ACT Government | ACT Health

Our reference: **FOI20/27**

Dear

DECISION ON YOUR ACCESS APPLICATION

I refer to your application under section 30 of the *Freedom of Information Act 2016* (FOI Act) received by ACT Health Directorate (ACTHD) on Tuesday 23 June 2020.

This application requested access to:

> *"For the previous four weeks,*
>
> *a. all correspondence, emails , briefs, and written communication from Dr Kerryn Coleman Chief Health Officer, ACT Health (or an Executive Assistant or Officer) to the Chief Minister, Attorney-General and/or the Minister for Health relating to restrictions on gambling during Covid-19.*
>
> *b. any advice provided to ACT Health from the Australian Health Protection Principle Committee in relation to gambling.*
>
> *c. Any responses provided to ClubsACT or Canberra Community Clubs by ACT Health or Dr Kerryn Coleman Chief Health Officer (or an Executive Assistant or Officer) in relation to reopening plans/submissions, emails/letters sent seeking clarification of restriction elements or requests for meetings. "*

As confirmed, the '*previous four weeks*' period is considered from 29 May 2020.

I am an Information Officer appointed by the Director-General of ACT Health Directorate (ACTHD) under section 18 of the FOI Act to deal with access applications made under Part 5 of the Act. ACTHD was required to provide a decision on your access application by **Tuesday 11 August 2020**.

I have identified 13 documents holding the information within the scope of your access application. This is outlined in the schedule of documents included at Attachment A to this decision letter.

Decisions

I have decided to:

- grant part access to ten documents; and
- refuse access to three documents.

My access decisions are detailed further in the following statement of reasons and the documents released to you are provided as Attachment B to this letter.

In reaching my access decision, I have taken the following into account:

- The FOI Act;
- The contents of the documents that fall within the scope of your request; and
- The *Human Rights Act 2004*.

Partial Access

I have decided to grant partial access to ten documents at reference 1-3 and 7-13.

Public Interest Factors Favouring Disclosure

The following factors were considered relevant in favour of the disclosure of the documents:

- Schedule 2.1(a)(i) promote open discussion of public affairs and enhance the government's accountability; and
- Schedule 2.1(a)(viii) reveal the reason for a government decision and any background or contextual information that informed the decision.

Public Interest Factors Favouring Non-Disclosure

The following factors were considered relevant in favour of the non-disclosure of the documents:

- Schedule 2.2(a)(ii) prejudice the protection of an individual's right to privacy, or any other right under the *Human Rights Act 2004;* and
- Schedule 2, 2.2(a)(x) prejudice intergovernmental relations.

Documents at reference 1 and 2 contain information that is partially comprised of Cabinet information. The information is therefore taken to be contrary to the public interest to release under Schedule 1.6 (1) Cabinet Information (d) the disclosure of which would reveal any deliberation of Cabinet. I determined the information identified is contrary to the public interest and I have decided not to disclose this information.

Ten of the identified documents contain information that I consider, on balance, to be contrary to the public interest to disclose under the test set out in section 17 of the Act as the information contained in these folios is partially comprised of personal information, such as email addresses and mobile contact numbers of both government and non-government employees.

Documents at reference 7-12 include information that was considered as part of a deliberative process of the Australian Health Protection Principal Committee and the release of this information would prejudice the intergovernmental relationship between the ACT Government and the Department of Health. Some attachments that are part of the AHPPC meeting papers are publicly available publications and have been included in this response as relevant information.

Additionally, documents at reference 3, 7 and 9 include information that is out of the scope of your application.

Refuse Access

I have decided not to grant access to three documents at reference 4-6. The information contained in this document is comprised of Cabinet information and I therefore considered contrary to the public interest to release, under Schedule 1, 1.6 (1) Cabinet Information.

Charges

Processing charges are not applicable to this request.

Disclosure Log
Under section 28 of the FOI Act, ACTHD maintains an online record of access applications called a disclosure log. The scope of your access application, my decision and documents released to you will be published in the disclosure log not less than three days but not more than 10 days after the date of this decision. Your personal contact details will not be published.

https://www.health.act.gov.au/about-our-health-system/freedom-information/disclosure-log.

Ombudsman review
My decision on your access request is a reviewable decision as identified in Schedule 3 of the FOI Act. You have the right to seek Ombudsman review of this outcome under section 73 of the Act within 20 working days from the day that my decision is published in ACT Health's disclosure log, or a longer period allowed by the Ombudsman.

If you wish to request a review of my decision you may write to the Ombudsman at:

The ACT Ombudsman
GPO Box 442
CANBERRA ACT 2601
Via email: ACTFOI@ombudsman.gov.au
Website: ombudsman.act.gov.au

ACT Civil and Administrative Tribunal (ACAT) review
Under section 84 of the Act, if a decision is made under section 82(1) on an Ombudsman review, you may apply to the ACAT for review of the Ombudsman decision. Further information may be obtained from the ACAT at:

ACT Civil and Administrative Tribunal
Level 4, 1 Moore St
GPO Box 370
Canberra City ACT 2601
Telephone: (02) 6207 1740
http://www.acat.act.gov.au/

Further assistance
Should you have any queries in relation to your request, please do not hesitate to contact the FOI Coordinator on (02) 5124 9831 or email HealthFOI@act.gov.au.

Yours sincerely

Meg Brighton
Deputy Director-General
Health Systems, Policy and Research

11 August 2020

ACT Government | ACT Health

FREEDOM OF INFORMATION SCHEDULE OF DOCUMENTS

Please be aware that under the *Freedom of Information Act 2016*, some of the information provided to you will be released to the public through the ACT Government's Open Access Scheme. The Open Access release status column of the table below indicates what documents are intended for release online through open access.
Personal information or business affairs information will not be made available under this policy. If you think the content of your request would contain such information, please inform the contact officer immediately.
Information about what is published on open access is available online at: http://www.health.act.gov.au/public-information/consumers/freedom-information

APPLICANT NAME	WHAT ARE THE PARAMETERS OF THE REQUEST	FILE NUMBER
[redacted]	*"For the previous four weeks,* *a. all correspondence, emails, briefs, and written communication from Dr Kerryn Coleman Chief Health Officer, ACT Health (or an Executive Assistant or Officer) to the Chief Minister, Attorney-General and/or the Minister for Health relating to restrictions on gambling during Covid-19.* *b. any advice provided to ACT Health from the Australian Health Protection Principle Committee in relation to gambling.* *c. Any responses provided to ClubsACT or Canberra Community Clubs by ACT Health or Dr Kerryn Coleman Chief Health Officer (or an Executive Assistant or Officer) in relation to reopening plans/submissions, emails/letters sent seeking clarification of restriction elements or requests for meetings. "*	FOI20/27

Ref Number	Page Number	Description	Date	Status Decision	Factor	Open Access release status
a. all correspondence, emails, briefs, and written communication from Dr Kerryn Coleman Chief Health Officer, ACT Health (or an Executive Assistant or Officer) to the Chief Minister, Attorney-General and/or the Minister for Health relating to restrictions on gambling during Covid-19.						

1.	1-36	Email: Cabinet Number Request – 20-350 – Chief Health Officer Directions- Easing of Restrictions- Stage 2 (Step 2.2) with attachments	04/06/2020	Partial release	Schedule 2, 2.2(a)(ii) prejudice the protection of an individual's right to privacy or any other right under the *Human Rights Act 2004;* Schedule 1, 1.6 Cabinet information	Yes
2.	37-66	Email: Cabinet Number Request – 20-351 – Chief Health Officer Directions- Easing of Restrictions- Stage 3 with attachment	04/06/2020	Partial release	Schedule 2, 2.2(a)(ii) Schedule 1, 1.6	Yes
3.	67-90	Email: FW: COR20/15525 – Brief to Minister for Health – Stage 2.2 Easing of Restrictions- 19 June 2020 with attachments Please note: The Human Rights Act Assessment attachment has been removed as out of scope	19/06/2020	Partial release	Schedule 2, 2.2(a)(ii) Out of scope	Yes
4.	91-101	Recommendations 20/322 Chief Health Officer Directions- Easing of Restrictions – Stage 2.2	Signed by CHO on 09/06/2020	Not for release	Schedule 1, 1.6	Yes
5.	102-108	Recommendations 20/322 Chief Health Officer Directions- Easing of Restrictions – Stage 2.2	Signed by CHO on 10/06/2020	Not for release	Schedule 1, 1.6	Yes

6.	109-123	For Security and Emergency Management Committee of Cabinet	Signed by a/g CHO on 25/06/2020	Not for release	Schedule 1, 1.6	Yes
b. any advice provided to ACT Health from the Australian Health Protection Principle Committee in relation to gambling.						
7.	124-176	Email: Updated FINAL- AHPPC meeting papers for Friday 5 June with attachments Please note: The following out of scope attachments have not been included: Amendments to the 14-day self-quarantine measure for air crew List of cruise ships and cruise ship restrictions attachment Revised advice for residential ages care facilities International traveller's hotel quarantine request form and cross border travel for international travellers in quarantine	05/06/2020	Partial release	Schedule 2, 2.2(a)(ii) Out of scope Schedule 2, 2.2(a)(x) prejudice intergovernmental relations	Yes
8.	177-197	Email: FOR INFO: 20.06.05 AHPPC COVID-19 TC Outcomes AND Lancet article on distancing and face masks with attachments	05/06/2020	Partial release	Schedule 2, 2.2(a)(ii) Schedule 2, 2.2(a)(x)	Yes
9.	198-229	Email: ACTION – AHPPC meeting papers for Monday 8 June with attachments	07/06/2020	Partial release	Schedule 2, 2.2(a)(ii) Out of scope Schedule 2, 2.2(a)(x)	Yes

10.	230-235	Email: FOR INFO: 20.06.08 AHPPC Emergency TC COVID 19 Outcomes with attachment	08/06/2020	Partial release	Schedule 2, 2.2(a)(ii) Schedule 2, 2.2(a)(x)	Yes
11.	236-245	Email: URGENT ACTION: Please flag by 6pm if you have any issues with the attached papers with attachments	09/06/2020	Partial release	Schedule 2, 2.2(a)(ii) Schedule 2, 2.2(a)(x)	Yes
12.	246-256	Email: NOTING: Papers on Principles for implementation of Stage 3 & Physical Distancing and Density Restrictions with attachments	10/06/2020	Partial release	Schedule 2, 2.2(a)(ii) Schedule 2, 2.2(a)(x)	Yes
c. *Any responses provided to ClubsACT or Canberra Community Clubs by ACT Health or Dr Kerryn Coleman Chief Health Officer (or an Executive Assistant or Officer) in relation to reopening plans/submissions, emails/letters sent seeking clarification of restriction elements or requests for meetings.*						
13.	257-260	Email: FW: Walk-Through of Clubs	09/06/2020	Partial release	Schedule 2, 2.2(a)(ii)	Yes
Total Number of Documents						
13.						

Pond, Aleks (Health)

From:	Elliott, Tracey
Sent:	Thursday, 4 June 2020 2:50 PM
To:	Chicco, Dee (Health)
Cc:	Cabinet Office; Cameron, Susan; McEntee, Eileen; Matthews, StaceyN; Morris, Ben
Subject:	Cabinet Number Request - 20-350 - Chief Health Officer Directions - Easing of Restrictions - Stage 2 (Step 2.2)
Attachments:	GOVERNMENT & STAKEHOLDER RELATIONS - Government & Assembly Matters - Submission - Chief Health Officer Directions - Easing of Restrictions - Stage 2 (Step 2.2).tr5

UNCLASSIFIED Sensitive: Cabinet

Hi Dee

As requested your Cabinet number is *20-350 - Chief Health Officer Directions - Easing of Restrictions - Stage 2 (Step 2.2)* scheduled for 9 June 2020.

Note that early consultation should be undertaken with:
- Stacey Matthews, Policy and Cabinet Division, CMTEDD
- Ben Morris, Finance and Budget Division, Treasury (cc Susan Cameron and Eileen McEntee).

In addition, if your Cabinet paper involves the drafting of legislation, early consultation should be undertaken with the:
- Parliamentary Counsel's Office via mary.toohey@act.gov.au
- JACS Human Rights Scrutiny team at JACSScrutinyTeam@act.gov.au
- JACS LPP Criminal Law team at JACSLPPCriminal@act.gov.au (if the Bill covers any offences).

All Cabinet items are now subject to new Open Access requirements as described in section 23 of the *Freedom of Information Act 2016*.
- All Cabinet papers should be drafted using fresh templates from the Cabinet Resources SharePoint site. Templates and the Open Access Assessment attachment are all available.
- Templates saved on shared drives and personal drives are out of date and **should not be used**.
- Please contact Cabinet Office if you have any questions regarding the Open Access requirements.

