ Vaccines therefore protect not only those who are vaccinated, but those who cannot get vaccinated as well. For example:
 - 138.1. Preliminary findings from the UK's immunisation programme show that the odds of new SARS-CoV2 infections in the community reduced by 70% after two doses of the Pfizer vaccine.
 - 138.2. Similarly, the national vaccination campaign in Israel has resulted in a 77% drop in COVID-19 cases following booster vaccination of the elderly after two doses of the Pfizer vaccine.
 - 138.3. Several studies have investigated the effect of two doses of the Pfizer vaccine against viral infection. These studies consistently found that vaccination significantly reduced the rate of viral infections in the observed cohorts.⁵⁶
139. Larger studies performed in situations with different levels of associated infection and prevention control measures (IPC) in fully vaccinated cohorts are required to understand the extent to which vaccination prevents SARS-CoV-2 transmission.⁵⁷
140. Vaccination against COVID-19 represents a significant opportunity to assist in bringing the impact of the disease under control. The proportion of a population that gets vaccinated – can also influence vaccine effectiveness. When a large enough proportion of the population is vaccinated, herd immunity begins to come into play.

*In the context of global pandemic and the continuous emergence of SARS-CoV-2 variants, accelerating vaccination and improving vaccination coverage is still the most important and urgent matter, and it is also the final means to end the pandemic.*⁵⁸

141. Vaccinations play a key role in managing the risk of COVID-19 in the workplace and therefore provide an effective way to mitigate the risk to business continuity and support the continuing provision of our services.

⁵⁴ Ministry of Health. (2021). COVID-19: Vaccine effectiveness and protection. (9 December 2021). Page 2

⁵⁵ Ministry of Health. (2021). COVID-19 Science Updates: COVID-19 vaccines and their effect on viral transmission. (7 May 2021). https://www.health.govt.nz/system/files/documents/pages/science_updates_7_may_2021.pdf

⁵⁶ Ministry of Health. (2021). COVID-19 Science Updates: COVID-19 vaccines and their effect on viral transmission. https://www.health.govt.nz/system/files/documents/pages/science_updates_7_may_2021.pdf

⁵⁷ Ministry of Health. (2021). COVID-19 Science Updates: COVID-19 vaccines and their effect on viral transmission. https://www.health.govt.nz/system/files/documents/pages/science_updates_7_may_2021.pdf

⁵⁸ Liu, Q., Qin, C., Liu, M. et al. (2021). Effectiveness and safety of SARS-CoV-2 vaccine in real-world studies: a systematic review and meta-analysis. *Infect Dis Poverty* 10, 132. (2021). <https://doi.org/10.1186/s40249-021-00915-3>

142. Without vaccination we are reliant on existing control measures that are not as effective and may not be sustainable or realistic over time.
143. Government guidance (released 27 November 2021) confirmed that local government can determine whether a public facility or service can implement a vaccination requirement, and that it is possible to do so if a) a risk assessment has been completed, and b) the risk assessment determines the risk is unacceptably high for staff and or customers without vaccine pass requirements.

144. Te Kawa Mataaho Public Service Commission guidance (2021) identifies:

“As a general principle, agencies [public service agencies] should require the use of a Vaccine Pass as a condition of entry for visitors, (other than recipients of a service) including for contractors to the workplace.”⁵⁹

⁵⁹ Te Kawa Mataaho Public Service Commission. (2021). Public Service workforce guidance for the COVID-19 Protection Framework. <https://www.publicservice.govt.nz/resources/public-service-workforce-guidance-for-the-covid-19-protection-framework/?e6967=6975-vaccine-passes-and-access-to-public-services>

Residual Risk Score

145. The residual risk level is determined by looking at the likelihood and consequence of infection if a vaccine pass was used alongside other controls.

Our **Inherent Risk** is illustrated below (See Section: Inherent Risk Score, page 27 for discussion on this).

		Consequence				
		Insignificant	Minor	Moderate	Major	Severe
Likelihood	Almost certain	Medium	High	High	Extreme	Extreme
	Likely	Medium	Medium	High	High	Extreme
	Possible	Low	Medium	Medium	High	High
	Unlikely	Low	Low	Medium	High	High
	Rare	Low	Low	Medium	Medium	High

Unvaccinated worker/person transmitting to unvaccinated worker/person

Vaccinated worker/person transmitting to unvaccinated worker/person

Essential service team contract COVID-19

Vaccinated worker/person transmitting to vaccinated worker/person

Unvaccinated worker/person transmitting to vaccinated worker/person

146. The residual risk score indicates that a vaccine pass and a fully vaccinated workforce would offer a significant mitigation of the risks presented by COVID-19 when combined with all other current controls in place.

