IN THE COURT OF APPEAL OF NEW ZEALAND

I TE KŌTI PĪRA O AOTEAROA

CA218/2022
[2024] NZCA 74

BETWEEN	NZTSOS INCORPORATED Appellant
AND	MINISTER FOR COVID-19 RESPONSE First Respondent
	DIRECTOR-GENERAL OF HEALTH Second Respondent
	ATTORNEY-GENERAL Third Respondent

Hearing:	19 April 2023
Court:	Gilbert, Collins and Goddard JJ
Counsel:	M I Hague and T G Stewart for Appellant D Jones and O Kiel for Respondents
Judgment:	26 March 2024 at 2 pm

JUDGMENT OF THE COURT

A The appeal is dismissed.

B There is no order for costs.

REASONS OF THE COURT

(Given by Gilbert J)

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Introduction

[1] The appellant is an association of education sector professionals and workers incorporated under the Incorporated Societies Act 1908.[1] The appellant unsuccessfully sought judicial review in the High Court challenging the lawfulness of the COVID-19 Public Health Response (Vaccinations) Order 2021 (referred to in this judgment as the Vaccination Order or the Order) made under the COVID-19 Public Health Response Act 2020 (the Act) requiring affected workers in the education sector to be vaccinated.

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1 This Act has since been repealed and replaced by the Incorporated Societies Act 2022.

[2] Shortly after the hearing in the High Court, but before the judgment was delivered, the Prime Minister publicly announced on 23 March 2022 that the vaccine mandate for the education sector would be revoked from 4 April 2022.

[3] Notwithstanding this development, Cooke J considered that the appellant's claims should be determined because of the potential that any relief granted by the Court may have an impact on existing employment issues.[2] However, the Judge dismissed the appellant's claims for the detailed reasons set out in his judgment delivered on 8 April 2022. In summary, the Judge found:

(a) The right to be free to refuse to undergo medical treatment assured by s 11 of the New Zealand Bill of Rights Act 1990 (BORA) is a fundamental right based on the concept of personal autonomy as well as informed consent.[3] However, the right is not absolute and is subject to reasonable limits, prescribed by law, that are demonstrably justified in a free and democratic society under s 5 of BORA.[4]

(b) The Crown had met the onus of showing that the vaccination mandate was justified in the education sector. It was important for students to be able to learn in a physical school environment. In effect, the community was requiring significant numbers of children to congregate with others, and with adults. This created a risk of COVID-19 infection for the children but primarily for the community they interacted with. A risk minimisation approach was justified.[5]

(c) The exemption criteria were not unduly narrow, nor had they been applied in an unreasonable, irrational, or overly rigid way.[6]

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2 *NZDSOS Inc v Minister for COVID-19 Response* [2022] NZHC 716, (2022) 18 NZELR 833 [High Court judgment] at [33].
3 At [53] and [156].
4 At [46]–[52] and [156].
5 At [77]–[143] and [158].
6 At [145]–[154] and [166].

Issues on appeal

[4] The appellant advances four grounds of appeal. The parties submitted the following list of issues for determination:

(a) Did the High Court err in determining that the right affirmed by s 11 of BORA was not absolute?

(b) Did the High Court err in determining that the exemption criteria were not ultra vires the Act?

(c) Did the High Court err in determining that the exemption criteria were not too narrow, and were not being unreasonably applied by the second respondent?

(d) Did the High Court err in determining that the limitation on the s 11 right of affected education workers was demonstrably justified under s 5 of BORA?

Relevant legislation and orders

[5] Before addressing these issues, we summarise the legislative provisions and the particular orders relevant to the appeal. It is important to bear in mind that the orders were temporary and formed part of a package of measures the Government introduced at various stages in response to the evolving health threats posed by the COVID-19 global pandemic. The lawfulness of the orders must be assessed in the context of the circumstances prevailing at the time. The factual background and relevant context was set out by the Judge in some detail as well as the change in circumstances that led to the revocation of the vaccine mandate for the education sector.[7] We need not fully repeat that background information for the purposes of this judgment. We will address the relevant factual context as necessary when we come to the fourth issue concerning whether the limit on the s 11 BORA right was reasonable and demonstrably justified.

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7 At [4]–[34].

BORA

[6] The right to refuse medical treatment is separately provided for as a standalone right in New Zealand under s 11 of BORA:

> **11 Right to refuse to undergo medical treatment**
>
> Everyone has the right to refuse to undergo any medical treatment.

[7] Sections 4, 5 and 6 of BORA provide:

> **4 Other enactments not affected**
>
> No court shall, in relation to any enactment (whether passed or made before or after the commencement of this Bill of Rights),—
>
> (a) hold any provision of the enactment to be impliedly repealed or revoked, or to be in any way invalid or ineffective; or
>
> (b) decline to apply any provision of the enactment—
>
> by reason only that the provision is inconsistent with any provision of this Bill of Rights.
>
> **5 Justified limitations**
>
> Subject to section 4, the rights and freedoms contained in this Bill of Rights may be subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.
>
> **6 Interpretation consistent with Bill of Rights to be preferred**
>
> Wherever an enactment can be given a meaning that is consistent with the rights and freedoms contained in this Bill of Rights, that meaning shall be preferred to any other meaning.

The Act

[8] The Act came into force on 13 May 2020 and was to be automatically repealed after two years unless repealed earlier.[8] Its purpose, at the time the Order was extended, was set out in s 4:[9]

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[8] COVID-19 Public Health Response Act 2020, ss 2 and 3. This section was amended by the COVID-19 Public Health Response (Extension of Act and Reduction of Powers) Amendment Act 2022 so that the Act is repealed 2 years after Royal assent of that Act on 25 November 2022.

[9] The purpose has since been amended by the COVID-19 Public Health Response (Extension of Act and Reduction of Powers) Amendment Act 2022, removing the reference to MIQF costs in s 4(cb).

> **4 Purpose**
>
> The purpose of this Act is to support a public health response to COVID-19 that—
>
> (a) prevents, and limits the risk of, the outbreak or spread of COVID-19 (taking into account the infectious nature and potential for asymptomatic transmission of COVID-19); and
>
> (b) avoids, mitigates, or remedies the actual or potential adverse effects of the COVID-19 outbreak (whether direct or indirect); and
>
> (c) is co-ordinated, orderly, and proportionate; and
>
> (ca) allows social, economic, and other factors to be taken into account where it is relevant to do so; and
>
> (cb) is economically sustainable and allows for the recovery of MIQF costs; and
>
> (d) has enforceable measures, in addition to the relevant voluntary measures and public health and other guidance that also support that response.

[9] The Minister for COVID-19 Response was authorised by s 11 of the Act to make COVID-19 orders in accordance with s 9. The principal order that is the subject of the present challenge — the Vaccination Order — was made by the Minister in reliance on this provision.[10] At the time the Vaccination Order was made on 28 April 2021, s 9 of the Act read as follows:

> **9 Minister may make COVID-19 orders**
>
> (1) The Minister may make a COVID-19 order in accordance with the following provisions:
>
> (a) the Minister must have had regard to advice from the Director-General about—
>
> (i) the risks of the outbreak or spread of COVID-19; and
>
> (ii) the nature and extent of measures (whether voluntary or enforceable) that are appropriate to address those risks; and
>
> (b) the Minister may have had regard to any decision by the Government on the level of public health measures appropriate to respond to those risks and avoid, mitigate, or

[10] The appellant defined "the Vaccination Order" under challenge as being the order that came into force on 30 April 2021 and any amendments to the order up to date of the pleading (10 February 2022).

remedy the effects of the outbreak or spread of COVID-19 (which decision may have taken into account any social, economic, or other factors); and

(ba) the Minister must be satisfied that the order does not limit or is a justified limit on the rights and freedoms in the New Zealand Bill of Rights Act 1990; and

(c) the Minister—

(i) must have consulted the Prime Minister, the Minister of Justice, and the Minister of Health; and

(ii) may have consulted any other Minister that the Minister (as defined in this Act) thinks fit; and

(d) before making the order, the Minister must be satisfied that the order is appropriate to achieve the purpose of this Act.

(2) Nothing in this section requires the Minister to receive specific advice from the Director-General about the content of a proposed order or proposal to amend, extend, or revoke an order.