Many thanks

Tracey Elliott | Cabinet Administrative Officer | Cabinet, Assembly and Government Business
Phone 02 6207 6406 | Email tracey.elliott@act.gov.au
Chief Minister, Treasury and Economic Development Directorate | ACT Government
Level 5 Canberra Nara Centre | GPO Box 158 Canberra ACT 2601 | www.act.gov.au

I acknowledge the traditional custodians of the ACT the Ngunnawal people, and their continuing connection to land and community. I pay my respect to them, and to the Elders both past and present

Cabinet number request

PLEASE NOTE:

1. *After approval to develop an item for Cabinet consideration is given by the relevant portfolio minister(s), this form should be submitted by the directorate Cabinet Liaison Officer via WhoGCM (CAB2018/49).*
2. *Once lodged on WhoGCM, please email CabinetOffice@act.gov.au to notify that a new request has been lodged for actioning.*
3. *Once a Cabinet number has been allocated, appropriate security must be applied to all material relating to the Cabinet item. To facilitate this, drafters should be provided with the following advice.*
   a. *Cabinet documents must not be emailed – instead, secure electronic transmission must be undertaken via directorate electronic document record management systems (EDRMS) or secure drives.*
   b. *The* **SENSITIVE: CABINET** *DLM must be applied to any email communication in relation to Cabinet items.*
4. *All attendee requests must be made via the relevant portfolio minister's office. The Chief Minister's office will settle attendees with ministerial offices in the weeks before the Cabinet/subcommittee meeting.*

Expected title — Chief Health Officer Directions - Easing of Restrictions - Stage 2 (Step 2.2)

Meeting type — Cabinet

Paper type — Submission

Minister — Rachel Stephen-Smith MLA

Ministerial title — Minister for Health

Requested Cabinet date — 09/06/2020

Priority set by responsible Minister

** Further information on categories is provided here*

Category 1 — Once set by the responsible minister, Category 1 papers *are not allowed to be rescheduled* without discussion between the relevant Minister's office and the Chief Minister's office.

- ☐ **Budget**
- ☒ **Government priorities**

Category 2 — Normal Cabinet business – select type of business:

- ☐ **Government business**
- ☐ **Community engagement**
- ☐ **Cabinet business**

Category 3 — Appointments and Cabinet business for noting only

- ☐ **Cabinet business for noting**
- ☐ **Appointments**

Responsible directorate — ACT Health Directorate

Descriptor & purpose — Update Cabinet on Easing of Restrictions – Stage 2 (Step 2.2)

Is restricted circulation required? — No

** Circulation will only be restricted in exceptional circumstances. Please contact Cabinet Office for guidance before submission of this form.*

Is there a timing imperative?	Yes – required to go to Cabinet on 9 June to ease restrictions in the ACT

** Provide details if a Cabinet decision is required by a particular date (for items such as intergovernmental agreements or scheduled introduction of a Bill). For appointments, provide expiry dates and if there is a need for Standing Committee consultation.*

Projected Assembly date	N/A

Minister's office clearance by:	
Adviser name	Catherine Bergin
Title	Chief of Staff
Drafting/contact officer(s) is:	
Name	Kerryn Coleman
Title	Chief Health Officer
Phone	
Email	Kerryn.Coleman@act.gov.au

Overview of Cabinet categories

Category 1

- Once a Cabinet number has been allocated and the item appears on the forward forecast, Category 1 items will not be allowed to be rescheduled without a discussion between the relevant minister's office and the Chief Minister's office.
- The intention is for directorates and the relevant minister's office to commit to delivering the Cabinet item by an achievable date.
- Category 1 recognises these items as important and needing to follow a full Cabinet circulation process (including circulation for both exposure draft and final review), with time for ministers to read, consider and discuss them in Cabinet.
  - **Budget**: All items relating to budget as well as submissions being provided in the budget context.
  - **Government priorities** *(previously Strategic Government Priorities):* This includes all submissions relating to the delivery of:
    - ... election commitments
    - ... the Parliamentary Agreement
    - ... all policy approvals for legislation
    - ... any submission relating to a Government process, plan, strategy.

Category 2

- These items are normal Cabinet business. They will generally be less time critical.
- To help focus ministers and directorates on the purpose of the submission, Category 2 items will be broken into specific headings.
  - **Government business**: Any submissions relating to the work of the Assembly such as:
    - government responses to Private Members Bills and committees, as well as Government responses to federal committees or external groups, including the Auditor-General; and
    - ministerial statements and Assembly Business Papers would also be considered here if necessary – assuming there is a reason why they cannot be considered by the appropriate Government Business Subcommittee.
  - **Community engagement**: Any submissions with community engagement that do not fall within the Category 1 heading. Examples of submissions in this category would be draft masterplans, local shopping centre upgrades, etc.
  - **Cabinet business**: General submissions that do not easily fall anywhere else.

Category 3

- These items are generally 'tick and flick' items that can be noted as a group, unless these is an exception.
  - **Cabinet business for noting**: Any submission that is only for noting, such as where a paper or response has already been submitted.
  - **Appointments.**

Pond, Aleks (Health)

From:	Elliott, Tracey on behalf of Cabinet Office
Sent:	Thursday, 4 June 2020 3:02 PM
To:	Chicco, Dee (Health)
Cc:	Cabinet Office; Cameron, Susan; McEntee, Eileen; Matthews, StaceyN; Morris, Ben
Subject:	Cabinet Number Request - 20-351 - Chief Health Officer Directions – Easing of Restrictions – Stage 3
Attachments:	GOVERNMENT & STAKEHOLDER RELATIONS - Government & Assembly Matters - Submission - Chief Health Officer Directions – Easing of Restrictions – Stage 3.tr5

UNCLASSIFIED Sensitive: Cabinet

Hi Dee

As requested your Cabinet number is *20-351 - Chief Health Officer Directions – Easing of Restrictions – Stage 3* scheduled for 3 July 2020.

Note that early consultation should be undertaken with:

- Stacey Matthews, Policy and Cabinet Division, CMTEDD
- Ben Morris, Finance and Budget Division, Treasury (cc Susan Cameron and Eileen McEntee).

In addition, if your Cabinet paper involves the drafting of legislation, early consultation should be undertaken with the:

- Parliamentary Counsel's Office via mary.toohey@act.gov.au
- JACS Human Rights Scrutiny team at JACSScrutinyTeam@act.gov.au
- JACS LPP Criminal Law team at JACSLPPCriminal@act.gov.au (if the Bill covers any offences).

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Phone 02 6207 6406 | Email tracey.elliott@act.gov.au
Chief Minister, Treasury and Economic Development Directorate | ACT Government
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Cabinet number request

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   b. *The* **SENSITIVE: CABINET** *DLM must be applied to any email communication in relation to Cabinet items.*
4. *All attendee requests must be made via the relevant portfolio minister's office. The Chief Minister's office will settle attendees with ministerial offices in the weeks before the Cabinet/subcommittee meeting.*

** Indicates guidance information*

Expected title Chief Health Officer Directions – Easing of Restrictions – Stage 3

Meeting type SEMC

Paper type Submission

Minister Rachel Stephen-Smith MLA

Ministerial title Minister for Health

Requested Cabinet date 03/07/2020

Priority set by responsible Minister

** Further information on categories is provided here*

Category 1 — Once set by the responsible minister, Category 1 papers *are not allowed to be rescheduled* without discussion between the relevant Minister's office and the Chief Minister's office.

- ☐ **Budget**
- ☐ **Government priorities**

Category 2 — Normal Cabinet business – select type of business:

- ☐ **Government business**
- ☐ **Community engagement**
- ☐ **Cabinet business**

Category 3 — Appointments and Cabinet business for noting only

- ☐ **Cabinet business for noting**
- ☐ **Appointments**

Responsible directorate ACT Health Directorate

Descriptor & purpose Update Cabinet on Easing of Restrictions - Stage 3

Category 2

- These items are normal Cabinet business. They will generally be less time critical.
- To help focus ministers and directorates on the purpose of the submission, Category 2 items will be broken into specific headings.
  - **Government business**: Any submissions relating to the work of the Assembly such as:
    - government responses to Private Members Bills and committees, as well as Government responses to federal committees or external groups, including the Auditor-General; and
    - ministerial statements and Assembly Business Papers would also be considered here if necessary – assuming there is a reason why they cannot be considered by the appropriate Government Business Subcommittee.
  - **Community engagement**: Any submissions with community engagement that do not fall within the Category 1 heading. Examples of submissions in this category would be draft masterplans, local shopping centre upgrades, etc.
  - **Cabinet business**: General submissions that do not easily fall anywhere else.

Category 3

- These items are generally 'tick and flick' items that can be noted as a group, unless these is an exception.
  - **Cabinet business for noting**: Any submission that is only for noting, such as where a paper or response has already been submitted.
  - **Appointments**.

Is restricted circulation required?	No ** Circulation will only be restricted in exceptional circumstances. Please contact Cabinet Office for guidance before submission of this form.*
Is there a timing imperative?	Yes ** Provide details if a Cabinet decision is required by a particular date (for items such as intergovernmental agreements or scheduled introduction of a Bill). For appointments, provide expiry dates and if there is a need for Standing Committee consultation.*
Projected Assembly date	N/A

Minister's office clearance by:	
Adviser name	Click or tap here to enter text.
Title	Click or tap here to enter text.

Drafting/contact officer(s) is:	
Name	Kerryn Coleman
Title	Chief Health Officer
Phone	
Email	Kerryn.Coleman@act.gov.au

Overview of Cabinet categories

Category 1

- Once a Cabinet number has been allocated and the item appears on the forward forecast, Category 1 items will not be allowed to be rescheduled without a discussion between the relevant minister's office and the Chief Minister's office.
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    - ... election commitments
    - ... the Parliamentary Agreement
    - ... all policy approvals for legislation
    - ... any submission relating to a Government process, plan, strategy.

Pond, Aleks (Health)

From:	Rad, Chadia (Health)
Sent:	Friday, 19 June 2020 12:27 PM
To:	Health Ministerial Liaison Officer
Cc:	Wijemanne, Naveen (Health)
Subject:	FW: COR20/15525 - Brief to Minister for Health - Stage 2.2 Easing of Restrictions - 19 June 2020
Attachments:	Clearance sheet - EBM COVID response and CHO.PDF; Brief to Minister - stage 2.2 easing - Attachment D.PDF; Brief to Minister - stage 2.2 easing - Attachment C.PDF; Brief to Minister - stage 2.2 easing - Attachment B.PDF; Brief to Minister - stage 2.2 easing - Attachment A.PDF; Brief to Minister for Health - Stage 2.2 Easing of Restrictions - 19 June 2020 copy.docx
Follow Up Flag:	Follow up
Flag Status:	Flagged
Categories:	Ange

UNCLASSIFIED

Hi team
Can you please TRIM this and confirm record number

Many thanks
Chadia

Chadia Rad | A/g Senior Director, Ministerial and Government Services
Phone: 5124 6216 | Mobile: [redacted] Email: Chadia.Rad@act.gov.au Communications and Government Relations, Office of the Director-General | ACT Health Directorate Level 5, 6 Bowes Street Phillip ACT 2606
health.act.gov.au

-----Original Message-----
From: McNeill, Laura (Health) <Laura.McNeill@act.gov.au> On Behalf Of ACT Health Office of the Chief Health Officer
Sent: Friday, 19 June 2020 12:18 PM
To: Wijemanne, Naveen (Health) <Naveen.Wijemanne@act.gov.au>; Rad, Chadia (Health) <Chadia.Rad@act.gov.au>
Cc: ACT Health Office of the Chief Health Officer <ACTHealthOCHO@act.gov.au>; Dal Molin, Vanessa (Health) <Vanessa.DalMolin@act.gov.au>
Subject: COR20/15525 - Brief to Minister for Health - Stage 2.2 Easing of Restrictions - 19 June 2020

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Hi Team,

I believe you are expecting this one. Urgent brief to Minister re Stage 2.2 restrictions.

Attachment TRIM refs below:

Record Number:COR20/15530
Title:Clearance sheet - EBM COVID response and CHO

Record Number:COR20/15529
Title:Brief to Minister - stage 2.2 easing - Attachment D

Record Number:COR20/15528
Title:Brief to Minister - stage 2.2 easing - Attachment C

Record Number:COR20/15527
Title:Brief to Minister - stage 2.2 easing - Attachment B

Record Number:COR20/15526
Title:Brief to Minister - stage 2.2 easing - Attachment A

Cheers
Laura

ACT Government | ACT Health

CORRESPONDENCE CLEARANCE

Subject: **Brief to Minister for Health - Stage 2.2 Easing of Restrictions - 19 June 2020 copy**

Number: **COR20/15525** Date Due: ....

Director-General - ACT Health: .... Date: ....

Deputy Director-General - Health Systems, Policy and Research: .... Date: ....

Chief Health Officer: .... Date: 19/6/20

Coordinator-General - Mental Health and Wellbeing: .... Date: ....

Professional Leads: .... Date: ....

Contextually Correct ☐	Grammatically Correct ☐	Spell Checked ☐

Executive Group Manager ____________________ Date: ....

Executive Branch Manager: ____________________ Date: 19/6

Senior Director / Director - Area name: ____________________ Date: ....

Manager - Area name: ____________________ Date: ....

Communications - ACT Health Directorate: .... Date: ....

Ministerial and Government Services - ACT Health Directorate: .... Date: ....

Other: .... Date: ....

MINISTERIAL BRIEF

ACT Health Directorate

UNCLASSIFIED

To:	Minister for Health	Tracking No.: MIN20/1122
CC:	Kylie Jonasson, Director-General, ACT Health Rebecca Cross, Coordinator General, Whole of Government (Non-Health) Response to COVID-19 Meg Brighton, Deputy Director-General	
From:	Dr Kerryn Coleman, ACT Chief Health Officer	
Subject:	Stage 2.2 Easing of Restrictions	
Critical Date:	19 June 2020	
Critical Reason:	Stage 2.2 Easing of Restrictions came into effect from 12 noon on 19 June 2020	

Purpose

To brief you on the Chief Health Officer's decision to give effect to Stage 2.2 easing of restrictions, as considered by Cabinet on 11 June 2020.

