COVID-19 EMERGENCY POWERS (NEW ZEALAND)

DISCUSSION: SOME NOTES ON THE PROCESS OF THE PASSING OF LAWS IN THE TIME OF COVID-19 (2019-2022).

Contents

‘Most of the measures employed to counter the pandemic aren’t prompted or supported by data, and those measures carry grave physical, ethical and political consequences.’

Prof. Julie Ponesse, bioethicist, 2022.

Introduction

It’s questionable that civil society can anticipate quite the concentration of power has impacted the legislative process, if we consider the evidence by way of reporting in New Zealand media. This discussion document hopes to clarify the legal structures in place, and when they were enacted. It seeks to draw attention to the fact that from 2019 onwards, a very small exclusive group of Ministers retained oversight over the enactment of legislation, and the affirmation that the legislation does not contravene human rights.

This discussion calls attention to strange inconsistencies, an extraordinary disconnect between the scientific and grey literature on risk, and the activities of the machinery of government. Civil society has been witness to a rapid passing of laws which it appears, lack scientific basis, and jettison principles of public health, but which have assumed all the power of primary legislation. The passing of such legislation would normally proceed in the open, with debate, rather than behind closed doors.

I also draw attention to October 2021 consultations relating to an amendment to the primary COVID-19 Public Health Response Act 2020. These appeared finely calibrated (if not gamed) to *not* occur at the same time that controversial vaccine mandates were expanded into the public sector.

I propose that by showing the events over the process of time, it can be demonstrated that these actors have ignored and undermined their fiduciary responsibility to New Zealand civil society. I consider this is of importance, as I am concerned that the measures of coercion and compliance, including the jettisoning of the established principle of informed consent have the potential to fundamentally shatter or in the least, produce a major metabolic rift in civil societies’ trust, or belief that New Zealand is a fair and accountable democratic society.

N.B. I am aware that there are likely to be incorrect statements or links, as I am attempting to discuss such issues that an expert in public and administrative law might have more familiarity with. Therefore, this is undertaken to the best of my ability, and with intention to provide information that is fact based, informed by judgement and not misleading.

The role of the COVID-19 Public Health Response Act 2020

I suggest that from the start, the *purpose* of the overriding Act which informed all the legislation that then arose from a badly formulated purpose. The purpose fundamentally misdirected ongoing lawmaking, the machinery of government, the public, and the ‘campaign.’ The purpose then subsequently excluded any obligation to dually reflect the nature of risk, or to uphold enshrined public health principles such as the protection of health, informed consent, and proportionality.

The COVID-19 Public Health Response Act 2020 purpose states that:

> **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.

The purpose of an overarching Act in a pandemic should be to ensure that health is protected to ensure that the production of rules under the Act, the Orders would not harm health.

Section 9 of the Act gave the Minister the power to make Orders – to prevent the risk of the outbreak or spread of COVID-19.. This was never articulated. At most, 'health' was an 'other'.

> 9 (1)(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 remedy the effects of the outbreak or spread of COVID-19 (which decision may have taken into account any social, economic, or other factors);

The Act was enacted on May 13 2020. The clinical trial data and post-marketing data demonstrated *before that* date that the novel vaccine could cause harm. It was also scientifically known by that date that risk was stratified to the aged and infirm and those with severe and complicated health conditions.

The signatories to the Pfizer contract understood that the endpoints in the clinical trial did not include prevention of transmission of infection, nor did the clinical trials require prevention of hospitalisation and death. While the technology was markedly different, the short-term COVID-19 endpoints more closely reflected the desired response of a symptom suppressant, like many medical treatments on the market today.

As I have previously discussed, the trials were shortened, and the novel vaccine was offered to the placebo participant group. The general public were unaware of such nuances. The public were largely unaware that mRNA gene therapy injections were new technology, and that the vastly different from traditional live attenuated virus or inactivated vaccines. This led I believe, to conflation by the public, the health sector and the judiciary that the vaccine was a generic product.

Therefore, the SARS-COV-2 respiratory virus was unlikely to place most of the New Zealand population at risk and therefore the Act's purposes should reflect the principle of proportionality. Of course, such comments are but whimsy.