[10] Section 11 of the Act set out the orders that could be made by the Minister (or the Director-General of Health under an equivalent power in s 10). In relation to persons, the Act provided:

11 Orders that can be made under this Act

(1) The Minister or Director-General may in accordance with section 9 or 10 (as the case may be) make an order under this section for 1 or more of the following purposes:

(a) to require persons to refrain from taking any specified actions that contribute or are likely to contribute to the risk of the outbreak or spread of COVID-19, or require persons to take any specified actions, or comply with any specified measures, that contribute or are likely to contribute to preventing the risk of the outbreak or spread of COVID-19, including (without limitation) requiring persons to do any of the following:

(i) stay in any specified place or refrain from going to any specified place:

(ii) refrain from associating with specified persons:

(iii) stay physically distant from any persons in any specified way:

(iv) refrain from travelling to or from any specified area:

(v) refrain from carrying out specified activities (for example, business activities involving close personal contact) or require specified activities to be carried out only in any specified way or in compliance with specified measures:

(vi) be isolated or quarantined in any specified place or in any specified way:

(vii) refrain from participating in gatherings of any specified kind, in any specified place, or in specified circumstances:

(viii) report for and undergo a medical examination or testing of any kind, and at any place or time, specified and in any specified way or specified circumstances:

(ix) provide, in specified circumstances or in any specified way, any information necessary for the purpose of contact tracing:

(x) satisfy any specified criteria before entering New Zealand from a place outside New Zealand, which may include being registered to enter an MIQF on arrival in New Zealand:

…

[11] Section 12 of the Act contained general provisions relating to COVID-19 orders. This relevantly read:

12 General provisions relating to COVID-19 orders

(1) A COVID-19 order may—

(a) impose different measures for different circumstances and different classes of persons or things:

(b) apply,—

(i) in relation to people, generally to all people in New Zealand or to any specified class of people in New Zealand:

(ii) in relation to things that can be specified under section 11, to any class of those things or to all of those things:

(iii) in relation to anything else,—

(A) generally throughout New Zealand:

(B) in any area, however described:

(c) exempt (with or without conditions) from compliance with or the application of any provisions of the order any person or thing or class of persons or things:

(d) authorise any person or class of persons to—

(i) grant an exemption (with or without conditions) referred to in paragraph (c); or

(ii) authorise (with or without conditions) a specified activity that would otherwise be prohibited by the order:

(e) if any thing can be prohibited under section 11, permit that thing but only subject to specified conditions.

(2) However, a COVID-19 order—

(a) may not apply only to a specific individual:

…

The Vaccination Order

[12] The Minister purportedly made the Vaccination Order under s 11 of the Act and in accordance with the requirements recorded in s 9 of the Act. The Vaccination Order came into force on 30 April 2021 and prohibited "affected persons" from carrying out work unless they were vaccinated. The Vaccination Order did not apply to education sector workers at that time.

[13] We set out the relevant provisions in the Vaccination Order below:

7 Duty of affected person not to carry out work unless vaccinated

An affected person must not carry out work or otherwise conduct an activity at a place unless they are vaccinated.

8 Duties of relevant PCBUs in relation to vaccinations

(1) A relevant PCBU must not allow an affected person to carry out work or otherwise conduct an activity at a place unless satisfied that the affected person is vaccinated.

(2) A relevant PCBU—

(a) must notify each affected person of their duty to be vaccinated; and

(b) must not prevent the affected person from reporting for, and undergoing, vaccination during their working hours, if vaccinations are available during those hours.

9 Exceptions

(1) This clause applies despite anything in clause 7 or 8.

(2) A chief executive may authorise a person who has not been vaccinated to enter and carry out work at a place if the work—

(a) is unanticipated, necessary, and time-critical and cannot be carried out by a person who is vaccinated; and

(b) must be carried out to prevent the place from ceasing operations.

(3) A person who is authorised to enter a place under subclause (2) may be authorised to re-enter as many times as is necessary to complete the work.

(4) A person who is not vaccinated may enter a place without approval if they—

(a) need to enter to preserve or protect a person's life, health, or safety in an emergency; or

(b) are authorised or required to by law.

(5) In this clause, **chief executive**,—

(a) in relation to a managed isolation facility or managed quarantine facility, means a chief executive of the public service agency responsible for the place where the work is carried out:

(b) in relation to any other place, means a chief executive of the relevant PCBU for whom the person described in subclause (2) carries out work.

10 Duties of relevant PCBUs regarding vaccination status

(1) The relevant PCBU must—

(a) ask the Ministry of Health to confirm whether an affected person is vaccinated; or

(b) access the register specified in clause 12 to confirm whether the person is vaccinated.

(2) The relevant PCBU must notify the affected person that—

(a) the affected person has a duty to be vaccinated; and

(b) the relevant PCBU has checked the affected person's vaccination status under subclause (1).

(3) The relevant PCBU must, as soon as practicable, notify the Ministry of Health—

(a) of any change reported to the relevant PCBU under clause 11:

(b) that a person that the relevant PCBU has engaged or employed has ceased to be an affected person for the relevant PCBU.

11 Duties of affected person regarding vaccination status

An affected person who is to carry out work at a place—

(a) must allow the relevant PCBU to access any records regarding the COVID-19 vaccination status of the affected person that the Ministry of Health may have:

(b) must notify the relevant PCBU of any change in their vaccination status as soon as practicable, including the dates on which they receive any injections of the Pfizer/BioNTech COVID-19 vaccine.

[14] An "affected person" was defined in cl 4 of the Vaccination Order as "a person who belongs to a group (or whose work would cause them to belong to a group)". A "group" was defined to mean a group of affected persons specified in sch 2. At the time the Order was made, sch 2 listed persons working at quarantine and managed isolation facilities and various persons working at airports or other ports. A relevant PCBU was defined as in s 17 of the Health and Safety at Work Act 2015, meaning a person conducting a business or undertaking.

The COVID-19 Public Health Response (Vaccinations) Amendment Order (No 3) 2021

[15] On 22 October 2021, the Minister made a further order under s 11 and 15(1) of the Act — the COVID-19 Public Health Response (Vaccinations) Amendment Order (No 3) 2021. This order came into force at 11.59 pm on 25 October 2021. Among other things, the order brought education sector workers within the scope of the Vaccination Order. In particular, sch 2 of the Vaccination Order was amended to include:[11]

[11] COVID-19 Public Health Response (Vaccinations) Amendment Order (No 3) 2021, cl 14.

Schedule 2

Groups of affected persons

…

Part 9: Groups in relation to affected education services

9.1 Workers over the age of 12 years who carry out work at or for an affected education service (including as a volunteer or an unpaid worker) and who—

(a) may have contact with children or students in the course of carrying out that work; or

(b) will be present at the affected education service at a time when children or students are also present

9.2 Providers of a home-based education and care service

Exemptions

[16] At the same time as the Vaccination Order was extended to cover education workers, cl 7A that provided for exemptions was amended to provide that an exemption in certain circumstances would apply to education workers:[12]

7A Exemption from duty under clause 7

(1) This clause applies to an affected person who belongs to a group specified in Part 6, 7, 8, or 9 of the table in Schedule 2.

(2) An affected person may carry out certain work without being vaccinated if—

(a) the affected person has particular physical or other needs that a suitably qualified health practitioner (in the course of examining the person) determines would make it inappropriate for the person to be vaccinated; and

(b) in any case where the affected person belongs to the group specified in Part 6 of the table in Schedule 2, the relevant PCBU who employs or engages the affected person has provided the register with written confirmation that a suitably qualified health practitioner—

(i) has examined the affected person; and

(ii) has determined that vaccinating the affected person would be inappropriate.

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12 Clause 5.

> (3) If the affected person is a health practitioner, the examination referred to in subclause (2) must be undertaken by another health practitioner who is suitably qualified to conduct the examination.

[17] The exemption in cl 7A was revoked on 7 November 2021 and replaced with a centralised process whereby exemptions could only be granted by the Director-General of Health on the basis of specified criteria published in the *Gazette*.[13] The exemption criteria were narrow and based solely on clinical grounds. The initial criteria set by the Director-General on 12 November 2021 were as shown in Schedule 1 attached to this judgment. These were replaced on 19 January 2022 with the criteria listed in Schedule 2.

[18] We note that the Act was amended on 26 November 2021 so that the power to specify COVID-19 vaccination exemption criteria was no longer contained in the Order, in exercise of the power in s 12(1)(d) of the Act.[14] This was achieved by the enactment of the COVID-19 Response (Vaccinations) Legislation Act 2021 which inserted a new s 5(3) into the Act, as follows:[15]

> (3) The Director-General may make a notice specifying (for the purposes of all or any legislation in, or made under, this Act)—
>
> (a) COVID-19 vaccination exemption criteria:
>
> (b) for the purposes of a COVID-19 vaccination, the required doses for each COVID-19 vaccine or combination of COVID-19 vaccines.

[19] As noted, the Vaccination Order was revoked insofar as it applied to the education sector as from 11.59 pm on 4 April 2022.[16] In effect, the Vaccination Order prevented unvaccinated education workers from attending their workplaces to carry out their normal duties from the time school recommenced (ranging from 31 January 2022 to 8 February 2022) until the Order was revoked on 4 April 2022, a period of around eight to nine weeks. While the period covered by the Order was comparatively short, the consequences of the Order for many were far reaching. School boards were

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13 COVID-19 Public Health Response (Required Testing and Vaccinations) Amendment Order 2021, cls 9 and 11. Clause 11 also required that the exemption criteria be published on a publicly accessible Internet site maintained by or on behalf of the New Zealand Government.