Recommendations

That you:

1. Note the information contained in this brief;

   Noted / Please Discuss

2. Note the COVID Checkpoint Monitoring Report at Attachment A to this brief;

   Noted / Please Discuss

3. Note the signed Public Health (Restricted Activities – Gatherings, Business or Undertakings) Emergency Direction 2020 (No. 3) at Attachment B to this brief;

   Noted / Please Discuss

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4. Note the Human Rights Act Assessment at Attachment C to this brief;

Noted / Please Discuss

5. Note the COVID Checkpoint 'Check up' at Attachment D to this brief; and

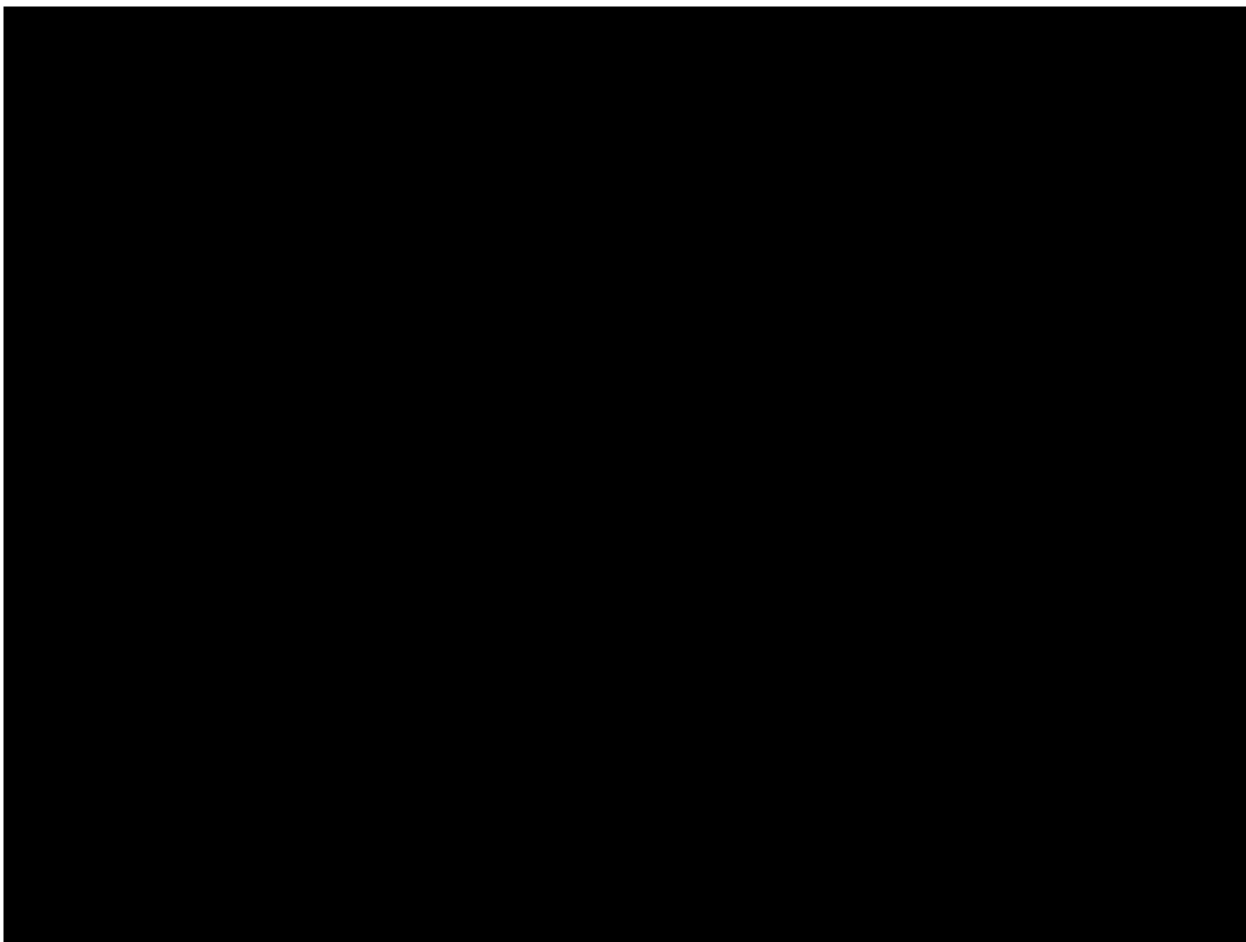
Noted / Please Discuss

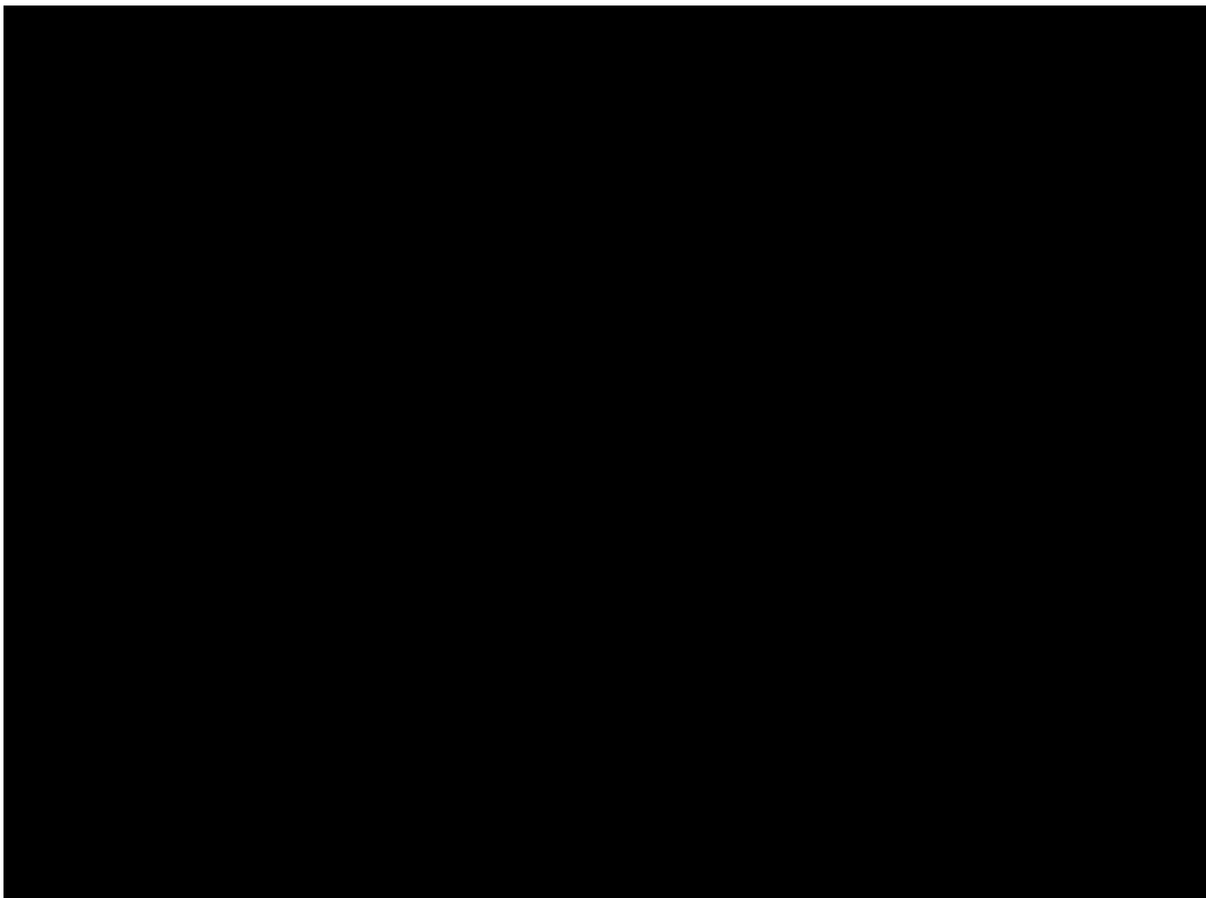
6. Agree to share this brief and the attachments with the Chief Minister and your other ministerial colleagues as appropriate.

Agreed / Not Agreed / Please Discuss

Rachel Stephen-Smith MLA 19/6/20

Minister's Office Feedback

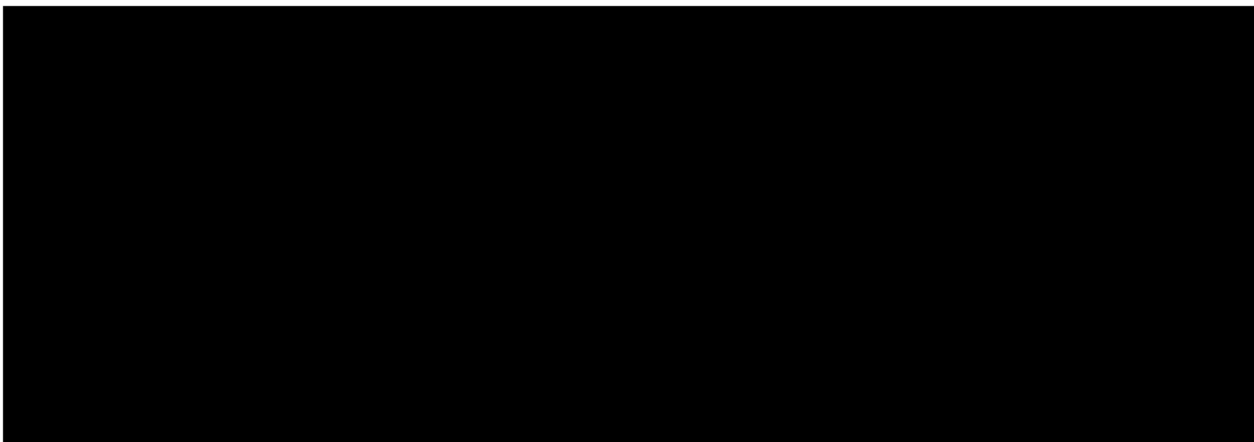




Benefits/Sensitivities

17. The announcement for Stage 2.2 easing of restrictions has been well received by the majority of business and industry.

18. Some businesses which remain closed have raised concerns about the impacts on their viability. However, it is important to note that only high-risk businesses remain closed, which is consistent with advice from the AHPPC and equivalent measures which remain in place within other jurisdictions.



Attachments

Attachment	Title
Attachment A	COVID Checkpoint Monitoring Report
Attachment B	Public Health (Restricted Activities – Gatherings, Business or Undertakings) Emergency Direction 2020 (No. 3)
Attachment C	Human Rights Act Assessment
Attachment D	COVID Checkpoint 'Check up'

CANBERRA RECOVERY PLAN
STEP 2.2 CHECK POINT CHECK-UP

Easing of COVID-19 restrictions in the ACT is taking place in stages to enable us to carefully monitor the situation in the ACT. As we ease restrictions, remaining flexible and readily able to respond to the changing circumstances of the pandemic is important.

Canberra's Recovery Plan has several check points along the way, so that each stage can be assessed before moving to the next. These health checks are crucial to helping to keep us safe moving forward.

Below is a summary of the check point that has been undertaken prior to the signing of the new Public Health Directions that will enact the move to Step 2.2 of the Plan, from 12 noon on Friday 19 June 2020.

DISEASE SURVEILLANCE MEASURE	STATUS
CONFIRMED COVID-19 CASES	
0 cases notified in the past week	◯
0 active cases	◯
12 days since the last case notified	◯
66 days since the last locally acquired (unknown epi link) case notified	◯
TESTING	
Total number of tests collected in the ACT – 24,971	◯
Daily average of tests collected in the past week – 379	◯
COMMUNITY ACCEPTANCE OF RESTRICTIONS	
High rates of business compliance with public health directions and physical distancing requirements	◯
In the June Community YourSay Panel COVID-19 Survey, 90% of respondents said they 'practised physical distancing' and 85% said they 'washed their hands more regularly' either "a great deal" or "quite a bit"	◯
HEALTH PREPARADNESS	
The impact of COVID-19 cases on our tertiary health system hasbeen manageable with 16 cases in hospital and 6 in ICU. There are no active cases in the ACT at present	◯
SUMMARY OF COVID-19 CASES FROM SURROUNDING NSW	
In the past week there has been 0 cases confirmed in surrounding NSW, and 24 cases in NSW total	◯

LEGEND

● REVIEW ◯ PROCEED WITH CAUTION ◯ ON TRACK

National considerations

The ACT is closely monitoring disease surveillance in other jurisdictions. Cases continue to be detected, predominantly in Victoria and NSW, with an average of 12 cases reported daily in the last week. While the majority of cases in Victoria continue to be overseas acquired, there are several cases where the source of infection is still under investigation. This serves as a reminder of the ongoing risk of resurgence in cases and is something that we will monitor closely moving forward.

For COVID-19 stats across all jurisdictions, visit the **Australian Government Department of Health website**. This information is updated daily.

Restrictions are easing but your responsibility hasn't

As we allow more people to come together, we need to continue to mitigate the public health risks by having appropriate control measures in place. This is not just a requirement for businesses. It extends to all Canberrans.

While our community research shows high rates of Canberrans modifying their behaviours to be COVID safe, there is always room for improvement. We must continue to maintain physical distancing and practice good hygiene measures.

If you are sick, then please stay at home. If you have symptoms, then please get tested at one of the ACT's testing venues. This is particularly important as people begin to travel more.