Many principles enshrined in the Health Act 1956, somewhat strangely, were not adopted for the purposes of stewardship of New Zealand throughout the COVID-19 event.
Please note, at no place is a register (or Bill Digest, or Docket) where the public could view consultation by the relevant Ministers Parker, Hipkins, Little and Verrall as the pandemic event progressed. Such information could demonstrate that the Ministers were privy to reviews of the

evidence in the peer reviewed literature relating to both age stratified risk from infection from the respiratory virus SARS-COV-2 and risk of hospitalisation and death from COVID-19, lodged with any government department. Such information would inform decision-making relating to risk and the necessity for mandates as variables changed. Documentation could demonstrate regular reviews documenting the changing knowledge relating to the safety and efficacy of the novel mRNA gene therapies, referred to as 'vaccines' in the legislation were undertaken.

Such transparency would promote trust in Ministerial activities. This did not occur.

Setting the timeline & sundry matters

Perhaps the simplest way to illustrate a what appears to be, *predetermined* march of legislation, is through a timeline and a discussion regarding the introduction of vaccine mandates. In addition, I draw from government manuals and law publications to demonstrate obligations of state actors in law to uphold particular principles that promote transparency and accountability and inspire trust in governance that is in the interests of civil society.

I also ask questions, because it is difficult to understand how the COVID-19 laws sit in relation to the fiduciary obligations, and shifts in related Acts.

Throughout this document I capitalise the word *Orders* in order to draw attention to their role as a legal instrument. (This is not convention). I presume these Orders are an Order in Council, known as a commencement order, bringing legislation into force. These are secondary legislation. However, the Legislation Act 2019 states that 'Order in Council means an order made by the Governor-General in Council'.

Were these Orders defined as mere regulations in law? The Cabinet Manual states (p.112):

> 'Regulations usually deal with matters of detail or implementation, matters of a technical nature, or matters likely to require frequent alteration or updating. The authority to make regulations is set out in the relevant Act. Regulations should not, in general, deal with matters of substantive policy, have retrospective operation, purport to levy taxes, or contain provisions that purport to amend primary legislation.'

The principles should be established in the overarching Act of Parliament. The principles and policies in the Act then guide and inform lower order regulation. With an enormous onslaught of Orders that put the mandates in place, the principles needed to be watertight, if they were to protect civil society from harm.

Orders are the instruments, as secondary, or subordinate legislation, that have regulated behaviour throughout COVID-19. The overarching legislation focussed on public health measures appropriate to respond to those risks and avoid, mitigate, or remedy the effects of the outbreak or spread of COVID-19. Such legislation swept the whole of the population into the unfolding regime.

The legislation fundamentally demolished the capacity for the doctor-patient informed consent process to be carried out honestly and ethically. From the clinical trials onwards (where deaths in the mRNA vaccinated group were higher than in the placebo group, page 23 here) the novel vaccine was identified as distinctly unsafe. The science was certainly unsettled, yet the government's actions removed the capacity of civil society to exercise autonomy and weigh their options.

Informed consent is important, because it is the individual that bears the consequence of the medical treatment. For younger people, the risk is greater, as the adverse consequences have potential to span decades.

Shifting & changing: The Legislation & Secondary Legislation Act

The Parliamentary Counsel Office (PCO) drafts secondary legislation, (unless the Attorney-General otherwise directs), Clause 67(d)(i). It was the Attorney-General, (the Hon David Parker was sworn in, on 26 October 2017) that oversaw the Legislation Bill, (introduced June 2017, with Royal Assent November 2019) which became the Legislation Act 2019.

Some thoughts on this. A paper, "Regulatory Impact Statement: Regulating for Better Legislation – What is the Potential of a Regulatory Responsibility Act?" (The Treasury, February 2011), now unavailable, was cited as reference in the Regulatory Impact Statement in the Bill Digest. Did this document hold the key to early aims?

The Legislation Act 2012 contained some 29 references regarding the powers of the A-G, while the references nearly doubled to 51 in the Legislation Act 2019. What changed?

This was followed by the Secondary Legislation Bill, also overseen by the Hon David Parker which was introduced December 2019 and which received Royal Assent March 24 2021. The Bills Digest contains no information. Why are there so few gaps, and where Bills are produced, so few Regulatory Impact Statements appearing that directly relate to the Bill at hand?