14 COVID-19 Response (Vaccinations) Legislation Act 2021, s 18.

15 Section 4(5).

16 COVID-19 Public Health Response (Protection Framework and Vaccinations) Amendment Order 2022, cl 26.

not funded to carry the cost of unvaccinated staff and were to rely on employment law should a person choose not to be vaccinated. They may have had little option but to terminate the employment of some affected individuals. For these individuals, the consequences were particularly harsh, including the loss of their livelihoods and careers. It is fair to say that the vaccine mandate was a highly controversial and divisive issue.

Is the right to refuse medical treatment absolute?

[20] Mr Hague, for the appellant, submits that the right to refuse medical treatment assured under s 11 of BORA is an absolute right that may not be capable of being subject to demonstrably justified limits under s 5. He notes that the s 11 right forms part of the same family of rights which are grouped in BORA under the heading "*Life and security of the person*". These rights include the right not to be deprived of life (except on such grounds as are established by law and are consistent with the principles of fundamental justice) (s 8), the right not to be subjected to torture or cruel treatment (s 9) and the right not to be subjected to medical or scientific experimentation (s 10). Mr Hague places emphasis on the Supreme Court's decision in *Fitzgerald v R* in which it was held that the right not to be subjected to torture or cruel treatment was so fundamental that no limit on it could be justified.[17] He says the same approach must be taken to the s 11 right to refuse to undergo medical treatment. In the circumstances of this case, he argues that the right should be afforded "the same, or near the same, degree of protection by the Courts as those rights in ss 8–10 of [BORA]".

[21] The Supreme Court's decision in *New Health New Zealand Inc v South Taranaki District Council* authoritatively determined that the right to refuse to undergo medical treatment is not absolute and may be subject to reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society in terms of s 5 of BORA.[18] The Supreme Court held by a majority that the fluoridation of drinking

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17 *Fitzgerald v R* [2021] NZSC 131, [2021] 1 NZLR 551 at [38] per Winkelmann CJ, [160] per O'Regan and Arnold JJ, and [241] per Glazebrook J.

18 *New Health New Zealand Inc v South Taranaki District Council* [2018] NZSC 59, [2018] 1 NZLR 948 at [144] per O'Regan and Ellen France JJ, [176] per Glazebrook J, and [307]–[308] per Elias CJ.

water by councils meant that residents in the district were required to undergo medical treatment. In practice, they could not avoid drinking the fluoridated water and were therefore denied their choice to accept or reject medical treatment. However, the majority readily found that this right was subject to a "reasonable limits" analysis under s 5.

[22] The s 11 right is unquestionably of fundamental importance, but this does not mean that it can never yield, regardless of the circumstances, even where it is necessary to protect the health and safety of others. As the Judge pointed out, such a limitation was envisaged from the outset.[19] The White Paper on BORA presented to the House in 1985 by the Hon Geoffrey Palmer, then Minister of Justice, included the following comment on the proposed right to refuse to undergo any medical treatment:[20]

> This provision has no equivalent in the International Covenant, nor in any other international human rights instrument. It enacts as a general principle that everyone has the right to refuse to undergo any medical treatment. This right is of course subject to Article 3 [what became s 5], but it is anticipated that this would permit persons to be treated against their will only where this is necessary to protect the health and safety of other persons, and not simply where their refusal of treatment will detrimentally affect their own health.

[23] The recognition in New Zealand of room for reasonable limits being placed on the s 11 right is consistent with comparable jurisdictions where an equivalent right has been recognised. For example, mandatory vaccination requirements were found not to violate the United States Constitution in *Jacobson v Commonwealth of Massachusetts*:[21]

> There is, of course, a sphere within which the individual may assert the supremacy of his own will and rightfully dispute the authority of any human government, especially of any free government existing under a written constitution, to interfere with the exercise of that will. But it is equally true that in every well-ordered society charged with the duty of conserving the safety of its members the rights of the individual in respect of his liberty may at times, under the pressure of great dangers, be subjected to such restraint, to be enforced by reasonable regulations, as the safety of the general public may demand.

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19 High Court judgment, above n 2, at [48]-[49].

20 Geoffrey Palmer "A Bill of Rights for New Zealand: A White Paper" [1984–1985] 1 AJHR A6 at [10.166].

21 *Jacobson v Commonwealth of Massachusetts* 197 US 11 (1905), 25 S Ct 358 at 29.

[24] A recent example is the decision of the European Court of Human Rights in *Vavřička v Czech Republic* upholding the decision of the Czech legislature to require pre-school children to be vaccinated against infectious diseases as a condition of attendance:[22]

> The Court considers that it cannot be regarded as disproportionate for a State to require those for whom vaccination represents a remote risk to health to accept this universally practised protective measure, as a matter of legal duty and in the name of social solidarity, for the sake of the small number of vulnerable children who are unable to benefit from vaccination. In the view of the Court, it was validly and legitimately open to the Czech legislature to make this choice, which is fully consistent with the rationale of protecting the health of the population. The notional availability of less intrusive means to achieve this purpose, as suggested by the applicants, does not detract from this finding.

[25] In this respect, the right to refuse medical treatment can be contrasted with the right not to be subjected to torture or cruel treatment under s 9. Self-evidently, torture or cruel treatment could never be justified in a free and democratic society.[23] This explains why the s 9 right has been variously described as "absolute", "illimitable" and "irreducible".[24] However, the Supreme Court's decision in *New Health* puts beyond doubt that the s 11 right is in a different category and is not an absolute right that can never be limited under any circumstances.

[26] This ground of appeal must be rejected.

Were the exemption criteria ultra vires the Act?

[27] The appellant argues that the exemption criteria "were ultra vires in that they were over-rigid and arbitrary". In particular, the appellant complains that no allowance was made for medical exemption where the individual circumstances were particularly compelling, or where there were mental health issues relating to the vaccine or the circumstances, or where denial of an exemption would have financial or other consequences in an individual case. The appellant also contends that

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22 *Vavřička v Czech Republic* ECHR 47621/13, 8 April 2021 at [306].

23 *Fitzgerald v R*, above n 17, at [78] per Winkelmann CJ.

24 At [160] per O'Regan and Arnold JJ. See also *Taunoa v Attorney-General* [2007] NZSC 70, [2008] 1 NZLR 429 at [77] per Elias CJ; and *R v Hansen* [2007] NZSC 7, [2007] 3 NZLR 1 at [65] per Blanchard J.

alternative measures such as rapid antigen testing (RAT) were not given adequate consideration.

[28] The appellant provided evidence of cases where exemptions were declined or unavailable despite arguably compelling medical circumstances. For example, a primary school teacher gave evidence that he was harmed by his first vaccination on 27 November 2021, being diagnosed with pericarditis upon admission to hospital on 3 December 2021. This teacher subsequently applied through his doctor for a temporary medical exemption based on this event, but the application was declined by the Director-General on 22 December 2021. Another deponent, a former school principal, sought an exemption on the grounds that he had previously suffered three heart attacks and he was concerned about contraindications from the COVID-19 vaccines. Numerous similar examples were provided in evidence on behalf of the appellant.

[29] Part of the relief sought in the second amended statement of claim on this ground of review was an order quashing or setting aside the exemption criteria. Such relief, if granted, would have left the mandate in place but with the challenged exemptions removed. Ms Stewart, who presented this part of the argument for the appellant, confirmed at the hearing that the appellant does not seek this relief, unsurprisingly.

[30] Ms Stewart also clarified that the argument is not that the exemption criteria were not authorised by the empowering legislation. Instead, the complaint on this aspect of the appeal is that the exemptions were so narrowly crafted that the measure as a whole was unduly restrictive and therefore not compliant with BORA. We see this argument as being more appropriately addressed under the fourth ground of appeal where we consider whether the limit on the right imposed by the measure as a whole, including the exemptions, was reasonable and demonstrably justified. We will return to the issue arising out of the exemptions at that stage. This ground of appeal, as a standalone ground, must be dismissed because the pleaded relief sought in connection with it is not desired and the exemption criteria are plainly not ultra vires the Act.

Were the exemption criteria applied unreasonably?

[31] This ground of appeal focuses not on the adequacy of the exemption criteria themselves, but rather on the appellant's additional complaint that the exemption criteria were unreasonably *applied* by the Director-General. The second amended statement of claim pleaded that the Director-General "is refusing applications for exemption by affected persons, despite that such applicants satisfy the statutory criteria". The relief sought is "[a] declaration that the [Director-General] is to grant exemptions to all applicants who satisfy the statutory criteria".

[32] The appellant's submissions in support of this ground stray into the same territory covered by the previous ground in that they elaborate on and reinforce the challenge to the adequacy of the exemption criteria. For example, it is contended that the exemption criteria were too narrow and failed to meet the circumstances of particular cases, including "past reactions, natural immunity, and individual choice (including choices for reason of religious belief)". Counsel acknowledged the considerable overlap in the grounds of appeal. For the reasons already given, we consider the substance of the complaint that the exemption criteria were too narrow is most appropriately addressed in the context of the fourth ground of appeal, namely whether the measure overall was a reasonable and demonstrably justified limit on the right to refuse to undergo medical treatment.