RESTRICTIONS MAY HAVE EASED BUT YOUR RESPONSIBILITY HASN'T

Stay 1.5m apart

Maintain good hand hygiene

Stay home if you are unwell

Get tested if you have symptoms of COVID-19

More information at covid19.act.gov.au

Australian Capital Territory

Public Health (Restricted Activities – Gatherings, Business or Undertakings) Emergency Direction 2020 (No 3)

Notifiable Instrument NI2020-332

made under the

Public Health Act 1997, s 120 (Emergency actions and directions)

1. Name of instrument

This instrument is the *Public Health (Restricted Activities – Gatherings, Business or Undertakings) Emergency Direction 2020 (No 3).*

2. Commencement

This instrument commences at 12.00 noon on 19 June 2020.

3. Public Health Emergency Direction

I, Dr Kerryn Coleman, Chief Health Officer, consider it necessary or desirable to alleviate the emergency declared under the *Public Health (Emergency) Declaration 2020 (No 1)* [NI2020-153] (the **declared emergency**) on 16 March 2020, to give the directions as set out in the schedule.

4. Duration

This Direction is in force for the period ending on the day the declared emergency (as extended or further extended) ends, unless it is earlier revoked.

5. Revocation

This instrument revokes the *Public Health (Restricted Activities – Gatherings, Business or Undertakings) Emergency Direction 2020 (No 2)* [NI2020-317].

Dr Kerryn Coleman
Chief Health Officer
18 June 2020

ACT Government | ACT Health

Public Health Emergency Direction

Public Health Act 1997

Made under the Public Health Act 1997, section 120 (Emergency actions and directions)

I, Dr Kerryn Coleman, Chief Health Officer, consider it necessary or desirable to alleviate the emergency declared under the *Public Health (Emergency) Declaration 2020 (No 1)* [NI2020-153] (the **declared emergency**) on 16 March 2020, to give the directions as set out below.

The purpose of these directions is to restrict non-essential gatherings and the operation of non-essential businesses and undertakings in order to limit the spread of coronavirus disease 2019 (**COVID-19**), caused by the novel coronavirus SARS-CoV-2.

PART 1 — NON-ESSENTIAL GATHERINGS

Directions

A. Outdoor areas

1. From 12 noon on 19 June 2020, a person must not organise or attend a **gathering** of more than 100 people in an **outdoor space** except where otherwise provided in this Direction.

B. Non-residential premises

2. Except where otherwise provided in this Direction, from 12 noon on 19 June 2020, a person:
   a. who owns, controls or operates **non-residential premises** in the Australian Capital Territory must take reasonable steps to not allow or organise a **gathering** of more than 100 people to occur at the **non-residential premises**; or
   b. must not attend a **gathering** of more than 100 people at **non-residential premises** in the Australian Capital Territory.

3. Any **gathering** of people in an **indoor space** of **non-residential premises** must observe social distancing of 1 person per 4 square metres.

C. Exemption

4. The Chief Health Officer may, in writing and subject to any conditions that the Chief Health Officer considers necessary, exempt a person from this Direction on compassionate or other grounds that the Chief Health Officer considers reasonable or appropriate.

PART 2 — CLOSURE OF NON-ESSENTIAL BUSINESS OR UNDERTAKING

Directions

A. Non-Essential Business or Undertaking

5. From 12 noon on 19 June 2020, a person who owns, controls or operates a **non-essential business or undertaking** in the Australian Capital Territory must not operate that business or undertaking except where provided in Part 3 of this Direction.

6. Direction A5 does not prohibit a person who owns, controls or operates a **non-essential business or undertaking** from entering the **premises** of the **non-essential business or undertaking** provided that a **gathering** of no more than 10 people are at the premises and social distancing of 1 person per 4 square metres is observed.

7. Direction A5 does not prohibit the operation of a **non-essential business or undertaking** to the extent that the **non-essential business or undertaking** operates solely on an online or virtual basis (for example, a streaming service), or through delivery, take-away or pickup services (for example, by selling gift vouchers or products).

PART 3 — MATTERS RELEVANT TO THESE DIRECTIONS

A. Enforcement

8. If a person fails to comply with any of the directions in this Direction, an **authorised person** may then direct the person to do such things as are reasonably necessary to comply with this Direction including, upon request, to produce proof of identification to the authorised person.

9. If a person fails to comply with any of the directions in this Direction, then the **authorised person** may take all reasonable steps to enforce compliance with this Direction pursuant to section 121 of *Public Health Act 1997.*

B. Guidance

10. Risk mitigation guidance is provided at **Attachment A** to this Direction. This guidance relates to all situations in which people are gathered together, whether included or excluded from the definition of **gathering**. It also relates to all businesses and undertakings, whether included or excluded from the definition of **non-essential business or undertaking.**

C. COVID-19 Safety Plan

11. Any requirement for the businesses or undertakings in Part 3, paragraphs 17(b), 17(g), 17(j), 17(n), 17(o), 17(p), 17(r) and 17(s), of this Direction to develop, adhere to, and produce a COVID-19 Safety Plan takes effect from 12 noon on 26 June 2020.

D. Definitions

For the purposes of this Direction:

12. An **indoor space** means an area, room or premises that is, or are, substantially enclosed by a roof and walls (of solid construction and stretching from floor to ceiling), regardless of whether the roof or walls or any part of them are:
    a. permanent or temporary; or
    b. open or closed.

13. An **outdoor space** means a space that is not an **indoor space** or a part of residential premises.

14. **Non-residential premises** has the same meaning as ***premises*** in the *Public Health Act 1997* but does not include residential premises.

15. Except where otherwise provided in this Direction, a **gathering** means a group of people occupying a single **indoor space** or **outdoor space** at the same time, but does not include a **gathering**:
    a. at an airport that is necessary for the normal business of the airport; or
    b. in relation to public transportation, including in public transport vehicles or at public transportation facilities such as stations, platforms and stops; or
    c. for the purposes of or related to private transportation; or
    d. at a medical or health service facility that is necessary for the normal business of the facility; or
    e. in relation to providing support or care to a person with a disability; or
    f. for emergency services purposes; or
    g. for law enforcement purposes; or
    h. at a disability or aged care facility that is necessary for the normal business of the facility; or
    i. at a correctional centre, place of detention under the *Children and Young People Act 2008* or other place of custody; or
    j. at a court or tribunal; or
    k. at the Australian Capital Territory Legislative Assembly or Commonwealth Parliament for the purpose of its normal operations; or
    l. at a food market, supermarket, grocery store, retail store, or shopping centre that is necessary for the normal business of those premises; or
    m. to attend at a restaurant or café to collect or deliver takeaway meals and beverages and where social distancing of 1 person per 4 square metres is observed; or

n. at an office building, workplace factory or construction site (or any other workplace that is not excluded from operation by Part 3 of this Direction), that is necessary for the normal operation of those premises; or

o. at a school, university, educational institution or childcare facility that is necessary for the normal business of the facility; or

p. at a hotel or motel that is necessary for the normal operation of accommodation services.

16. For paragraph 15(o), a school event that involves members of the community in addition to staff and students is not necessary for the normal business of the facility.

17. A **non-essential business or undertaking** means any of the following, whether operated on a for-profit or not-for-profit basis or purely as a private social activity:

a. a business that supplies liquor for consumption **ON** the premises, but not to the extent that:

i. each **gathering** does not exceed 100 customers seated in any **indoor space** and 100 customers seated in any **outdoor space** and where social distancing of 1 customer per 4 square metres is observed**;** and

ii. it involves service to customers consuming alcohol without a meal each group does not exceed 10 customers seated together; and

iii. it asks for a first name and contact phone number (for contact tracing purposes) of each person who attends and, if provided, keeps a record of those details and the date and time at which the person attended; and

iv. it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person**;

b. a hotel, whether licensed or unlicensed, but not:

i. any part of the hotel constituted by a bottleshop; or

ii. to the extent that it provides accommodation, function facilities, takeaway meals or a meal delivery service; and

iii. where an organised function or event does not exceed 100 people (excluding staff working at the function) in any **indoor** space and 100 people (excluding staff working at the function) in any **outdoor** space and where social distancing of 1 customer per 4 square metres is observed; and

iv. if it asks for a first name and contact phone number (for contact tracing purposes) of each person who attends and, if provided, keeps a record of those details and the date and time at which the person attended; and

v. if it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person**;

ACT Health

c. a restaurant, café or canteen, other than to the extent that it provides takeaway meals or a meal delivery service, but not:

   i. a café or canteen at a hospital; or

   ii. a café or canteen at a residential aged care facility; or

   iii. a café or canteen at a school; or

   iv. a café or canteen at a correctional centre; or

   v. a café or canteen at a community sporting facility; or

   vi. a military café or canteen; or

   vii. a café or canteen that provides food or drink to those experiencing homelessness; or

   viii. to the extent that:

      A. each **gathering** does not exceed 100 customers seated in any **indoor space** and 100 customers seated in any **outdoor space** and where social distancing of 1 customer per 4 square metres of is observed**;** and

      B. it involves service to customers consuming alcohol without a meal each group does not exceed 10 customers seated together; and

      C. it asks for a first name and contact phone number (for contact tracing purposes) of each person who attends and, if provided, keeps a record of those details and the date and time at which the person attended; and

      D. it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person;**

d. a food court, but not:

   i. to the extent that it provides takeaway meals or a meal delivery service;

e. a gym, health club, fitness centre, wellness centre, or a centre providing yoga barre or spin facilities, but not:

   i. to the extent that it involves a **gathering** of no more than 100 people (including staff and any other personnel), and where social distancing of 1 person per 4 square metres is observed; and

   ii. where at least one staff member is on the premises at all times when those premises are open; and

   iii. if it asks for a first name and contact phone number (for contact tracing purposes) of each person who attends and, if provided, keeps a record of those details and the date and time at which the person attended; and

   iv. if it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person**;

f. a bootcamp or personal trainer, but not:

    i. to the extent that it involves a **gathering** of no more than 100 people (including trainers) and where social distancing of 1 person per 4 square metres is observed; and

    ii. if it asks for a first name and contact phone number (for contact tracing purposes) of each person who attends and, if provided, keeps a record of those details and the date and time at which the person attended; and

    iii. if it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person**;

g. an **organised sporting activity** but not:

    i. if it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person**; and

    ii. to the extent that it involves a **gathering** of no more than 100 people and where social distancing of 1 person per 4 square metres is observed; and

    iii. to the extent that it involves low or non-contact training or competition activities; or

    iv. to the extent that it involves full contact training;

h. a swimming pool, but not:

    i. to the extent that it is used as a **hydrotherapy pool**; or

    ii. to the extent that it is used by **gatherings** of no more than 100 people with a maximum of 4 swimmers per lane and where social distancing of 1 person per 4 square metres is observed; and

    iii. if it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person**;

i. a community centre or facility or a youth centre or facility, but not:

    i. to the extent that the centre or facility hosts essential voluntary or public services, such as food banks or services for those experiencing homelessness; or

    ii. to the extent that the centre or facility hosts essential services for vulnerable children and families, or for young people at risk of homelessness or engagement with the youth justice system; or

    iii. to the extent that it allows **gatherings** of no more than 100 people and where social distancing of 1 person per 4 square metres is observed;

    Note: If the facility is being used for an activity such as dance or martial arts or another activity addressed separately in this Direction, the provisions relevant to those activities also need to be complied with.

    Example: A person holding a dance class in a community hall will need to comply with the rules regarding organised sporting activities.

j. a **place of worship,** other than for the purposes of a **wedding, funeral** or **religious ceremony**, but not:

   i. if it provides a visitor book in which attendees can enter their first name, contact phone number, and date and time of visit if they choose; and

   ii. where social distancing of 1 person per 4 square metres is observed; and

   iii. if it involves a gathering of no more than 100 people and it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person**; but

   iv. if the gathering does not exceed 20 people, the development of a **COVID-19 Safety Plan** is not required;

k. a library, but not:

   i. where social distancing of 1 person per 4 square metres is observed; and

   ii. if it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person**;

l. a gallery, museum, national institution or historic site, but not:

   i. where social distancing of 1 person per 4 square metres is observed; and

   ii. where a group of people attending a tour at the premises does not exceed more than 20 people (excluding necessary personnel to facilitate the activity) and the tour is limited to a duration of no more than 2 hours; and

   iii. where an organised function or event:

      A. does not exceed 100 people (excluding staff working at the function) in any **indoor** space and 100 people (excluding staff working at the function) in any **outdoor** space; and

      B. where social distancing of 1 person per 4 square metres is observed; and

      C. it asks for a first name and contact phone number (for contact tracing purposes) of each person who attends and, if provided, keeps a record of those details and the date and time at which the person attended; and

   iv. if it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person**;

m. an outdoor amusement park or attraction, but not:

   i. where social distancing of 1 person per 4 square metres is observed; and

   ii. where a group of people attending a tour at the premises does not exceed more than 20 people (excluding necessary personnel to facilitate the activity) and the tour is limited to a duration of not more than 2 hours; and

   iii. where an organised function or event:

      A. does not exceed 100 people (excluding staff working at the function) in any indoor space and 100 people (excluding staff working at the function) in any outdoor space; and

B. where social distancing of 1 person per 4 square metres is observed; and

C. it asks for a first name and contact phone number (for contact tracing purposes) of each person who attends and, if provided, keeps a record of those details and the date and time at which the person attended; and

iv. if it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person**;

n. a cinema or movie theatre, but not:

i. to the extent that it involves a **gathering** of no more than 100 people attending a session (including staff and any other personnel) and where social distancing of 1 person per 4 square metres is observed; and

ii. where individual and group bookings are seated at least 1.5 metres apart from each other; and

Example: If a person books a ticket to attend on their own, they should be seated at least 1.5 metres from a person who has made a separate booking. If a group of 10 books together, they can sit together, but need to be at least 1.5 metres away from other groups/individuals.

iii. to the extent that it involves a **gathering** of no more than 100 people in a lobby or foyer area (including staff and any other personnel) and where social distancing of 1 person per 4 square metres is observed; and

iv. if it asks for a first name and contact phone number (for contact tracing purposes) of each person who attends and, if provided, keeps a record of those details and the date and time at which the person attended; and

v. if it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person;**

o. an open-air drive-in cinema, but not:

i. to the extent that it involves no more than 100 vehicles attending a session and where the vehicles are parked at least 1.5 metres apart; and

ii. to the extent that it involves a **gathering** of no more than 100 people in an outdoor space and where social distancing of 1 person per 4 square metres is observed; and

Example: If the event organiser plans external activities at the same venue as the drive-in cinema (for example activities for children before or after the cinema session) then gatherings of no more than 100 people should be enforced by the event organiser.