- 146.1. The **Extreme risk** of an Unvaccinated worker/person transmitting to unvaccinated worker/person would be eliminated
- 146.2. The **High risk** of a Vaccinated worker/person transmitting to unvaccinated worker/person would be eliminated
- 146.3. The **High risk** of a Unvaccinated worker/person transmitting to vaccinated worker/person would be eliminated
- 146.4. The Medium risk of Vaccinated worker/person transmitting to vaccinated worker/person would remain
- 146.5. The likelihood that an Essential Team contracts COVID-19 would be reduced

		Consequence				
		Insignificant	Minor	Moderate	Major	Severe
Likelihood	Almost certain	Medium	High	High	Extreme	Extreme
	Likely	Medium	Medium	High	High	Extreme
	Possible	Low	Medium	Medium	High	High
	Unlikely	Low	Low	Medium	High	High
	Rare	Low	Low	Medium	Medium	High

Vaccinated worker/person transmitting to vaccinated worker/person

Essential Services team contract COVID-19

Conclusion

147. Through our assessment of all information available it became evident that the best way to protect our workers and the community we serve, is to introduce a vaccination requirement alongside our other controls.
148. Vaccination is the only control currently known to reduce the seriousness of consequences if infected, the likelihood of infection and likelihood of transmission if infected.
149. Reliance on the less effective controls as substitutes to vaccination requirements will potentially limit our ability to keep our workers and others safe. While most of our current control strategies are necessary, few are sufficient.⁶⁰
150. Due to the potentially serious consequences associated with COVID-19, any level of risk, even low risk, needs to be addressed and reduced.
151. Wherever possible, alternative offerings of services are already in place or will be further explored to better enable non-vaccinated residents to continue to access Council services.
152. A Council vaccination mandate will mitigate the risks to business continuity and provision of essential services to our city. The consequences of our failure to deliver essential services could have serious health, economic and environmental consequences. Reducing risks to business continuity and provision of essential services, including risk of service closures or reduction, will also reduce the risks to job security for our employees.
153. Based on this risk assessment, the Christchurch City Council has determined that anyone eligible to be vaccinated entering a Christchurch City Council workplace will require the My Vaccine Pass. This requirement, includes all workers, elected members, contractors and other third parties.

⁶⁰ Sehgal N J and Milton D K. (2021). Applying the Hierarchy of Controls: What Occupational Safety Can Teach us About Safely Navigating the Next Phase of the Global COVID-19 Pandemic. *Front. Public Health* 9:747894.
<https://www.frontiersin.org/articles/10.3389/fpubh.2021.747894/full#B11>

Appendix 1. Feedback from Staff

154. The Council has sought feedback from staff on its potential approach to COVID-19, this included:
 - 154.1. Staff Survey to gauge uptake of the COVID-19 vaccine and concerns (October 2021)
 - 154.2. Feedback on proposed policy approach to vaccination (November 2021)
 - 154.3. Feedback of draft vaccination policy (December 2021)
155. The October 2021 survey indicated that 93% of respondents had received at least the first dose of the vaccine. 650 respondents suggested additional controls.
156. The November 2021 feedback reflected a range of views ranging from a small number (11 submissions) raising concerns about the lack of efficacy of the vaccine and people's right to choose, to concerns about co-workers not being vaccinated and the desire for mandatory vaccination for all workers.
157. The December 2021 feedback on the draft COVID-19 Vaccination Policy was sought from workers and elected members from 14 - 17 December 2021. 427 responses were received, which is around a 15% response rate.
158. 278 respondents (71%) indicated that they had concerns about working in an environment where unvaccinated people may be present, while 290 (76%) reported that they believe that their role should be conducted by a vaccinated person.
159. A significant amount of written feedback was received across all three questions asked. A number of key themes reoccurred throughout the feedback on each of the questions:
 - 159.1. The draft policy, the Council's current approach to vaccine requirements, and the controls in place to manage the risk of COVID-19 across the organisation do not provide the level of protection that most of our staff expect in the workplace. The majority of respondents who provided feedback in this area felt that there was not enough protection being provided to staff, particularly those who work in the Civic Offices, where a vaccine certificate is not currently required for working from the office. Others felt that the public were being afforded a higher level of protection than staff, with a lack of consistency in how the rules and vaccine requirements have been applied across our facilities.
 - 159.2. There is a high degree of concern about working in the office due to the higher risk of exposure to COVID-19 while there is no vaccine requirement in place for staff in the Civic Offices. Staff members who do not work in the Civic Offices are concerned that needing to come in for meetings will increase their risk of exposure, and the risk of exposing their teams who are working in vaccine mandated facilities where requirements are in place to protect our residents and communities.
 - 159.3. The draft policy and risk assessments have not gone far enough in considering the risk to the wider Council 'family', particularly where members of staff or their family members have health conditions that make them more vulnerable to COVID-19 or have children who are too young to be vaccinated.