[33] On the separate topic of whether the exemption criteria were *applied* unreasonably, the appellant's written submissions do no more than assert that there were "multiple cases of individuals who prima facie met the criteria, but [who] were unreasonabl[y] denied an exemption". This claim is supported by a footnote reference in the submissions to 440 pages of affidavit evidence.

[34] We see the value of this evidence as explaining how the exemption criteria operated on the ground and the practical implications for the individuals concerned. The evidence serves to illustrate how narrowly confined the exemption criteria were. The evidence is therefore helpful to our evaluation of the fourth ground of appeal. However, like the Judge, we consider this proceeding is not an appropriate vehicle for assessing decisions about whether or not particular individuals qualified for an

exemption on the basis of the gazetted criteria. This would require a challenge to the decision not to grant a particular exemption. No such decision is challenged by way of judicial review in this proceeding. We were also not referred to expert evidence addressing whether exemptions coming within the promulgated criteria were improperly denied in individual cases. The relief sought in the proceeding as set out above, cast in such general terms, would not be appropriate in any case. We therefore dismiss this ground of appeal and turn to the fourth ground which raises the critically important issue.

Was the Order a reasonable and demonstrably justified limitation on the right to refuse medical treatment?

The pleading

[35] The appellant pleaded that the Vaccination Order was not a reasonable limit on the right to refuse medical treatment. The appellant also relied on the limits imposed by the Vaccination Order on other human rights such as freedom of association between vaccinated and unvaccinated affected persons in society and affected workplaces and freedom of movement of unvaccinated affected persons. The appellant claimed that the Vaccination Order undermined societal and ethical norms in New Zealand, created two classes of affected persons (the vaccinated and the unvaccinated), and compromised the discharge of medical ethics and the professional independence of health practitioners and vaccinators who are ethically obliged to obtain uncoerced and informed consent from affected persons before administering any COVID-19 vaccine or booster.

[36] The appellant pleaded that the Vaccination Order was an unreasonable public health measure for the following reasons:

(a) It did not adopt orthodox modern health principles of voluntary compliance.

(b) It took no or insufficient account of the absence of long-term safety data and trials of the vaccines and boosters.

(c) It took no or insufficient account of the limited durability and efficacy of the vaccine and boosters. In particular, there was no sound scientific basis to assume that mass vaccination supported by coercive orders would provide sterilising immunity, materially reduce transmission in the community, or end or materially reduce the period of the epidemic in New Zealand.

(d) It did not provide tailored criteria for exemptions from vaccination for those patients, particularly young men and women aged in their late teens and twenties, who have or could suffer significant or life-threatening adverse events or side effects if vaccinated with COVID-19 vaccines and boosters.

(e) The narrow exemption criteria failed to take account of serious adverse events and side effects.

(f) It failed to have sufficient regard to the availability and effects of therapeutic treatments for infected persons.

[37] The appellant claimed that the Vaccination Order gave rise to disproportionate and destructive social and economic consequences including:

(a) School closures and reduced resourcing of schools through understaffing.

(b) Harm to the education and wellbeing of children and young people.

(c) Corrosive effects on workplace relations and personal relationships.

[38] The appellant pleaded that in these circumstances, the Minister was unable to show that he had sufficient grounds to be satisfied that the Vaccination Order was a reasonably justified limit on the pleaded rights and freedoms assured under BORA. Alternatively, the appellant claimed that if there were sufficient grounds when the Order was first made, the measure was no longer justified at the date of the pleading (10 February 2022) or at the date of the trial (3 to 7 March 2022).

[39] The relief sought under this ground of review was a declaration that the Vaccination Order was inconsistent with the right to refuse medical treatment and the rights of unvaccinated persons to freely move about and associate with other persons in education sector workplaces.

High Court judgment

[40] The Judge noted that two interrelated justifications were advanced by the respondents to bring education workers within the scope of the Vaccination Order. First, schools and other facilities are places where people regularly gather creating a risk of community transmission which should be minimised. Secondly, such an environment creates a risk to the children attending schools and education facilities also warranting a risk minimisation approach.[25] The Judge accepted that the periods of lockdown had compromised learning and development and there was a pressing need to get students back into a physical learning environment.[26] There was accordingly a degree of necessity or compulsion in requiring children and others to attend social gatherings of relatively high numbers of people on a daily basis, or at least regularly during the week. The Judge accepted the evidence that studies had shown that transmission occurs within school environments, mostly on an adult to adult and adult to child basis, rather than child to child. The schools were therefore potential transmission points for the wider community.[27]

[41] The Judge also accepted the evidence that protection of children formed a relevant part of the potential justification for the mandate. However, the Judge found that the main public benefit was the protection of the community that the children then interact with. Its primary purpose was to reduce the prospect of the schools being transmission points for a disease that could affect the carers, parents, and grandparents of those who attend the schools, and consequently the wider community.[28]

[42] The Judge observed that a measure might not be justified if there are other more rights-compliant means of achieving the outcome. Such alternatives might

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25 High Court judgment, above n 2, at [77].
26 At [78].
27 At [79].
28 At [80].

include a requirement for unvaccinated teachers to stay home if unwell, to have daily RAT tests in the school, and to follow other measures such as mask wearing and observing social distancing.[29] The Judge was sympathetic to the appellant's claim, stating that he regarded the potential justification for the mandate for education workers as being "less compelling" than in the health sector.[30]

[43] However, the Judge accepted there was clear evidence at the time the Vaccination Order was extended to cover education workers in late October 2021 that vaccination reduced both infection and onward transmission of the original versions of COVID-19 as well as reduced the seriousness of illness when it occurred and consequent hospitalisation and death rates.[31] A risk minimisation approach was potentially justified.[32] The Judge did not accept the appellant's expert evidence that there were unknown safety concerns or adverse economic and social effects such that mandating the vaccine was not justified.[33]

[44] While the Judge accepted that the Crown rightly saw vaccination as providing significant protection against community transmission of the Delta variant when the Order was made in October 2021, the question of whether that remained the case was "now much more debatable".[34] The emergence of the Omicron variant reduced the efficacy of vaccination in preventing community transmission. The Omicron variant was likely to be transmitted through the community in any event such that vaccination would have little beneficial effect and could even be harmful.[35] He stated:

> [105] I accept … the proposition that vaccination materially limits transmission of the Omicron variant is now much more debatable. At the time when the mandate was decided upon in October 2021, the complications caused by Omicron were not apparent. I accept that the Crown rightly saw vaccination as providing significant protection against community transmission of Delta at that stage. But the question is now less certain because of the nature of the Omicron variant and the emerging information.
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> …

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29 At [81].
30 At [81]. The High Court judgment dealt with a challenge to the Vaccine Order by health workers as well as education workers.
31 At [95].
32 At [158].
33 At [161]–[162].
34 At [105].
35 At [98].

> [107] For the reasons I have outlined, I nevertheless find it difficult to make definitive findings on the extent to which mandatory vaccination still meaningfully reduces the spread of the Omicron variant based on the evidence and submissions I have received. It would appear that New Zealand is experiencing a wave of Omicron infection in much the same way as other countries have. But I have not been provided with evidence on the dynamics of such waves of infection, and the effects of vaccination on them. Neither do I have evidence about any secondary waves, or the risks of further variants emerging apart from Dr Bloomfield's comment that any further variants would need to be even more infectious to outcompete with Omicron.
>
> [108] As I have explained, there is a limit on the ability of the parties, or the Court to assess these issues contemporaneously. I am not able to make definitive findings on the continued effectiveness of vaccination to suppress the transmission of the Omicron variant in current circumstances. I am able to find that it did based on the evidence in existence when the mandates were put in place, but the position is now far more contestable. I accept that an arguable basis for continued effect in materially suppressing transmission may still exist. I can go no further than this given what is before me.

[45] The Judge considered that the lawfulness of the mandate ultimately came down to a question of timing. Such a mandate could only be justified as an emergency measure. The mandate was justified at the time it was introduced in October 2021 when the Delta variant was the dominant strain. The emergence of the Omicron variant changed the dynamics and led to the Prime Minister's announcement on 23 March 2022 that the mandate for the education sector would be removed. The Judge was not persuaded that this change came too late or that the mandate had become unjustified prior to that point.[36]

Appellant's submissions

[46] Mr Hague notes that the main public benefit asserted for the education sector mandate was to protect carers and the wider community. However, he argues there was no evidence that the mandate contributed in a meaningful way to that benefit. He says the Judge did not adequately address this issue, the risks associated with the vaccine, or the availability of reasonable alternatives. Importantly, he contends that the Judge did not have sufficient regard to these matters when considering whether the limit on the right was demonstrably justified.