Example: If there is ability to exit a vehicle to purchase refreshments, then gatherings of no more than 100 people should be enforced by the event organiser.

iii. if it asks for a first name and contact phone number (for contact tracing purposes) of each driver of each vehicle and, if provided, keeps a record of those details and the date and time at which the person attended; and

iv. if it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person;**

p. an indoor or outdoor play centre, or an indoor arcade or amusement centre, but not:

i. to the extent that it involves a **gathering** of no more than 100 people (including staff and any other personnel) and where social distancing of 1 person per 4 square metres is observed; and

ii. if it asks for a first name and contact phone number (for contact tracing purposes) of each individual person, or one person in a group, who attends and, if provided, keeps a record of those details and the date and time at which the person attended; and

iii. if it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person;**

q. a gaming or gambling venue or a **casino**;

r. a **betting agency**, but not:

i. to the extent that it involves a **gathering** of no more than 100 people (including staff and any other personnel) for the purposes of allowing betting to take place, and where social distancing of 1 person per 4 square metres is observed; and

ii. if the betting agency is located within a licenced venue, the occupier of the venue must take reasonable steps to prevent customers from accessing other parts of the premises which are closed; and

iii. if it asks for a first name and contact phone number (for contact tracing purposes) of each person who attends and, if provided, keeps a record of those details and the date and time at which the person attended; and

iv. if it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person;**

s. performances in all locations, including in a concert venue, theatre, arena or auditorium, but not:

i. to the extent that it facilitates a rehearsal or a live or live-streamed performance in the premises with a **gathering** of no more than 100 people (including staff, any other personnel, and those necessary to facilitate the rehearsal or performance); and

ii. where social distancing of 1 person per 4 square metres is observed; and

iii. where attendees remain seated; and

iv. where individual and group bookings are seated at least 1.5 metres apart from each other; and

Example: If a person books a ticket to attend on their own, they should be seated at least 1.5 metres from a person who has made a separate booking. If a group of 10 books together, they can sit together, but need to be at least 1.5 metres away from other groups/individuals.

v. the extent that it involves a **gathering** of no more than 100 people (including staff, any other personnel, performers and those necessary to facilitate the rehearsal or performance) in a lobby or foyer area and where social distancing of 1 person per 4 square metres is observed; and

vi. if it asks for a first name and contact phone number (for contact tracing purposes) of each person who attends and, if provided, keeps a record of those details and the date and time at which the person attended; and

vii. if it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person**;

t. a hairdresser or barber, but not:

i. to the extent that it involves a **gathering** of no more than 100 people (including staff and any other personnel), and where social distancing of 1 person per 4 square metres is observed; and

ii. if it asks for a first name and contact phone number (for contact tracing purposes) of each person who attends and, if provided, keeps a record of those details and the date and time at which the person attended; and

iii. if it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person**;

u. a nail salon, but not:

i. to the extent that it involves a **gathering** of no more than 100 people (including staff and any other personnel), and where social distancing of 1 person per 4 square metres is observed; and

ii. if it asks for a first name and contact phone number (for contact tracing purposes) of each person who attends and, if provided, keeps a record of those details and the date and time at which the person attended; and

iii. if it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person**;

v. a tattoo or body modification studio, but not:

i. to the extent that it involves a **gathering** of no more than 100 people (including staff and any other personnel), and where social distancing of 1 person per 4 square metres is observed; and

ii. if it asks for a first name and contact phone number (for contact tracing purposes) of each person who attends and, if provided, keeps a record of those details and the date and time at which the person attended; and

iii. if it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person**;

w. a place that provides beauty therapy, tanning or waxing services, but not:

i. cosmetic services provided by a health practitioner registered by the Australian Health Practitioner Regulation Agency; or

ii. to the extent that:

A. it involves a **gathering** of no more than 100 people (including staff and any other personnel), and where social distancing of 1 person per 4 square metres is observed; and

B. it asks for a first name and contact phone number (for contact tracing purposes) of each person who attends and, if provided, keeps a record of those details and the date and time at which the person attended; and

C. it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person**;

x. a day spa or a place that provides massage services, but not:

i. massage services provided by or for allied health services, such as remedial, sports, and lymphatic massage; or

ii. to the extent that:

A. it involves a **gathering** of no more than 100 people (including staff and any other personnel) and where social distancing of 1 person per 4 square metres is observed; and

B. it asks for a first name and contact phone number (for contact tracing purposes) of each person who attends and, if provided, keeps a record of those details and the date and time at which the person attended; and

C. it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person**;

y. steam based services (including saunas, steam rooms, steam cabinets and bathhouses);

z. an auction house, but not;

i. to the extent that it involves a **gathering** of no more than 100 people (including staff and any other personnel) and where social distancing of 1 person per 4 square metres is observed; and

ii. if it asks for a first name and contact phone number (for contact tracing purposes) of each person who attends and, if provided, keeps a record of those details and the date and time at which the person attended; and

iii. if it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person**;

aa. a real estate auction, display home or an open house inspection, but not:

i. to the extent that it involves a **gathering** of no more than 100 people (including staff and any other personnel) and where social distancing of 1 person per 4 square metres is observed; and

ii. if it asks for a first name and contact phone number (for contact tracing purposes) of each person who attends and, if provided, keeps a record of those details and the date and time at which the person attended; and

iii. if it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person**;

bb. a strip club, brothel or an escort agency;

cc. a nightclub.

18. A **COVID-19 Safety Plan** means a plan:
    a. in writing that addresses how the business or undertaking will manage its operations to minimise the risks posed to any person by **COVID-19** because of the operation of the business or undertaking; and
    b. developed with regard to published guidance material endorsed by the Chief Health Officer.

19. **Authorised person** means an authorised person under section 121 of the *Public Health Act 1997*.

20. **Casino** has the same meaning as in the *Casino Control Act 2006*.

21. **Hydrotherapy pool** means a heated swimming pool (heated to 33 to 36 degrees Celsius) for use by people receiving hydrotherapy, who use the pool to undergo that therapy either on their own or with assistance from another person.

22. **Place of worship** means a building or place used for the purpose of religious worship by a congregation or religious group, whether or not the building or place is also used for counselling, social events, instruction or religious training.

23. **Wedding** means a wedding attended by a **gathering** of no more than 100 people (including the celebrant and the professional wedding photographer), where social distancing of 1 person per 4 square metres is observed and:
    a. at which attendees are asked for a first name and contact phone number (for contact tracing purposes) and, if provided, the organiser keeps a record of those details and the date and time at which the person attended; and
    b. it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person**.

24. **Funeral** means a funeral attended by a **gathering** no more than 100 mourners, where social distancing of 1 person per 4 square metres is observed and:
    a. at which attendees are asked for a first name and contact phone number (for contact tracing purposes) and, if provided, the organiser keeps a record of those details and the date and time at which the person attended; and
    b. it develops a **COVID-19 Safety Plan** to which it must adhere, and which it must produce when requested by an **authorised person**.

25. **Religious ceremony** means a religious ceremony attended by a **gathering** of no more than 100 people (including the person conducting the ceremony and any person necessary to support the conduct of the ceremony) and where social distancing of 1 person per 4 square metres is observed and where it provides a visitor book in which attendees can enter their first name, contact phone number, and date and time of visit if they choose.

26. **Organised sporting activity** means sporting activities arranged through peak sporting organisations, community clubs, commercial providers or individual activities, and includes dance activities, but does not include professional sport.

27. **Betting agency** means a TAB or KENO agency either in a stand-alone venue or within a licensed venue.

E. Note

28. All businesses or undertakings not subject to Part 2 must comply with Part 1 of this Direction.

29. Any requirement in this Direction to keep a record or where a record is provided pursuant to these directions, of name, contact phone number, and date and time of visit, requires the record to be kept for 28 days.

30. If there is any inconsistency between this Direction and any of the directions specified below, those directions are inoperative to the extent of any inconsistency:

    a. the *Public Health (Self-Isolation) Emergency Direction 2020* (NI2020-177);
    b. the *Public Health (Returned Travellers) Emergency Direction 2020* (NI2020-164); and
    c. the *Public Health (Returned Travellers) Emergency Direction 2020 (No 4)* (NI2020-269).

31. Pursuant to section 119(4B) of the *Public Health Act 1997* the Chief Health Officer is to advise the Minister every 30 days about the status of the emergency and whether the Chief Health Officer considers the declared emergency is still justified.

Penalties

Section 120 (4) of the *Public Health Act 1997* provides:

> A person must not, without reasonable excuse, fail to comply with a direction under this section.

Maximum Penalty:

In the case of a natural person, $8,000 (50 penalty units).

In the case of a body corporate, $40,500 (50 penalty units).

In the case of a utility that is a body corporate, $1,620,000 (2000 penalty units).

....

Dr Kerryn Coleman
Chief Health Officer

18 June 2020

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ACT Government | ACT Health

ATTACHMENT A - Risk Mitigation Guidance

This Direction should be read in conjunction with the guidance material prepared by the Chief Health Officer, including guidance material about how to prepare a **COVID-19 Safety Plan**, which is available at www.covid19.act.gov.au.

It is suggested that, as far as reasonably practicable, the following risk mitigation measures be applied to gatherings of 2 people or more:

- In a given occupied space, there be a density of no more than one person per 4 square metres of floor space (taking into account objects and items that may impact the total free space);

  Example: if an indoor space is 8.5 metres long and 4.5 metres wide, its total area is 38.25 square metres. Its density quotient is 9.56, so no more than 9 people would be permitted to be in the indoor space at the same time.

- Hand hygiene products and suitable waste receptacles should be available, to allow for frequent cleaning and waste disposal;
- Promote physical distancing of at least 1.5 metres between people wherever possible;
- The recommendations for unwell individuals to isolate at home and not attend published by the Commonwealth Department of Health should be promoted and displayed prominently so that they can be seen and read easily by a person at or near an entrance to the **indoor space**;
- For settings where there is ongoing movement and an increased number of interactions between people (for example food markets) and an individual's attendance is not in the course of their employment at the place, an individual's attendance should be less than 2 hours duration;
- Wherever possible, physical contact should be avoided; and
- Where activities involve the use of equipment, that equipment should be regularly cleaned and, where practicable, not be shared by people other than members of the same household.

Accessibility

If you have difficulty reading a standard printed document and would like an alternative format, please phone 13 22 81.

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Pond, Aleks (Health)

From: AHPPC Secretariat
Sent: Friday, 5 June 2020 11:08 AM
To:
Subject: Updated FINAL - AHPPC meeting papers for Friday 5 June [SEC=OFFICIAL]
Attachments: Agenda Item 3 - Att A - National communication plan to support COVID19 outbreaks for AHPPC.docx; Agenda Item 4 - COVID-19_Amendment to self quarantine for air crew_June 2020.docx; Agenda Item 5 - Attachment 1- cruise vessel restrictions - ~ Australian flagged 25 May 2020.docx; Agenda Item 5 - cruise vessel restrictions - 5 June 2020.docx; Agenda Item 6 - Draft AHPPC Aged Care Statement.docx; Agenda Item 7 - Attachment 1 - Expanded Stage 3.docx; Agenda Item 7 - Restrictions Tracker summary 03 June 0700hrs.pdf; Agenda Item 7 - Stratification of Stage 3 of the 3-Step Framework.docx; Agenda Item 8 - Att A - Onward Travel into SA - Exemptions Process.pdf; Agenda Item 8 - Cross border travel for international travellers in quarantine.docx; Agenda Item 8 - DRAFT AHPPC statement on the Need for Continued Vigilance_EF_MM_edits.docx; Agenda Item 3 - AHPPC summary of COVID outbreak communication plans.docx

CAUTION: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Good morning members

Apologies for the confusion, please find attached the final versions of the papers for AHPPC today.

We had a slight change to 'Agenda Item 8 – DRAFT AHPPC Statement on the Need for Continued Vigilance'.

Kind regards

Australian Health Protection Principal Committee (AHPPC)
of the Australian Health Ministers' Advisory Council (AHMAC)

Office of Health Protection | Australian Government Department of Health

A: MDP 140, GPO Box 9848, CANBERRA ACT 2601, Australia

I acknowledge the traditional custodians of the lands and waters where we live and work, and pay my respects to elders past and present.

From: AHPPC Secretariat
Sent: Friday, 5 June 2020 8:53 AM

Subject: FINAL - AHPPC meeting papers for Friday 5 June [SEC=OFFICIAL]

****NOTE: THESE PAPERS ARE COMMITTEE-IN-CONFIDENCE AND ARE NOT TO BE CIRCULATED****

Dear AHPPC members

Please note the FINAL attached papers for the meeting today. Included is attachment A for agenda item 8 (Cross border travel for international travellers in quarantine).