- 159.4. The draft policy appears to be putting the onus on vaccinated staff to protect themselves further, despite them feeling that they have already done the right thing and followed the public health advice on the best way to protect themselves, their colleagues, and their families.
160. There are some staff who feel that it would not be appropriate for the Council to apply a blanket vaccine requirement across all roles like some other councils have. These respondents regularly cited freedom of choice and concerns about the health impacts and efficacy of the vaccine as the reason for taking this view.

Appendix 2. Catering for unvaccinated residents

161. The Council is conscious that given the proportion of the Canterbury population that is vaccinated (93% fully vaccinated, and 97% partially vaccinated), the best community use and lowest overall financial cost to ratepayers is achieved by requiring a vaccine pass to access some of its facilities. Conversely, allowing unvaccinated people to use facilities would require limiting numbers or closing certain facilities (i.e. gyms), which would incur higher costs to all ratepayers.
162. Wherever possible we are working to provide alternative means of access to the services provided at the facilities that require vaccine passes. For instance, there are a number of library resources and fitness classes available to residents online. We are continuing to update these virtual services by adding more content to them and making it easier to access.
163. Digital and non-contact services available for vaccinated and non-vaccinated include:
 - 163.1. Free Wi-Fi available outside all libraries
 - 163.2. Digital content available 24/7, including resources to meet recreation and information needs (via the library website <https://my.christchurchcitylibraries.com>)
 - 163.3. Fingertip Library operating 8am to 6pm Monday to Friday; and 9.30am to 5pm Saturdays for contact by phone or email. The Fingertip Library is our library specific contact centre.
 - 163.4. Selected online programmes and activities available via the Library website
 - 163.5. Book a librarian reference service available
 - 163.6. Libraries to help people get Vaccine Passes, as needed using the non-contact channels above (will explore alternative solutions for those not connected digitally)
 - 163.7. Mobile and Outreach
 - 163.8. “Ready Reads” click and collect service is available from selected libraries.
 - 163.9. Group Fitness classes are available via Facebook.
 - 163.10. 6312 items in the Christchurch Art Gallery Collection Online
164. There are also four bookable Council-operated community facilities that will not require a vaccine pass – Abberley Park Hall, Harvard Lounge, Richmond Community Cottage and South New Brighton. In line with Government guidelines, we will undertake additional cleaning between groups and there are capacity constraints. The additional cleaning will attract an additional charge.

Appendix 3: Definitions

TERM	DEFINITION
Council	means the Christchurch City Council
Medically exempt	Means a person who has a COVID-19 vaccination exemption granted by the Director-General of Health under clause 9B of the COVID-19 Public Health Response (Vaccinations) Order 2021. Note that a medical exemption is only valid for up to six months.
NZ Pass Verifier	a tool provided by the Government that enables a Vaccine Pass to be verified as an authentic record of vaccination by scanning the QR code on the Vaccine Pass.
Person conducting a business or undertaking (PCBU)	Has the same meaning as in the Health and Safety at Work Act 2015 .
Personal information	As defined by the Privacy Act 2020 means information about an identifiable individual. Note that the Privacy Commissioner has determined that a person’s vaccination status is personal information.
Risk Assessment	An assessment of the risks of exposure, transmission and infection, and the potential consequences. It also considered the efficacy of available controls. The risk assessment was based on the role assessments, expert advice and relevant research.
Role Assessment	An assessment of a role to identify the risk of exposure to COVID-19 for workers and those they come in to contact with, role assessments are undertaken in consultation with managers and staff.
Vaccinated / Fully vaccinated	Means a person who has received all of the doses of a COVID-19 vaccine or combination of COVID-19 vaccines specified in the first column of the table in Schedule 3 of the COVID-19 Public Health Response (Vaccinations) Order 2021, administered in accordance with the requirements specified for that vaccine or combination of vaccines in the second column of that table, or as varied.
Vaccine Pass	Means a COVID-19 vaccination certificate (My Vaccine Pass) issued under the COVID-19 Public Health Response (COVID-19 Vaccination Certificate) Order 2021.
Worker	Has the same meaning as defined in the Health and Safety at Work Act 2015, being any individual who carries out work in any capacity for a PCBU, including work as- <ul style="list-style-type: none"> • an employee; or • a contractor or subcontractor; or

	<ul style="list-style-type: none">• an employee of a labour hire company who has been assigned to work in the business or undertaking; or• an outworker (including a home worker); or• an apprentice or a trainee; or• a person gaining work experience or undertaking a work trial; or• a volunteer worker; or• a person of a prescribed class.
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