[47] As to the benefit of the measure, Mr Hague makes the following points. Protection against transmission following vaccination waned quickly. Teachers were

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[36] At [165].

required to be vaccinated (first dose) by 15 November 2021 and to be fully vaccinated by 1 January 2022. They faced dismissal if they were not. However, they were not required to return to the workplace and have contact with children until February 2022 by which time, he says, the vaccine would not have provided the protection against transmission that was claimed by the respondents. Any protective benefit of the vaccine would continue to decline rapidly.

[48] By mid-February 2022, 95 per cent of the population aged 12 years and over had received at least two vaccine doses and only around three per cent of teachers remained unvaccinated. Evidence was emerging that the rate of community transmission from schools was no different from community transmission generally. Taking these matters into account, Mr Hague argues that the mandate provided little potential benefit and was not necessary from a community health perspective, especially given the availability of reasonable alternative measures such as staying home if unwell, mask wearing, daily RAT tests and social distancing.

[49] The risks associated with vaccination, including serious injury and death in rare cases, needed to be balanced against this marginal benefit. Mr Hague says the time available for legal and medical risk assessment was minimal, raising the threshold that must be satisfied to justify limiting a fundamental right through a blanket order.

[50] Mr Hague notes that there was considerable debate among the expert witnesses on these key issues. The appellant applied to cross-examine the respondents' experts, but the application was declined. The Judge was not able to determine the factual contest, but applied the precautionary approach endorsed by the Supreme Court in *New Health*.[37] Mr Hague contends that because the onus was on the respondents to show that the limit on the right to refuse medical treatment was demonstrably justified, and the respondents' experts did not rebut all material points made by the appellant's experts, the factual contest traversed in the expert evidence should have been resolved in favour of the appellant.

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[37] At [90]–[91]. The appellant also cites *Spencer v Canada (Attorney-General)* [2021] FC 361.

[51] Mr Hague submits that the measure does not survive scrutiny after applying the *Hansen* test.[38] In particular, he says the purpose — risk minimisation of community transmission from schools — was overly broad. Greater precision was required in defining the objective so as to enable a proper assessment of whether it justified interfering with fundamental rights. He also contends that the limiting measure was not rationally connected to the objective. In any case, Mr Hague argues that the limit on fundamental rights was not in due proportion to the objective.

Preliminary comments

[52] We commence with some general observations about the appellant's claim and the difficulties the Judge identified in making definitive findings for the purpose of the challenge to the Order in the later period after Omicron had emerged.

[53] The instrument under challenge is the Order amended by the Minister in October 2021 extending the Vaccination Order to the education sector. The lawfulness of the Order must be assessed at that time in the context of the prevailing circumstances in what was a national emergency arising out of a global pandemic. This would include current knowledge about the likely progression of the pandemic in New Zealand, the seriousness of the public health threats posed, the capacity of the health system to cope, and the range of available measures to respond adequately in the public interest. It needs to be kept in mind that decisions were required in circumstances of significant urgency and based on imperfect information.

[54] As stipulated in s 14(5) of the Act, the Minister was required to keep all of his COVID-19 orders under review. Following review, and where appropriate in light of new information and advice, he had the power under s 15 to amend, extend or revoke any order made by him at any time.

[55] It is clear that the Minister did in fact keep the Vaccination Order under review. The appellant does not directly challenge the adequacy of any such review, nor does it put forward any particular date when a review ought to have been undertaken that would have led to the earlier revocation of the Order (the essence of the appellant's

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[38] *R v Hansen*, above n 23.

case being that the Order was never justified). However, the appellant nominated two dates by which it claimed the Minister was not able "to show that he currently has sufficient grounds to [justify]" the continuation of the Order for the education sector — the date of the second amended statement of claim (10 February 2022) and the date of the trial (3–7 March 2022).

[56] We consider there are two problems with this approach. First, it suggests, incorrectly, that a lawful measure might suddenly become unlawful on a given day because of changed circumstances and without due consideration by the Minister of advice as to the appropriate response in the context of a timely review of the Order. Second, the appellant is effectively inviting the Court to carry out the review, a task Parliament entrusted to the Minister as the decision-maker. The Court's role is to review decisions made by the Minister in making the Order or following review of it. The Court may also direct that a review be undertaken by the Minister if he fails to discharge his obligation to do so. However, it is not for the Court to usurp the Minister's role by undertaking the review itself.

[57] Further, despite the expedited court process and the prompt delivery of the High Court's judgment, any utility in the orders sought as to the continued justification for the measure (whether as at 10 February or 7 March 2022) was overtaken by the Ministerial review leading to the Prime Minister's public announcement on 23 March 2022 that the Order would be revoked.

[58] We also share the Judge's concern that the appellant's approach of inviting the Court to make factual findings in rapidly changing circumstances as at the date of the hearing presents natural justice challenges. The pleadings define the case the respondents must meet, and they are entitled to tailor their evidence accordingly. The evidence can only address the pleaded issues at the date it is prepared in accordance with timetable directions. As the Judge said, "it is … not possible for the Court to review matters contemporaneously".[39]

[59] We wish to emphasise that we intend no criticism in making these general observations. They are merely intended to provide some context for consideration of

[39] High Court judgment, above n 2, at [64].

the appellant's complaints on appeal that the Judge ought to have gone further in resolving the evidential contest on the key factual issues such as the effectiveness of the vaccine in limiting transmission in the rapidly changing circumstances following the emergence of Omicron, the risks associated with the vaccine and consequently the adequacy of utilising reasonable alternative measures at that stage that were not rights limiting.

[60] Having made these preliminary comments, we commence our analysis by examining the lawfulness of the Order at the date it was made on 22 October 2021. This requires consideration of whether the acknowledged limit on the right to refuse medical treatment was reasonable and demonstrably justified in a free and democratic society. This boils down to whether the objective was sufficiently important to justify the interference and whether the means adopted to achieve the objective were proportionate. The evidential burden rests with the Crown to demonstrate this.

[61] The most widely cited approach to the issue of justification under s 5 of BORA is Tipping J's formulation in *Hansen*:[40]

> (a) does the limiting measure serve a purpose sufficiently important to justify curtailment of the right or freedom?
>
> (b) (i) is the limiting measure rationally connected with its purpose?
>
> (ii) does the limiting measure impair the right or freedom no more than is reasonably necessary for sufficient achievements of its purpose?
>
> (iii) is the limit in due proportion to the importance of the objective?

Was the objective sufficiently important to justify interference with protected rights?

[62] The first case of the Delta variant in New Zealand was identified on 17 August 2021. This strain was highly infectious compared to prior variants and had a shorter incubation period making it more difficult to contain its spread. On 18 October 2021, partially in response to the distinct challenges posed by the emergence of Delta, Cabinet decided to move from its initial elimination strategy to one of minimisation

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[40] *R v Hansen*, above n 23, at [104] per Tipping J. The test was drawn from the Supreme Court of Canada's decision in *R v Oakes* [1986] 1 SCR 103.

and protection. A key component of this strategy was to achieve 90 per cent (or higher) vaccination rates across all ethnicities, regions and ages throughout New Zealand. International studies had shown that the Pfizer vaccine (two doses) was highly effective in limiting the risks of infection, transmission and hospitalisation from Delta. While the effectiveness of the vaccine waned over several months, it could be restored with a booster. For these reasons, the Director-General considered that vaccination was a vital public health tool to be used in conjunction with other public health measures to minimise the spread of COVID-19. This was the immediate context for the Order being made on 22 October 2021.

[63] The purpose of the Order was to reduce the prospect of schools being community transmission points for a viral infectious disease that can cause severe illness and death. The primary concern was to protect the carers, parents, and grandparents of those who attended the schools, and consequently the wider community (particularly the vulnerable). While children were generally at risk of suffering only mild illness, there remained a risk that some would suffer serious illness or even death.

[64] We consider that the objective of providing a safe environment for children to return to school and protecting them and the wider community from serious illness or death as a result of infection and transmission of the virus within schools, as well as minimising the risk of the public health system being overwhelmed, was sufficiently important to justify interference with the BORA protected right.

[65] Mr Hague accepts that the objective was sufficiently important, but he contends that risk minimisation was overly broad and unquantifiable. He says that the lack of focus and specificity should have resulted in this aspect of the *Hansen* test failing. We do not accept this submission. It was obviously not possible to accurately quantify the potential harm. However, this does not mean that the objective was not sufficiently important for the purposes of satisfying this threshold issue. The emergence of the Delta variant represented a major health risk to the New Zealand public with potentially dire consequences, including serious illness and death. Mr Hague's argument about the extent of the benefit to be achieved by the Order in

the light of other measures that were not rights-limiting is better addressed as part of the proportionality inquiry addressed below.

Was there a rational connection between the measure and the objective?