AHPPC papers will be available on GOVTEAMS at the following link:

Agenda	Item	Speaker/s
1	Meeting opening • Welcome	Chair
2	CDNA Update	
3 Paper	Australian, State and Territory Government COVID-19 Communication Plans	
4 Paper	Quarantine arrangements of international air crew	
5 Paper	Cruise Ship Restrictions	
6 Paper	Finalisation of the Aged Care Statement	

7 Paper	Stratification of Step Three	
8	Other business • Draft AHPPC Statement on the Need for Continued Vigilance • Cross border travel for international travellers in quarantine • Jurisdictional Update	Chair
Next meeting on Tuesday 9 June 2020 AEST		

Kind regards

Australian Health Protection Principal Committee (AHPPC)
of the Australian Health Ministers' Advisory Council (AHMAC)

Office of Health Protection I Australian Government Department of Health

A: MDP 140, GPO Box 9848, CANBERRA ACT 2601, Australia

I acknowledge the traditional custodians of the lands and waters where we live and work, and pay my respects to elders past and present.

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Pond, Aleks (Health)

From:	AHPPC Secretariat
Sent:	Friday, 5 June 2020 7:51 PM
To:	
Subject:	FOR INFO: 20.06.05 AHPPC COVID-19 TC Outcomes AND Lancet article on distancing and face masks
Attachments:	Draft 20.06.05 AHPPC COVID-19 TC Outcomes.docx; Distancing and face masks - Lancet - June 2020.pdf

CAUTION: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Members,

Attached are the outcomes from today's meeting for your information.

Also attached for information, is the article referred to at Tuesday's meeting. Our apologies for not forwarding sooner.

Kind regards,

Australian Health Protection Principal Committee (AHPPC)
of the Australian Health Ministers' Advisory Council (AHMAC)

Office of Health Protection | Australian Government Department of Health

A: MDP 140, GPO Box 9848, CANBERRA ACT 2601, Australia

I acknowledge the traditional custodians of the lands and waters where we live and work, and pay my respects to elders past and present.

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Physical distancing, face masks, and eye protection to prevent person-to-person transmission of SARS-CoV-2 and COVID-19: a systematic review and meta-analysis

*Derek K Chu, Elie A Akl, Stephanie Duda, Karla Solo, Sally Yaacoub, Holger J Schünemann, on behalf of the COVID-19 Systematic Urgent Review Group Effort (SURGE) study authors**

Summary

Background Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) causes COVID-19 and is spread person-to-person through close contact. We aimed to investigate the effects of physical distance, face masks, and eye protection on virus transmission in health-care and non-health-care (eg, community) settings.

Methods We did a systematic review and meta-analysis to investigate the optimum distance for avoiding person-to-person virus transmission and to assess the use of face masks and eye protection to prevent transmission of viruses. We obtained data for SARS-CoV-2 and the betacoronaviruses that cause severe acute respiratory syndrome, and Middle East respiratory syndrome from 21 standard WHO-specific and COVID-19-specific sources. We searched these data sources from database inception to May 3, 2020, with no restriction by language, for comparative studies and for contextual factors of acceptability, feasibility, resource use, and equity. We screened records, extracted data, and assessed risk of bias in duplicate. We did frequentist and Bayesian meta-analyses and random-effects meta-regressions. We rated the certainty of evidence according to Cochrane methods and the GRADE approach. This study is registered with PROSPERO, CRD42020177047.

Findings Our search identified 172 observational studies across 16 countries and six continents, with no randomised controlled trials and 44 relevant comparative studies in health-care and non-health-care settings (n=25 697 patients). Transmission of viruses was lower with physical distancing of 1 m or more, compared with a distance of less than 1 m (n=10 736, pooled adjusted odds ratio [aOR] 0·18, 95% CI 0·09 to 0·38; risk difference [RD] –10·2%, 95% CI –11·5 to –7·5; moderate certainty); protection was increased as distance was lengthened (change in relative risk [RR] 2·02 per m; $p_{interaction}$=0·041; moderate certainty). Face mask use could result in a large reduction in risk of infection (n=2647; aOR 0·15, 95% CI 0·07 to 0·34, RD –14·3%, –15·9 to –10·7; low certainty), with stronger associations with N95 or similar respirators compared with disposable surgical masks or similar (eg, reusable 12–16-layer cotton masks; $p_{interaction}$=0·090; posterior probability >95%, low certainty). Eye protection also was associated with less infection (n=3713; aOR 0·22, 95% CI 0·12 to 0·39, RD –10·6%, 95% CI –12·5 to –7·7; low certainty). Unadjusted studies and subgroup and sensitivity analyses showed similar findings.

Interpretation The findings of this systematic review and meta-analysis support physical distancing of 1 m or more and provide quantitative estimates for models and contact tracing to inform policy. Optimum use of face masks, respirators, and eye protection in public and health-care settings should be informed by these findings and contextual factors. Robust randomised trials are needed to better inform the evidence for these interventions, but this systematic appraisal of currently best available evidence might inform interim guidance.

Funding World Health Organization.

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*Study authors are listed in the appendix and at the end of the Article

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Correspondence to: Prof Holger J Schünemann, Michael G DeGroote Cochrane Canada and McMaster GRADE Centres, McMaster University, Hamilton, ON L8N 3Z5, Canada
schuneh@mcmaster.ca

See Online for appendix

Introduction

As of May 28, 2020, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) has infected more than 5·85 million individuals worldwide and caused more than 359 000 deaths.[1] Emergency lockdowns have been initiated in countries across the globe, and the effect on health, wellbeing, business, and other aspects of daily life are felt throughout societies and by individuals. With no effective pharmacological interventions or vaccine available in the imminent future, reducing the rate of infection (ie, flattening the curve) is a priority, and prevention of infection is the best approach to achieve this aim.

SARS-CoV-2 spreads person-to-person through close contact and causes COVID-19. It has not been solved if

Research in context

Evidence before this study

We searched 21 databases and resources from inception to May 3, 2020, with no restriction by language, for studies of any design evaluating physical distancing, face masks, and eye protection to prevent transmission of the viruses that cause COVID-19 and related diseases (eg, severe acute respiratory syndrome [SARS] and Middle East respiratory syndrome [MERS]) between infected individuals and people close to them (eg, household members, caregivers, and health-care workers). Previous related meta-analyses have focused on randomised trials and reported imprecise data for common respiratory viruses such as seasonal influenza, rather than the pandemic and epidemic betacoronaviruses causative of COVID-19 (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2]), SARS (SARS-CoV), or MERS (MERS-CoV). Other meta-analyses have focused on interventions in the health-care setting and have not included non-health-care (eg, community) settings. Our search did not retrieve any systematic review of information on physical distancing, face masks, or eye protection to prevent transmission of SARS-CoV-2, SARS-CoV, and MERS-CoV.

Added value of this study

We did a systematic review of 172 observational studies in health-care and non-health-care settings across 16 countries and six continents; 44 comparative studies were included in a meta-analysis, including 25 697 patients with COVID-19, SARS, or MERS. Our findings are, to the best of our knowledge, the first to rapidly synthesise all direct information on COVID-19 and, therefore, provide the best available evidence to inform optimum use of three common and simple interventions to help reduce the rate of infection and inform non-pharmaceutical interventions, including pandemic mitigation in non-health-care settings. Physical distancing of 1 m or more was associated with a much lower risk of infection, as was use of face masks (including N95 respirators or similar and surgical or similar masks [eg, 12–16-layer cotton or gauze masks]) and eye protection (eg, goggles or face shields). Added benefits are likely with even larger physical distances (eg, 2 m or more based on modelling) and might be present with N95 or similar respirators versus medical masks or similar. Across 24 studies in health-care and non-health-care settings of contextual factors to consider when formulating recommendations, most stakeholders found these personal protection strategies acceptable, feasible, and reassuring but noted harms and contextual challenges, including frequent discomfort and facial skin breakdown, high resource use linked with the potential to decrease equity, increased difficulty communicating clearly, and perceived reduced empathy of care providers by those they were caring for.

Implications of all the available evidence

In view of inconsistent guidelines by various organisations based on limited information, our findings provide some clarification and have implications for multiple stakeholders. The risk for infection is highly dependent on distance to the individual infected and the type of face mask and eye protection worn. From a policy and public health perspective, current policies of at least 1 m physical distancing seem to be strongly associated with a large protective effect, and distances of 2 m could be more effective. These data could also facilitate harmonisation of the definition of exposed (eg, within 2 m), which has implications for contact tracing. The quantitative estimates provided here should inform disease-modelling studies, which are important for planning pandemic response efforts. Policy makers around the world should strive to promptly and adequately address equity implications for groups with currently limited access to face masks and eye protection. For health-care workers and administrators, our findings suggest that N95 respirators might be more strongly associated with protection from viral transmission than surgical masks. Both N95 and surgical masks have a stronger association with protection compared with single-layer masks. Eye protection might also add substantial protection. For the general public, evidence shows that physical distancing of more than 1 m is highly effective and that face masks are associated with protection, even in non-health-care settings, with either disposable surgical masks or reusable 12–16-layer cotton ones, although much of this evidence was on mask use within households and among contacts of cases. Eye protection is typically underconsidered and can be effective in community settings. However, no intervention, even when properly used, was associated with complete protection from infection. Other basic measures (eg, hand hygiene) are still needed in addition to physical distancing and use of face masks and eye protection.

SARS-CoV-2 might spread through aerosols from respiratory droplets; so far, air sampling has found virus RNA in some studies[2–4] but not in others.[5–8] However, finding RNA virus is not necessarily indicative of replication-competent and infection-competent (viable) virus that could be transmissible. The distance from a patient that the virus is infective, and the optimum person-to-person physical distance, is uncertain. For the currently foreseeable future (ie, until a safe and effective vaccine or treatment becomes available), COVID-19 prevention will continue to rely on non-pharmaceutical interventions, including pandemic mitigation in community settings.[9] Thus, quantitative assessment of physical distancing is relevant to inform safe interaction and care of patients with SARS-CoV-2 in both health-care and non-health-care settings. The definition of close contact or potentially exposed helps to risk stratify, contact trace, and develop guidance documents, but these definitions differ around the globe.

To contain widespread infection and to reduce morbidity and mortality among health-care workers and others in contact with potentially infected people, jurisdictions have issued conflicting advice about physical or social distancing. Use of face masks with or

without eye protection to achieve additional protection is debated in the mainstream media and by public health authorities, in particular the use of face masks for the general population;[10] moreover, optimum use of face masks in health-care settings, which have been used for decades for infection prevention, is facing challenges amid personal protective equipment (PPE) shortages.[11]

Any recommendations about social or physical distancing, and the use of face masks, should be based on the best available evidence. Evidence has been reviewed for other respiratory viral infections, mainly seasonal influenza,[12,13] but no comprehensive review is available of information on SARS-CoV-2 or related betacoronaviruses that have caused epidemics, such as severe acute respiratory syndrome (SARS) or Middle East respiratory syndrome (MERS). We, therefore, systematically reviewed the effect of physical distance, face masks, and eye protection on transmission of SARS-CoV-2, SARS-CoV, and MERS-CoV.

Methods

Search strategy and selection criteria

To inform WHO guidance documents, on March 25, 2020, we did a rapid systematic review.[14] We created a large international collaborative and we used Cochrane methods[15] and the GRADE approach.[16] We prospectively submitted the systematic review protocol for registration on PROSPERO (CRD42020177047; appendix pp 23–29). We have followed PRISMA[17] and MOOSE[18] reporting guidelines (appendix pp 30–33).

From database inception to May 3, 2020, we searched for studies of any design and in any setting that included patients with WHO-defined confirmed or probable COVID-19, SARS, or MERS, and people in close contact with them, comparing distances between people and COVID-19 infected patients of 1 m or larger with smaller distances, with or without a face mask on the patient, or with or without a face mask, eye protection, or both on the exposed individual. The aim of our systematic review was for quantitative assessment to ascertain the physical distance associated with reduced risk of acquiring infection when caring for an individual infected with SARS-CoV-2, SARS-CoV, or MERS-CoV. Our definition of face masks included surgical masks and N95 respirators, among others; eye protection included visors, faceshields, and goggles, among others.

We searched (up to March 26, 2020) MEDLINE (using the Ovid platform), PubMed, Embase, CINAHL (using the Ovid platform), the Cochrane Library, COVID-19 Open Research Dataset Challenge, COVID-19 Research Database (WHO), Epistemonikos (for relevant systematic reviews addressing MERS and SARS, and its COVID-19 Living Overview of the Evidence platform), EPPI Centre living systematic map of the evidence, ClinicalTrials.gov, WHO International Clinical Trials Registry Platform, relevant documents on the websites of governmental and other relevant organisations, reference lists of included papers, and relevant systematic reviews.[19,20] We hand-searched (up to May 3, 2020) preprint servers (bioRxiv, medRxiv, and Social Science Research Network First Look) and coronavirus resource centres of *The Lancet*, *JAMA*, and *N Engl J Med* (appendix pp 3–5). We did not limit our search by language. We initially could not obtain three full texts for evaluation, but we obtained them through interlibrary loan or contacting a study author. We did not restrict our search to any quantitative cutoff for distance.

Data collection

We screened titles and abstracts, reviewed full texts, extracted data, and assessed risk of bias by two authors and independently, using standardised prepiloted forms (Covidence; Veritas Health Innovation, Melbourne, VIC, Australia), and we cross-checked screening results using artificial intelligence (Evidence Prime, Hamilton, ON, Canada). We resolved disagreements by consensus. We extracted data for study identifier, study design, setting, population characteristics, intervention and comparator characteristics, quantitative outcomes, source of funding

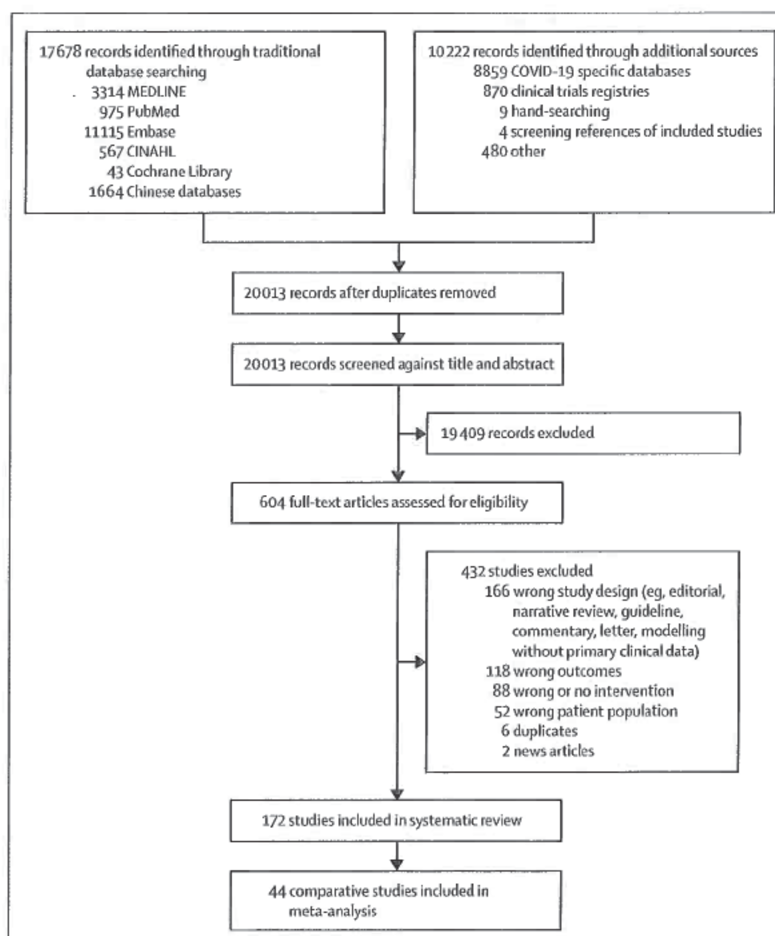


Figure 1: **Study selection**

	Population size (n)	Country	Setting	Disease caused by virus	Case definition (WHO)	Adjusted estimates	Risk of bias*
Alraddadi et al (2016)[34]	283	Saudi Arabia	Health care	MERS	Confirmed	Yes	********
Arwady et al (2016)[35]	79	Saudi Arabia	Non-health care (household and family contacts)	MERS	Confirmed	No	******
Bai et al (2020)[36]	118	China	Health care	COVID-19	Confirmed	No	*****
Burke et al (2020)[37]	338	USA	Health care and non-health care (including household and community)	COVID-19	Confirmed	No	****
Caputo et al (2006)[38]	33	Canada	Health care	SARS	Confirmed	No	*****
Chen et al (2009)[39]	758	China	Health care	SARS	Confirmed	Yes	*******
Cheng et al (2020)[40]	226	China	Non-health care (household and family contacts)	COVID-19	Confirmed	No	******
Ha et al (2004)[42]	117	Vietnam	Health care	SARS	Confirmed	No	**
Hall et al (2014)[43]	48	Saudi Arabia	Health care	MERS	Confirmed	No	***
Heinzerling et al (2020)[44]	37	USA	Health care	COVID-19	Confirmed	No	****
Ho et al (2004)[45]	372	Taiwan	Health care	SARS	Confirmed	No	********
Ki et al (2019)[47]	446	South Korea	Health care	MERS	Confirmed	No	******
Kim et al (2016)[48]	9	South Korea	Health care	MERS	Confirmed	No	*****
Kim et al (2016)[49]	1169	South Korea	Health care	MERS	Confirmed	No	******
Lau et al (2004)[50]	2270	China	Non-health care (households)	SARS	Probable	Yes	******
Liu et al (2009)[51]	477	China	Health care	SARS	Confirmed	Yes	*****
Liu et al (2020)[52]	20	China	Non-health care (close contacts)	COVID-19	Confirmed	No	*******
Loeb et al (2004)[53]	43	Canada	Health care	SARS	Confirmed	No	**
Ma et al (2004)[54]	426	China	Health care	SARS	Confirmed	Yes	*********
Nishiura et al (2005)[55]	115	Vietnam	Health care	SARS	Confirmed	Yes	********
Nishiyama et al (2008)[56]	146	Vietnam	Health care	SARS	Confirmed	Yes	******
Olsen et al (2003)[57]	304	China	Non-health care (airplane)	SARS	Confirmed	No	******
Park et al (2004)[58]	110	USA	Health care	SARS	Confirmed	No	**********
Park et al (2016)[59]	80	South Korea	Health care	MERS	Confirmed and probable	No	***
Peck et al (2004)[60]	26	USA	Health care	SARS	Confirmed	No	*********
Pei et al (2006)[61]	443	China	Health care	SARS	Confirmed	No	********
Rea et al (2007)[62]	8662	Canada	Non-health care (community contacts)	SARS	Probable	No	****
Reuss et al (2014)[63]	81	Germany	Health care	MERS	Confirmed	No	*****
Reynolds et al (2006)[64]	153	Vietnam	Health care	SARS	Confirmed	No	***
Ryu et al (2019)[65]	34	South Korea	Health care	MERS	Confirmed	No	******
Scales et al (2003)[66]	69	Canada	Health care	SARS	Probable	No	**
Seto et al (2003)[67]	254	China	Health care	SARS	Confirmed	Yes	********
Teleman et al (2004)[68]	86	Singapore	Health care	SARS	Confirmed	Yes	********
Tuan et al (2007)[69]	212	Vietnam	Non-health care (household and community contacts)	SARS	Confirmed	Yes	******
Van Kerkhove et al (2019)[46]	828	Saudi Arabia	Non-health care (dormitory)	MERS	Confirmed	Yes	********
Wang et al (2020)[41]	493	China	Health care	COVID-19	Confirmed	Yes	****

(Table 1 continues on next page)

www.thelancet.com Published online June 1, 2020 https://doi.org/10.1016/S0140-6736(20)31142-9

	n	Country	Setting	Disease caused by virus	Case definition (WHO)	Adjusted estimates	Risk of bias*
(Continued from previous page)							
Wang et al (2020)[70]	5442	China	Health care	COVID-19	Confirmed	No	*****
Wiboonchutikul et al (2016)[71]	38	Thailand	Health care	MERS	Confirmed	No	*****
Wilder-Smith et al (2005)[72]	80	Singapore	Health care	SARS	Confirmed	No	********
Wong et al (2004)[73]	66	China	Health care	SARS	Confirmed	No	*****
Wu et al (2004)[74]	375	China	Non-health care (community)	SARS	Confirmed	Yes	********
Yin et al (2004)[75]	257	China	Health care	SARS	Confirmed	Yes	******
Yu et al (2005)[76]	74	China	Health care	SARS	Confirmed	No	*******
Yu et al (2007)[77]	124 wards	China	Health care	SARS	Confirmed	Yes	*******

Across studies, mean age was 30–60 years. SARS=severe acute respiratory syndrome. MERS=Middle East respiratory syndrome. *The Newcastle-Ottawa Scale was used for the risk of bias assessment, with more stars equalling lower risk.

Table 1: Characteristics of included comparative studies

and reported conflicts of interests, ethics approval, study limitations, and other important comments.

Outcomes

Outcomes of interest were risk of transmission (ie, WHO-defined confirmed or probable COVID-19, SARS, or MERS) to people in health-care or non-health-care settings by those infected; hospitalisation; intensive care unit admission; death; time to recovery; adverse effects of interventions; and contextual factors such as acceptability, feasibility, effect on equity, and resource considerations related to the interventions of interest. However, data were only available to analyse intervention effects for transmission and contextual factors. Consistent with WHO, studies generally defined confirmed cases with laboratory confirmation (with or without symptoms) and probable cases with clinical evidence of the respective infection (ie, suspected to be infected) but for whom confirmatory testing either had not yet been done for any reason or was inconclusive.

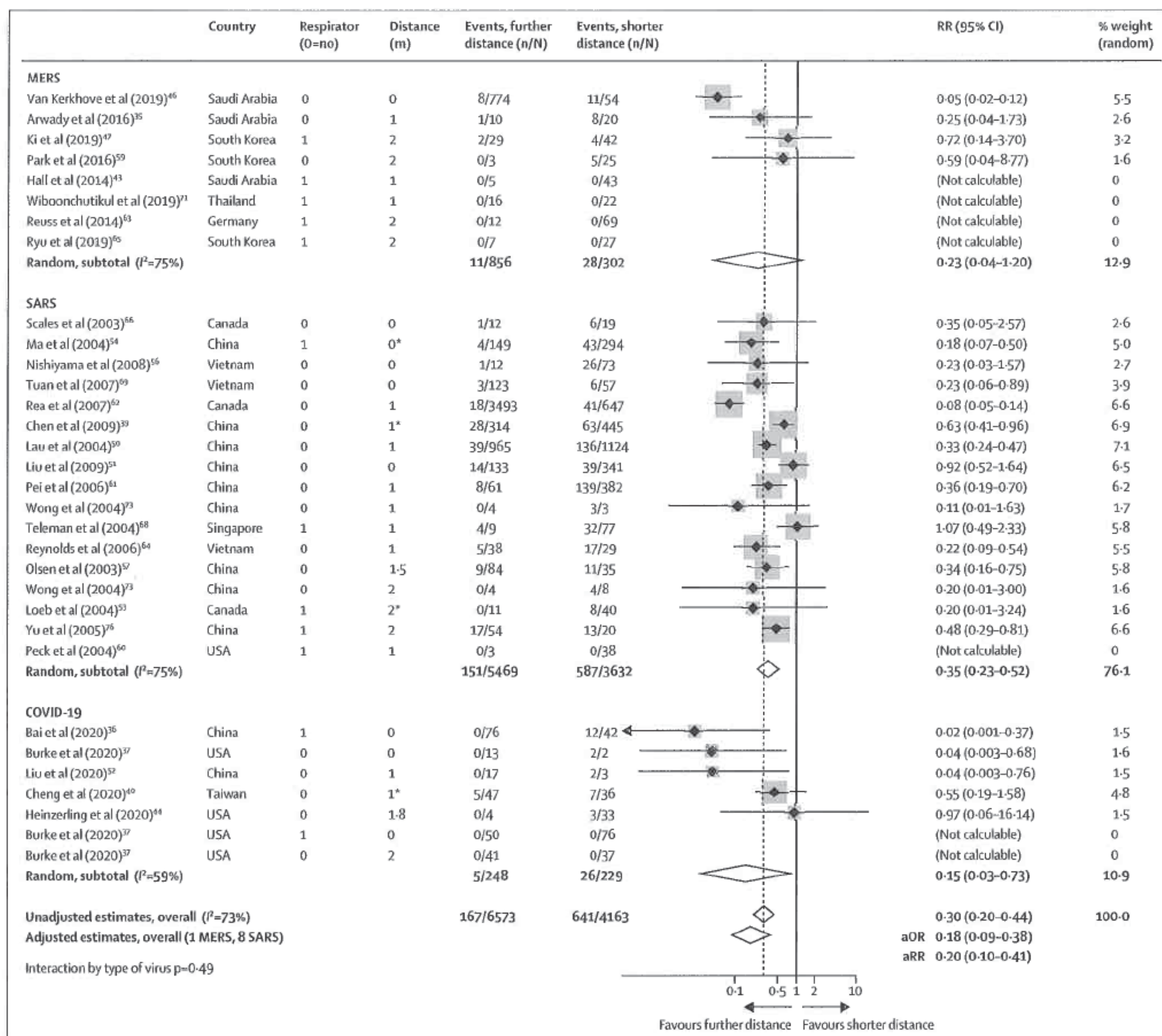
Data analysis

Our search did not identify any randomised trials of COVID-19, SARS, or MERS. We did a meta-analysis of associations by pooling risk ratios (RRs) or adjusted odds ratios (aORs) depending on availability of these data from observational studies, using DerSimonian and Laird random-effects models. We adjusted for variables including age, sex, and severity of source case; these variables were not the same across studies. Because between-study heterogeneity can be misleadingly large when quantified by I^2 during meta-analysis of observational studies,[21,22] we used GRADE guidance to assess between-study heterogeneity.[21] Throughout, we present RRs as unadjusted estimates and aORs as adjusted estimates.