[66] Mr Hague's argument on this issue is closely related to his "overly broad purpose" submission. In his written submissions, he acknowledges that even with the efficacy level claimed by the Director-General in his evidence after two doses of Pfizer, the rights-limiting measure could be said to be rational in the same sense that the purpose was sufficiently important. In oral argument, Mr Hague elaborated by saying it is difficult to assess whether there is a rational connection between the limiting measure and the objective sought to be achieved when the latter is "so fraught". In support of this submission, he referred to the evidence of Dr Town, the Chief Science Advisor at the Ministry of Health, who stated "it has not been easy to assess the risks that schools pose as potential source[s] of community spread". Dr Town also said that with appropriate safety measures in place, such as mask use, the level of COVID-19 within schools can be expected to be broadly reflective of the level in the wider community and not, as some initially feared, hothouses for the spread of the virus. Mr Hague contended that if the risk in schools was no greater than outside schools, the rational connection between the measure and the objective tends to fall away.

[67] In assessing the lawfulness of the Order at the time it was made in October 2021, it is necessary to review the evidence then available as to the effectiveness of the Pfizer vaccine in combating infection and transmission of the Delta variant. Delta was the dominant variant at that stage; Omicron had yet to emerge anywhere. We therefore put to one side in this part of the analysis the emerging evidence at the time of the High Court hearing indicating that the vaccine was proving less effective against Omicron.

[68] Dr Town explained that the effectiveness of the vaccine may be considered in relation to its ability to achieve three objectives — prevent infection, prevent onward transmission from those who are infected, and prevent severe illness leading to hospitalisation or death. Dr Town pointed to international studies published prior to

the making of the Order which indicated that the Pfizer vaccine was 79 to 93 per cent effective at preventing Delta infection within one to two months of receiving the second dose and 53 to 75 per cent effective more than three to four months after the second dose. Two doses of the vaccine were shown to be highly effective in preventing hospitalisation and death — well above 90 per cent. The vaccine was less effective in preventing transmission of Delta by people who are infected — a reduction of 30 to 50 per cent — but this takes no account of the high level of protection against infection leading to transmission.

[69] At the time the Order was made, it was plainly rational to conclude on the basis of the available scientific evidence that requiring education workers to be vaccinated would reduce the risk of infection and transmission as a result of large numbers of people being required to congregate in close company at schools on a near daily basis. We agree with the Judge that this threshold question was also satisfied.

Was the impairment of the right no greater than reasonably necessary?

[70] The question here is whether the limit on the right to refuse to undergo medical treatment was no greater than necessary to achieve the objective of providing a safe environment for children to return to school, minimising the risk of children and staff being infected and thereby limiting the spread of the virus to the wider community. No less rights-limiting measure was pleaded (other than that the exemptions should have been wider). The appellant's primary case was that alternative measures would have been sufficient, such as RAT tests, social distancing, mask wearing and staying home if unwell. However, these measures do not involve any impairment of the right to refuse to undergo medical treatment and therefore would not come at any cost to the s 11 right. Further, these measures were included as part of the package to address the risks of COVID-19, but they were not regarded as an adequate substitute, displacing the need for vaccination as a key protective measure.

[71] In support of its pleaded allegation that the Minister was unable to show that he had sufficient grounds to be satisfied that the Vaccination Order was a reasonably justified limit on the right to refuse medical treatment, the appellant noted that the Order failed to provide tailored criteria for exemptions from vaccination for those

persons, particularly young men and women aged in their late teens and twenties, who have or could suffer, significant or life-threatening adverse events or side effects from the vaccine.

[72] The criteria for exemption were based on recommendations made by the COVID-19 Vaccine Technical Advisory Group (CV TAG) and approved by the Director-General. In his memorandum dated 3 November 2021, Dr Town, writing in his capacity as Chief Science Advisor and Chair of CV TAG, recommended that the clinical criteria for medical exemption should be based on the following principles:

> ***Proposed principles of medical exemption***
>
> 15. There are very few situations where a vaccine is contraindicated and, as such, a medical exemption is expected to be rarely required.
>
> 16. Vaccinations may reasonably be temporarily deferred for individuals with some acute major medical conditions, such [as] undergoing major surgery or hospital admission for a serious illness. Typically, these conditions are considered time-limited, and therefore a temporary exemption is considered appropriate.
>
> 17. Exemptions are only to be given where a suitable alternative COVID-19 vaccine is not readily available for the individual.
>
> 18. Exemptions should be for a specified time, reflecting, for example, recovery from clinical conditions or the availability of alternate vaccines.
>
> 19. It is likely that most people who are not medically exempt can be safely vaccinated with extra precautions.

[73] Dr Town responded in his evidence to the appellant's claim that vaccination carried an increased risk of cardiovascular conditions in young men. He referred to international studies showing that myocarditis is a rare side effect of the Pfizer vaccine. He noted that as at 10 October 2021, there were 2,796 cases of myocarditis in the European Economic Area after an estimated 580 million doses. While the risk of myocarditis for young men may be higher than average, the risk of myocarditis following infection was higher still. The overall risk of myocarditis from COVID-19 infection was almost four times higher than from vaccination.

[74] The Director-General concurred with Dr Town's views as to the appropriateness of the exemption criteria. He added that a person with a history of myocarditis should be offered another type of vaccine. A person with a pre-existing

diagnosis of pericarditis or myocarditis for the Pfizer vaccine would come within the exemption criteria if no suitable alternative COVID-19 vaccine was available.

[75] It is therefore apparent, contrary to the appellant's claim, that the exemption criteria took account of, and indeed were specifically designed to cater for, those few individuals who were at risk of suffering serious or life-threatening adverse side effects if vaccinated. The exemption criteria were appropriately informed by international studies and worldwide experience with the use of the Pfizer vaccine.

[76] The Minister considered that the Vaccination Order was no wider than necessary to achieve the public health objective as it was to be applied to workers who may have direct or indirect contact with children and students and were thereby at risk of transmitting the virus to or from them. Based on the advice he received, the Minister considered that the health-based exemption criteria were appropriate to accommodate those who had genuine health reasons for not being vaccinated. He did not consider a broader regime of exemptions as being necessary or appropriate for public interest reasons.

[77] The exemption criteria were kept under review through an ongoing monitoring programme and were amended from time to time. However, they did not change materially. The principal change was to the process for obtaining an exemption — this was centralised to ensure consistency and prevent abuse.

[78] Clause 7A of the Order when originally amended in October 2021 provided for medical exemptions to be determined by a suitably qualified health practitioner. This clause was revoked on 5 November 2021 and replaced by an amended provision instituting a centralised exemption process whereby all exemptions would be granted by the Director-General on the basis of specified criteria. This amendment was prompted by concerns about abuse of the trust-based medical exemption model, including the improper selling of medical exemptions to patients unknown to the certifying medical practitioners. Such concerns were raised by a number of sources including the Chair of the New Zealand Medical Association. He wrote to the Minister for COVID-19 Response and the Minister of Health on 28 October 2021 expressing concern about doctors providing exemption certificates outside the guidelines through

an online clinic. He strongly recommended that urgent consideration be given to tightening up the exemption process to ensure the clinical guidelines were followed.

[79] The Director-General emphasised in his evidence the need for public compliance to ensure the effectiveness of the Government's multi-layered public health response. He was particularly concerned about the risks to public confidence and compliance with both voluntary and non-voluntary measures if people could see these measures being defeated by a minority of people who refused to comply.

[80] Notwithstanding the narrowly drawn exemptions based solely on clinical criteria, we consider the respondents demonstrated that the impairment of the s 11 right as a result of the measure was no greater than reasonably necessary to achieve the stated objective at the time the Order was made. Given the emphasis on achieving the highest practicable level of vaccination as a key protection against the spread of the virus at that time, we consider the Minister was entitled to reject more widely drawn criteria that would have allowed exemptions for personal circumstances and individual choice unrelated to potential medical risks associated with receiving the vaccine.

Was the limit in due proportion to the importance of the objective?

[81] As the former Chief Justice of Canada, Lamer CJ, has said, this comes down to whether the underlying object of the measure and the beneficial effects actually resulting from its implementation are proportional to the deleterious effects it has on fundamental rights and freedoms.[41]

[82] Mr Hague says that a vaccination mandate may have been in proportion to the importance of the objective if pre-mandate vaccination rates were lower, he suggests 80 per cent. He notes that the Government's aim of achieving an overall vaccination level of 90 per cent or higher in each District Health Board area across New Zealand was achieved on 16 December 2021. He submits that from that point, even from a policy perspective, there was no justification for the education sector mandate.

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41 *Dagenais v Canadian Broadcasting Corp* [1994] 3 SCR 835 at 887.

[83] However, this submission is really directed to the question of whether the mandate was demonstrably justified in the later period covered by the appellant's challenge — February to early March 2022. We address that question below. It is not suggested that actual vaccination rates achieved in mid-December 2021 could have any bearing on whether the Order was justified when it was made in October 2021. At that time, children under the age of 12 were not even eligible to be vaccinated. Young people aged between 12 and 18 had only become eligible for vaccination at the beginning of September 2021. Schools were therefore likely to be places where significant numbers of unvaccinated people would be present. The Minister also took into account that Māori and Pacific people traditionally have lower than average vaccination rates and were also likely to be disproportionately affected by the pandemic and disruption to education services. While we do not have the statistics as at the date of the Order, advice provided to the Director-General a week later on 28 October 2021 was that 72 per cent of the eligible population had received two doses of the vaccine. However, only 50 per cent of eligible Māori had done so. On that basis, even taking Mr Hague's suggested rate of 80 per cent as the threshold for justification, the mandate was a proportionate measure at the time the Order was made.

Did the Order remain demonstrably justified in February/early March 2022?

[84] This is a much more difficult question to answer and comes down to timing. We have found, in agreement with the Judge, that the Order requiring education workers to be vaccinated was a demonstrably justified limit on their right to refuse medical treatment in the circumstances existing at the time it was made on 22 October 2021. These circumstances did not change materially until Omicron emerged in New Zealand in December 2021.

[85] The Order required education workers to have the first dose of the vaccine by 15 November 2021 and the second dose by 1 January 2022. However, those who had not received their first dose by the November deadline would nevertheless be treated as vaccinated so long as they received their second dose by 1 January 2022.

[86] Omicron was first reported in South Africa on 24 November 2021 and the first case was detected in New Zealand on 10 December 2021. The goal of having at least

90 per cent of the eligible population vaccinated across all District Health Board areas throughout New Zealand was achieved on 16 December 2021.

[87] On 19 December 2021, the Director-General briefed the Minister on the emerging threat posed by Omicron. This new variant appeared to be more highly infectious than Delta and was expected to lead to a significant number of "breakthrough" infections. Recent advice indicated that immunity to this variant could be expected to wane from around four months following the second dose of the Pfizer vaccine and that a third dose may be necessary to achieve a high level of protection. For these reasons, the Director-General recommended that the booster dosing interval be reduced from six to four months and that mandatory booster doses should be considered for certain workers. The Minister presented these proposals to Cabinet the following day as part of a suite of measures to respond to Omicron. Cabinet authorised a group of ministers (the Prime Minister, Deputy Prime Minister, Minister for COVID-19 Response and Associate Minister for Health) to consider the appropriate response to Omicron over the holiday period and make final decisions.

[88] On 21 January 2022, the Minister made the COVID-19 Public Health Response (Vaccinations) Amendment Order 2022 making provision for booster doses. It may be noted that the Minister made this decision, effectively maintaining the Order in place, in the face of the appellant's challenge to its legality in these proceedings.[42] In his affidavit dated 18 February 2022, the Minister explained why he considered it was both necessary and proportionate for the Order to remain for the time being:

> 82. For the following reasons, it was my view that it was a justified limitation on the right not to undergo medical treatment that is affirmed by the New Zealand Bill of Rights Act 1990:
>
> 82.1 For the reasons, set out above, I had already determined that it was necessary and proportionate for the affected workers to receive a vaccine that was effective in limiting infection, transmission and hospitalisation.
>
> 82.2 The highly infectious nature of the Omicron variant reinforced my view that it was necessary and proportionate for the affected workers to receive vaccinations in order to minimise the spread of COVID-19 and so protect the vulnerable and our [health] system.

[42] The appellant commenced the proceedings on 1 November 2021 and the statement of defence on behalf of the Minister and the other respondents was filed on 13 January 2022.

> 82.3 The fact that a booster dose of the vaccine provides better protection against COVID-19 and its variants and may be essential to achieve a high level of protection against the Omicron variant, meant that the requirement to receive a booster dose was necessary to achieve the aim of effective vaccination across the affected workforces.

[89] The Minister's conclusions were supported by Dr Town. In his affidavit dated 16 February 2022, Dr Town stated that although Omicron was still in its early stages, emerging evidence from around the world indicated that it was more transmissible and had a higher secondary attack rate than Delta. The advice issued by the World Health Organisation (WHO) was that although the Omicron infection presented a lower risk of causing severe disease and death than with other variants, the very high levels of transmission associated with it had resulted in significant increases in hospitalisation, created overwhelming demands on health care systems in most countries and could lead to significant morbidity, particularly in vulnerable populations. The rapid spread of Omicron is evident from the fact it was already present in at least 89 countries at the time Dr Town completed his affidavit in mid-February, despite having emerged only a short time earlier.

[90] Despite the reduced protection through vaccination against what had become the dominant strain of COVID-19, vaccination was still seen as an important tool to protect the vulnerable, slow the inevitable spread of the virus and reduce the risk of the health system being overwhelmed. The Minister's concerns about the likely high rates of infection and transmission of Omicron were borne out. At the time of the High Court hearing in early March 2022, new cases of Omicron detected in the community had risen sharply from just above zero in early February 2022 to a seven-day rolling average peak of over 20,000 daily cases. This peak coincided with the beginning of the school year. The announcement to revoke the Order was made on 23 March 2022 when new daily cases were still very high but in steep decline.

[91] It is important to exclude hindsight when assessing whether the Order remained proportionate and demonstrably justified at the time of the Minister's review and continuation of the Order in mid to late January 2022 or at the time the evidence was prepared in mid-February. For the reasons already discussed, we consider this is the latest appropriate time period for carrying out the assessment in this proceeding.

Because Omicron was still in its early stages at that time, there was considerable uncertainty about its likely impact and the effectiveness of vaccination and other available measures to manage the associated public health risks.

[92] The Minister was entitled, and was arguably required, to take a precautionary approach in his decision-making in order to minimise the immediate and very real threat to public health posed by the outbreak of Omicron and the consequent likely demands on the health care system. The lack of certainty as to the magnitude of the risk and the effectiveness of the measures available to mitigate it could not excuse the Minister from discharging his responsibility to take appropriate action to protect the public, particularly the vulnerable. The greater the threat, the greater the justification for precautionary decision-making to protect the public against the threat in circumstances of uncertainty. As Sourgens suggests, there are three elements to the precautionary principle, all of which we consider apply here:[43]

> First, it has a threat element: it is applicable when there is a certain kind of threat, typically a threat of serious or irreparable damage. Second, it has an uncertainty element: a state may not or should not use scientific uncertainty as a reason for postponing action. Third, the first two elements are [operationalised] by means of a precautionary measure: the state adopts measures in order to anticipate, prevent or minimise the relevant threat.

[93] It is primarily because of the operation of this precautionary principle that we have not been persuaded we should interfere with the Judge's tentative conclusion that the Vaccination Order remained proportionate and demonstrably justified prior to mid-February 2022. In any case, we would not have been prepared to make either of the orders sought by the appellant in the notice of appeal, namely an order declaring the Vaccination Order invalid or an order setting it aside. There is no utility in making an order setting aside the Vaccination Order because it was revoked before the High Court judgment was delivered. There is no order left to set aside. Further, for the reasons given, we are satisfied the Vaccination Order was valid at the time it was made, and it did not suddenly become invalid prior to mid-February 2022 (or at any other time before it was revoked).

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[43] Frédéric Gilles Sourgens "The Precaution Presumption" (2020) 31 EJIL 1277 at 1278 (footnotes omitted).

[94] This is sufficient to dispose of the appeal. However, in deference to counsel's submissions and being cognisant of the genuine concerns of those represented by the appellant, we make the following additional comments.

[95] We accept the appellant's argument that there are known health risks associated with the administration of the vaccine. We also accept that long term safety data is not available and it is likely that the full extent of potential downstream risks are not yet known. That such risks may exist is not seriously contested, only the potential extent of them. These risks are relevant to the question of proportionality, but we do not consider they are sufficiently material to displace our overall conclusions as to the appropriate disposition of this appeal.

[96] There is ample evidence that the Pfizer vaccine is generally safe, albeit it may cause adverse side effects in some individuals. At the time the evidence was prepared, the Pfizer vaccine had been approved for use in at least 130 countries and more than 10 billion doses had been administered worldwide. Extensive safety monitoring had been carried out and was ongoing, for example, by the United States Centers for Disease Control and Prevention, the United States Food and Drug Administration and the European Medicine Agency. Given the vast populations in the United States and the European Union, the ongoing safety monitoring by these agencies provides significant assurance that the vaccine is safe. Further, Dr Town explained that 150 countries contribute anonymised data sourced from their national monitoring centres to a pooled database of the WHO Programme for International Drug Monitoring Programme based in Sweden. Dr Town was not aware of any governmental monitoring body that had concluded that the Pfizer vaccine was not safe.

[97] Dr Town addressed the known side effects of the vaccine. Common side effects (reported in every one in 10 to one in 100 people in clinical trials) include pain or swelling at the injection site, feeling tired or fatigued, headache, muscle aches, chills, joint pain, fever, redness at injection site and nausea. Uncommon side effects (reported in every one in 100 to one in 1,000 people in clinical trials) include enlarged lymph nodes, feeling unwell, pain in limb, insomnia and itching at injection site. Rare side effects (affecting one in 1,000 to one in 10,000 people) include temporary

one-sided facial drooping and temporary inflammation of the heart muscle (myocarditis). These side effects were published on the Ministry of Health's website.