We used the Newcastle-Ottawa scale to rate risk of bias for comparative non-randomised studies corresponding to every study's design (cohort or case-control).[23,24] We planned to use the Cochrane Risk of Bias tool 2.0 for randomised trials,[25] but our search did not identify any eligible randomised trials. We synthesised data in both narrative and tabular formats. We graded the certainty of evidence using the GRADE approach. We used the GRADEpro app to rate evidence and present it in GRADE evidence profiles and summary of findings tables[26,27] using standardised terms.[28,29]

For more on the **GRADEpro app** see https://www.gradepro.org

We analysed data for subgroup effects by virus type, intervention (different distances or face mask types), and setting (health care *vs* non-health care). Among the studies assessing physical distancing measures to prevent viral transmission, the intervention varied (eg, direct physical contact [0 m], 1 m, or 2 m). We, therefore, analysed the effect of distance on the size of the associations by random-effects univariate meta-regressions, using restricted maximum likelihood, and we present mean effects and 95% CIs. We calculated tests for interaction using a minimum of 10 000 Monte Carlo random permutations to avoid spurious findings.[30] We formally assessed the credibility of potential effect-modifiers using GRADE guidance.[21] We did two sensitivity analyses to test the robustness of our findings. First, we used Bayesian meta-analyses to reinterpret the included studies considering priors derived from the effect point estimate and variance from a meta-analysis of ten randomised trials evaluating face mask use versus no face mask use to prevent influenza-like illness in health-care workers.[31] Second, we used Bayesian meta-analyses to reinterpret the efficacy of N95 respirators versus medical masks on preventing influenza-like illness after seasonal viral (mostly influenza) infection.[13] For these sensitivity analyses, we used hybrid Metropolis-Hastings and Gibbs sampling, a 10 000 sample burn-in, 40 000 Markov chain Monte Carlo samples, and we tested non-informative and sceptical priors (eg, four time variance)[32,33] to inform



	Country	Respirator (0=no)	Distance (m)	Events, further distance (n/N)	Events, shorter distance (n/N)	RR (95% CI)	% weight (random)
MERS							
Van Kerkhove et al (2019)[46]	Saudi Arabia	0	0	8/774	11/54	0·05 (0·02–0·12)	5·5
Arwady et al (2016)[35]	Saudi Arabia	0	1	1/10	8/20	0·25 (0·04–1·73)	2·6
Ki et al (2019)[47]	South Korea	1	2	2/29	4/42	0·72 (0·14–3·70)	3·2
Park et al (2016)[59]	South Korea	0	2	0/3	5/25	0·59 (0·04–8·77)	1·6
Hall et al (2014)[43]	Saudi Arabia	1	1	0/5	0/43	(Not calculable)	0
Wiboonchutikul et al (2019)[71]	Thailand	1	1	0/16	0/22	(Not calculable)	0
Reuss et al (2014)[63]	Germany	1	2	0/12	0/69	(Not calculable)	0
Ryu et al (2019)[65]	South Korea	1	2	0/7	0/27	(Not calculable)	0
Random, subtotal (I^2=75%)				**11/856**	**28/302**	**0·23 (0·04–1·20)**	**12·9**
SARS							
Scales et al (2003)[66]	Canada	0	0	1/12	6/19	0·35 (0·05–2·57)	2·6
Ma et al (2004)[54]	China	1	0*	4/149	43/294	0·18 (0·07–0·50)	5·0
Nishiyama et al (2008)[56]	Vietnam	0	0	1/12	26/73	0·23 (0·03–1·57)	2·7
Tuan et al (2007)[69]	Vietnam	0	0	3/123	6/57	0·23 (0·06–0·89)	3·9
Rea et al (2007)[62]	Canada	0	1	18/3493	41/647	0·08 (0·05–0·14)	6·6
Chen et al (2009)[39]	China	0	1*	28/314	63/445	0·63 (0·41–0·96)	6·9
Lau et al (2004)[50]	China	0	1	39/965	136/1124	0·33 (0·24–0·47)	7·1
Liu et al (2009)[51]	China	0	0	14/133	39/341	0·92 (0·52–1·64)	6·5
Pei et al (2006)[61]	China	0	1	8/61	139/382	0·36 (0·19–0·70)	6·2
Wong et al (2004)[73]	China	0	1	0/4	3/3	0·11 (0·01–1·63)	1·7
Teleman et al (2004)[68]	Singapore	1	1	4/9	32/77	1·07 (0·49–2·33)	5·8
Reynolds et al (2006)[64]	Vietnam	0	1	5/38	17/29	0·22 (0·09–0·54)	5·5
Olsen et al (2003)[57]	China	0	1·5	9/84	11/35	0·34 (0·16–0·75)	5·8
Wong et al (2004)[73]	China	0	2	0/4	4/8	0·20 (0·01–3·00)	1·6
Loeb et al (2004)[53]	Canada	1	2*	0/11	8/40	0·20 (0·01–3·24)	1·6
Yu et al (2005)[76]	China	1	2	17/54	13/20	0·48 (0·29–0·81)	6·6
Peck et al (2004)[60]	USA	1	1	0/3	0/38	(Not calculable)	0
Random, subtotal (I^2=75%)				**151/5469**	**587/3632**	**0·35 (0·23–0·52)**	**76·1**
COVID-19							
Bai et al (2020)[36]	China	1	0	0/76	12/42	0·02 (0·001–0·37)	1·5
Burke et al (2020)[37]	USA	0	0	0/13	2/2	0·04 (0·003–0·68)	1·6
Liu et al (2020)[52]	China	0	1	0/17	2/3	0·04 (0·003–0·76)	1·5
Cheng et al (2020)[40]	Taiwan	0	1*	5/47	7/36	0·55 (0·19–1·58)	4·8
Heinzerling et al (2020)[44]	USA	0	1·8	0/4	3/33	0·97 (0·06–16·14)	1·5
Burke et al (2020)[37]	USA	1	0	0/50	0/76	(Not calculable)	0
Burke et al (2020)[37]	USA	0	2	0/41	0/37	(Not calculable)	0
Random, subtotal (I^2=59%)				**5/248**	**26/229**	**0·15 (0·03–0·73)**	**10·9**
Unadjusted estimates, overall (I^2=73%)				**167/6573**	**641/4163**	**0·30 (0·20–0·44)**	**100·0**
Adjusted estimates, overall (1 MERS, 8 SARS)						**aOR 0·18 (0·09–0·38)**	
						aRR 0·20 (0·10–0·41)	
Interaction by type of virus p=0·49							

Figure 2: **Forest plot showing the association of COVID-19, SARS, or MERS exposure proximity with infection**

SARS=severe acute respiratory syndrome. MERS=Middle East respiratory syndrome. RR=relative risk. aOR=adjusted odds ratio. aRR=adjusted relative risk. *Estimated values; sensitivity analyses excluding these values did not meaningfully alter findings.

mean estimates of effect, 95% credibility intervals (CrIs), and posterior distributions. We used non-informative hyperpriors to estimate statistical heterogeneity. Model convergence was confirmed in all cases with good mixing in visual inspection of trace plots, autocorrelation plots, histograms, and kernel density estimates in all scenarios. Parameters were blocked, leading to acceptance of approximately 50% and efficiency greater than 1% in all cases (typically about 40%). We did analyses using Stata version 14.3.

Role of the funding source

The funder contributed to defining the scope of the review but otherwise had no role in study design and data collection. Data were interpreted and the report drafted and submitted without funder input, but according to contractual agreement, the funder provided review at the time of final publication. The corresponding author had full access to all data in the study and had final responsibility for the decision to submit for publication.

	Studies and participants	Relative effect (95% CI)	Anticipated absolute effect (95% CI), eg, chance of viral infection or transmission		Difference (95% CI)	Certainty*	What happens (standardised GRADE terminology)[29]
			Comparison group	Intervention group			
Physical distance ≥1 m vs <1 m	Nine adjusted studies (n=7782); 29 unadjusted studies (n=10 736)	aOR 0·18 (0·09 to 0·38); unadjusted RR 0·30 (95% CI 0·20 to 0·44)	Shorter distance, 12·8%	Further distance, 2·6% (1·3 to 5·3)	−10·2% (−11·5 to −7·5)	Moderate†	A physical distance of more than 1 m probably results in a large reduction in virus infection; for every 1 m further away in distancing, the relative effect might increase 2·02 times
Face mask vs no face mask	Ten adjusted studies (n=2647); 29 unadjusted studies (n=10 170)	aOR 0·15 (0·07 to 0·34); unadjusted RR 0·34 (95% CI 0·26 to 0·45)	No face mask, 17·4%	Face mask, 3·1% (1·5 to 6·7)	−14·3% (−15·9 to −10·7)	Low‡	Medical or surgical face masks might result in a large reduction in virus infection; N95 respirators might be associated with a larger reduction in risk compared with surgical or similar masks§
Eye protection (faceshield, goggles) vs no eye protection	13 unadjusted studies (n=3713)	Unadjusted RR 0·34 (0·22 to 0·52)¶	No eye protection, 16·0%	Eye protection, 5·5% (3·6 to 8·5)	−10·6% (−12·5 to −7·7)	Low‖	Eye protection might result in a large reduction in virus infection

Table based on GRADE approach.[20–23] Population comprised people possibly exposed to individuals infected with SARS-CoV-2, SARS-CoV, or MERS-CoV. Setting was any health-care or non-health-care setting. Outcomes were infection (laboratory-confirmed or probable) and contextual factors. Risk (95% CI) in intervention group is based on assumed risk in comparison group and relative effect (95% CI) of the intervention. All studies were non-randomised and evaluated using the Newcastle-Ottawa Scale; some studies had a higher risk of bias than did others but no important difference was noted in sensitivity analyses excluding studies at higher risk of bias; we did not further rate down for risk of bias. Although there was a high I^2 value (which can be exaggerated in non-randomised studies)[22] and no overlapping CIs, point estimates generally exceeded the thresholds for large effects and we did not rate down for inconsistency. We did not rate down for indirectness for the association between distance and infection because SARS-CoV-2, SARS-CoV, and MERS-CoV all belong to the same family and have each caused epidemics with sufficient similarity; there was also no convincing statistical evidence of effect-modification across viruses; some studies also used bundled interventions but the studies include only those that provide adjusted estimates. aOR=adjusted odds ratio. RR=relative risk. SARS-CoV-2=severe acute respiratory syndrome coronavirus 2. SARS-CoV=severe acute respiratory syndrome coronavirus. MERS-CoV=Middle East respiratory syndrome coronavirus. *GRADE category of evidence; high certainty (we are very confident that the true effect lies close to that of the estimate of the effect); moderate certainty (we are moderately confident in the effect estimate; the true effect is probably close to the estimate, but it is possibly substantially different); low certainty (our confidence in the effect estimate is limited; the true effect could be substantially different from the estimate of the effect); very low certainty (we have very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect). †The effect is very large considering the thresholds set by GRADE, particularly at plausible levels of baseline risk, which also mitigated concerns about risk of bias; data also suggest a dose-response gradient, with associations increasing from smaller distances to 2 m and beyond, by meta-regression; we did not rate up for this domain alone but it further supports the decision to rate up in combination with the large effects. ‡The effect was very large, and the certainty of evidence could be rated up, but we made a conservative decision not to because of some inconsistency and risk of bias; hence, although the effect is qualitatively highly certain, the precise quantitative effect is low certainty. §In a subgroup analysis comparing N95 respirators with surgical or similar masks (eg, 12–16-layer cotton), the association was more pronounced in the N95 group (aOR 0·04, 95% CI 0·004–0·30) compared with other masks (0·33, 0·17–0·61; $p_{interaction}$=0·090); there was also support for effect-modification by formal analysis of subgroup credibility. ¶Two studies[54,71] provided adjusted estimates with n=295 in the eye protection group and n=406 in the group not wearing eye protection; results were similar to the unadjusted estimate (aOR 0·22, 95% CI 0·12–0·39). ‖The effect is large considering the thresholds set by GRADE assuming that ORs translate into similar magnitudes of RR estimates; this mitigates concerns about risk of bias, but we conservatively decided not to rate up for large or very large effects.

Table 2: GRADE summary of findings

Results

We identified 172 studies for our systematic review from 16 countries across six continents (figure 1; appendix pp 6–14, 41–47). Studies were all observational in nature; no randomised trials were identified of any interventions that directly addressed the included study populations. Of the 172 studies, 66 focused on how far a virus can travel by comparing the association of different distances on virus transmission to people (appendix pp 42–44). Of these 66 studies, five were mechanistic, assessing viral RNA, virions, or both cultured from the environment of an infected patient (appendix p 45).

44 studies were comparative[34–77] and fulfilled criteria for our meta-analysis (n=25 697; figure 1; table 1). We used these studies rather than case series and qualitative studies (appendix pp 41–47) to inform estimates of effect. 30 studies[34,37,41–45,47–51,53–56,58–61,64–70,72,74,75] focused on the association between use of various types of face masks and respirators by health-care workers, patients, or both with virus transmission. 13 studies[34,37–39,47,49,51,54,58,60,61,65,75] addressed the association of eye protection with virus transmission.

Some direct evidence was available for COVID-19 (64 studies, of which seven were comparative in design),[36,37,40,41,44,52,70] but most studies reported on SARS (n=55) or MERS (n=25; appendix pp 6–12). Of the 44 comparative studies, 40 included WHO-defined confirmed cases, one included both confirmed and probable cases, and the remaining three studies included probable cases. There was no effect-modification by case-definition (distance $p_{interaction}$=0·41; mask $p_{interaction}$=0·46; all cases for eye protection were confirmed). Most studies reported on bundled interventions, including different components of PPE and distancing, which was usually addressed by statistical adjustment. The included studies all occurred during recurrent or novel outbreak settings of COVID-19, SARS, or MERS.

Risk of bias was generally low-to-moderate after considering the observational designs (table 1), but both within studies and across studies the overall findings were similar between adjusted and unadjusted estimates. We did not detect strong evidence of publication bias in the body of evidence for any intervention (appendix pp 15–18). As we did not use case series data to inform estimates of effect of each intervention, we did not systematically rate risk of bias of these data. Therefore, we report further only those studies with comparative data.