[98] The exemption criteria were designed to enable a small group of people for whom the vaccine presents a potential health risk to obtain an exemption on that ground. However, the criteria made no allowance for other legitimate objections, including for example, on religious or cultural grounds. The evidence provided by numerous lay witnesses on behalf of the appellant demonstrates the practical implications of such narrowly confined criteria. It brings into sharp focus the serious implications for some individuals who were faced with dismissal or succumbing to the impingement on their human dignity by complying with the Order.[44] We consider the strictly confined nature of the exemption criteria is relevant to the proportionality issue. It meant that in practice, the Order delivered particularly harsh outcomes to a relatively small number of people.

[99] These matters factor into the issue that has concerned us most. The mandate undoubtedly contributed to the high rate of vaccination, but by late-January or early February 2022 this benefit must have been largely spent. Only around three per cent of teachers remained unvaccinated. This comparatively small number, or at least many of them, were likely to have held such deep-seated concerns about receiving the vaccine that they were prepared to face dismissal rather than be vaccinated by the 1 January 2022 deadline. We acknowledge that these unvaccinated teachers will not have been evenly spread regionally and it is likely that higher percentages would have existed in some vulnerable communities. Nonetheless, given the high vaccination rates that had been achieved by January/February 2022, the expectation that vaccination would be less effective against Omicron and the virus would become endemic in the community in fairly short order, we would have expected some consideration of whether alternative measures might have been sufficient to accommodate this small group of teachers and other affected education workers. In other words, consideration of whether the incremental benefit of maintaining the Vaccination Order continued to justify the impairment of their fundamental right to

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[44] Dignity interests have been emphasised in various human rights cases, notably *Seales v Attorney-General* [2015] NZHC 1239, [2015] 3 NZLR 556 and *Attorney-General v Udompun* [2005] 3 NZLR 204 (CA). The Supreme Court confirmed that dignity interests lie behind s 11 of BORA in *New Health New Zealand Inc v South Taranaki Council*, above n 18, at [231] per Elias J.

refuse to undergo medical treatment. We have seen no discussion of this in the memoranda or briefing materials prepared by the Ministry of Health or in the Cabinet papers.

[100] However, whether the Order ought to have been revoked earlier is not something we can determine on this appeal, nor would it affect its disposition for the reasons given above.

Costs

[101] The respondents sought costs if the appeal is dismissed. The appellant resists an award of costs on the basis the appeal concerns a matter of public interest, and it acted reasonably in the conduct of the appeal.

[102] We accept the appellant's submission that this is an appropriate case to decline making any order for costs. There was, and remains, considerable public interest in the issues raised in this appeal, particularly whether limitations on fundamental constitutional rights protecting concepts of personal autonomy, bodily integrity, and dignity were justifiably interfered with for the greater public good. These are difficult questions upon which there is legitimate public debate. While the appellant has not succeeded on the appeal, in part because of the difficulties referred to above, it might be said that the position it took, focusing on the February/March 2022 period, was vindicated by the Minister's decision to revoke the Order in respect of the education sector about two weeks after the hearing in the High Court. That strongly suggests the position the appellant advanced was meritorious.

Result

[103] The appeal is dismissed.

[104] There is no order for costs.

Solicitors:
Frontline Law Ltd, Wellington for Appellant
Crown Law Office | Te Tari Turi o te Karauna, Wellington for Respondents

Schedule 1

Specified COVID-19 Vaccination Exemption Criteria

Pursuant to clause 9B(12) of the COVID-19 Public Health Response (Vaccinations) Order 2021, I, Dr Ashley Bloomfield, Director-General of Health, determine criteria in Schedule 1 below as specified COVID-19 vaccination exemption criteria.

Schedule 1

Step	Vaccine	Category	Criteria Details
1	All COVID-19 Vaccines	1A. COVID-19 Infection	• PCR-confirmed SARS-CoV-2 infection until complete recovery from the acute illness. *Note:* Chronic symptoms following COVID-19 ("Long COVID") is not a contraindication to COVID-19 vaccine but does warrant a clinical discussion with the patient regarding the benefits and risks.
		1B. Serious Adverse Event to previous dose	• Serious adverse event attributed to a previous dose of the same COVID-19 vaccine with no other cause identified. • An adverse event is considered serious for the purposes of these criteria if it: ◦ Requires in-patient hospitalisation or prolongation of existing hospitalisation or results in persistent or significant disability/ incapacity; and ◦ Has been reported to CARM; and ◦ Has been determined following review by, and/or on the opinion of, a relevant medical specialist to be associated with a risk of recurrence of the serious adverse event if another dose of the same vaccine is given.
		1C. Unable to tolerate administration due to risk to self or others	Unable to tolerate vaccine administration with resulting risk to themselves or others.
2	Pfizer Vaccine	2A. Anaphylaxis	• Anaphylaxis to the first dose of the vaccine or known severe allergy to the excipients of the vaccine as per the datasheet provided to Medsafe. This criterion will be removed as an exemption when there is an alternative vaccine available in New Zealand. Many of these individuals will be able to be safely vaccinated in a controlled environment, and we recommend clinical immunologist/specialist assessment.
		2B. Myocarditis / Pericarditis	Myocarditis/pericarditis following the first dose of the vaccine.
		2C. Inflammatory Cardiac Illness	Inflammatory cardiac illness within the past 6 months including: acute myocarditis, pericarditis, endocarditis, acute rheumatic fever or acute rheumatic heart disease (ie, with active myocardial inflammation).
		2D. Acute Decompensated Heart Failure	Acute decompensated heart failure.
3	Trial Vaccine	3A. Non-Placebo participant in a vaccine trial	Those who are confirmed as having the vaccine (i.e., non-placebo) in any COVID-19 vaccine trial in Aotearoa New Zealand.

Dated at Wellington this 12th day of November 2021.

DR ASHLEY BLOOMFIELD, Director-General of Health, Ministry of Health.

Revocation and Replacement—Specified COVID-19 Vaccination Exemption Criteria

Pursuant to section 5(3)(a) of the COVID-19 Public Health Response Act 2020, I, Dr Ashley Bloomfield, Director-General of Health, determine the criteria in Schedule 1 below as specified COVID-19 vaccination exemption criteria:

Schedule 1

Category			**Criteria Details**
1	Acute illness	1A. COVID-19 Infection	• PCR-confirmed SARS-CoV-2 infection (within the last three months). *Note:* Chronic symptoms following COVID-19 ("Long COVID") is not a contraindication to COVID-19 vaccine but does warrant a clinical discussion with the patient regarding the benefits and risks.
		1B. Acute moderate to severe (non-COVID) illness	• Documented acute moderate to severe illness (e.g., severe pneumonia); and • advised to defer vaccination by a vaccination specialist (advice available to health care providers at IMAC, 0800IMMUNE@auckland.ac.nz).
		1C. High Dose Immunosuppression	• Receiving high dose immunosuppressive treatment and vaccination would be more effective if deferred for a short period (several weeks) (eg. vasculitis).
2	Previous reaction to a COVID-19 vaccine	2A. Significant Adverse Reaction to previous dose	• Significant adverse reaction (eg. diagnosed anaphylaxis) attributed to a previous dose of the same COVID-19 vaccine with no other cause identified; and • inappropriate to rechallenge with same COVID-19 vaccine; and • no alternative appropriate COVID-19 vaccine available. *Note:* An adverse reaction is considered significant for the purposes of these criteria if it: • requires in-patient hospitalisation or prolongation of existing hospitalisation or results in persistent or significant disability/incapacity; and • has been reported to CARM; and • has been determined following review by, and/or on the opinion of a relevant medical specialist that the risk of vaccination is greater than the potential benefits.
3	Pre-existing condition impacting on vaccination	3A. Vaccine administration needs a supportive arrangement to meet individual care requirements	• Lead health practitioner has identified individual care requirements to support vaccine administration and the individual is unable to attend at an open access vaccination site; and • lead health practitioner needs time to arrange a suitably supportive environment or specialised care to administer the vaccine.
		3B. Pre-existing diagnosis impacting on COVID-19 vaccination	• Pre-existing diagnosis is a contra-indication to specific COVID-19 vaccine (e.g., pericarditis/myocarditis for Pfizer), and • no alternative appropriate COVID-19 vaccine available.
		3C. Terminal illness	• Life expectancy of less than 6 months
4	Vaccine Trials	4A. Non-Placebo participant in a vaccine trial	• Those who are verified as having two doses of the trial vaccine (i.e., non-placebo) in any approved COVID-19 vaccine trial in Aotearoa New Zealand.

Dated at Wellington this 17th day of January 2022.

Dr ASHLEY BLOOMFIELD, Director-General of Health, Ministry of Health.

Note: This notice revokes and replaces the notice dated 12 November 2021 and published in the *New Zealand Gazette*, 12 November 2021, Notice No. 2021-go4910.