With great power comes a fiduciary responsibility

The development, enactment and oversight of law can be associated with extensive power. The Cabinet Manual advises that officials must be fair, impartial, responsible, and trustworthy. In addition, bills must comply with certain legal principles and any aspects of a bill that have implications for, or may be affected by:

> (a) the principles of the Treaty of Waitangi;
> (b) the rights and freedoms contained in the New Zealand Bill of Rights Act 1990 and the Human Rights Act 1993;
> (c) the principles in the Privacy Act 1993;
> (d) international obligations; and
> (e) the guidance in the LAC Guidelines.

The Legislation Design and Advisory Committee, Legislation Guidelines, 2021 Edition offer some guide to the behaviour of officials:

'People and institutions that wield power must do so within legal limits, and be accountable for their actions; everybody is equal before the law and is subject to it.'
However, the COVID-19 Public Health Response Bill was rammed through in one day. There was no opportunity for appropriate public scrutiny and deliberation. However, then it followed that the vast bulk of secondary legislation, as Orders, have also evaded deliberative and transparent scrutiny before being published on the Parliamentary Counsel Office website.

The Attorney-General

The Crown Law website states that the Attorney-General's

> 'first role is that of the senior Law Officer of the Crown with principal responsibility for the Government's administration of the law'…'second is that of a Minister of the Crown with ministerial responsibility for the Crown Law Office, the Serious Fraud Office and the Parliamentary Counsel Office. Traditionally in New Zealand the Attorney-General also has policy portfolio responsibilities not connected with those of the Attorney-General.'

P.A. Joseph has discussed:

> 'The Attorney-General is a cabinet minister but by convention the Attorney exercises independent judgement in the public interest.'…' The Attorney also exercises independent judgement when advising Cabinet on the following matters: whether a claim should be made for public interest immunity against disclosure in court of cabinet or departmental documents, whether a minister served with legal process was discharging ministerial duties which would warrant indemnity by the Crown, or whether the Crown should indemnify a minister for legal fees of counsel engaged prior to Cabinet being consulted.' (Joseph, P.A. Constitutional and Administrative Law in New Zealand, 14th Ed., 9.5.3)

The Attorney-General (A-G), the Hon David Parker was responsible for production, release and deployment of the COVID-19 Public Health Response Act 2020 which was introduced and received Royal Assent in May 2020.

I query whether the A-G has failed to exercise the independence required of his position, in the oversight of the overarching legislation which has provided the purposes and principles, guiding the whole of government COVID-19 response. The Act appears to be a political document, as the drafters elected not to include important principles in the Health Act 1956, including a responsibility to protect health, and many the principles of infectious disease management.

The Cabinet Manual (p.110) states that the

> 'Attorney-General is required to draw to the attention of the House any bill that appears to be inconsistent with the rights and freedoms contained in the New Zealand Bill of Rights Act.'

However, as I have discussed, the Attorney-General put the original legislation, the COVID-19 Public Health Response Act 2020, in place. Is it just me that considers this to be an extraordinary conflict of interest?

The Attorney-General gave Ministers the power to make Orders in the first iteration of the COVID-19 Public Health Response Act 2020. The assurance that the COVID-19 Public Health Response Bill did not impact rights and freedoms under New Zealand Bill of Rights Act 1990 (BORA) was transferred to the Ministry of Justice, to the Hon Andrew Little as Acting Attorney General – who provided that assurance on May 11, 2020. (Little was appointed Minister of Health in November 2020.)

Vaccines, which were *not* referred to in the November 20th version of the COVID-19 Public Health Response Act 2020 were introduced in the November 26th reprint. Vaccines were mentioned 157

times in the November 26th version of Act which was the version (reprint) in place on December 4 2021, just prior to when mandates were expanded at scale to encompass the general public.

What happened in November 2021?

October 2021 - COVID-19 Public Health Response Amendment Bill (No 2)

Just prior to the massive surge in vaccines regulation, the New Zealand public were granted a total of 10 days (30 Sept to Oct 11) to submit to the COVID-19 Public Health Response Amendment Bill (No 2). This Bill resulted in amendments to the COVID-19 Public Health Response Act, tightening controls and increasing penalties.

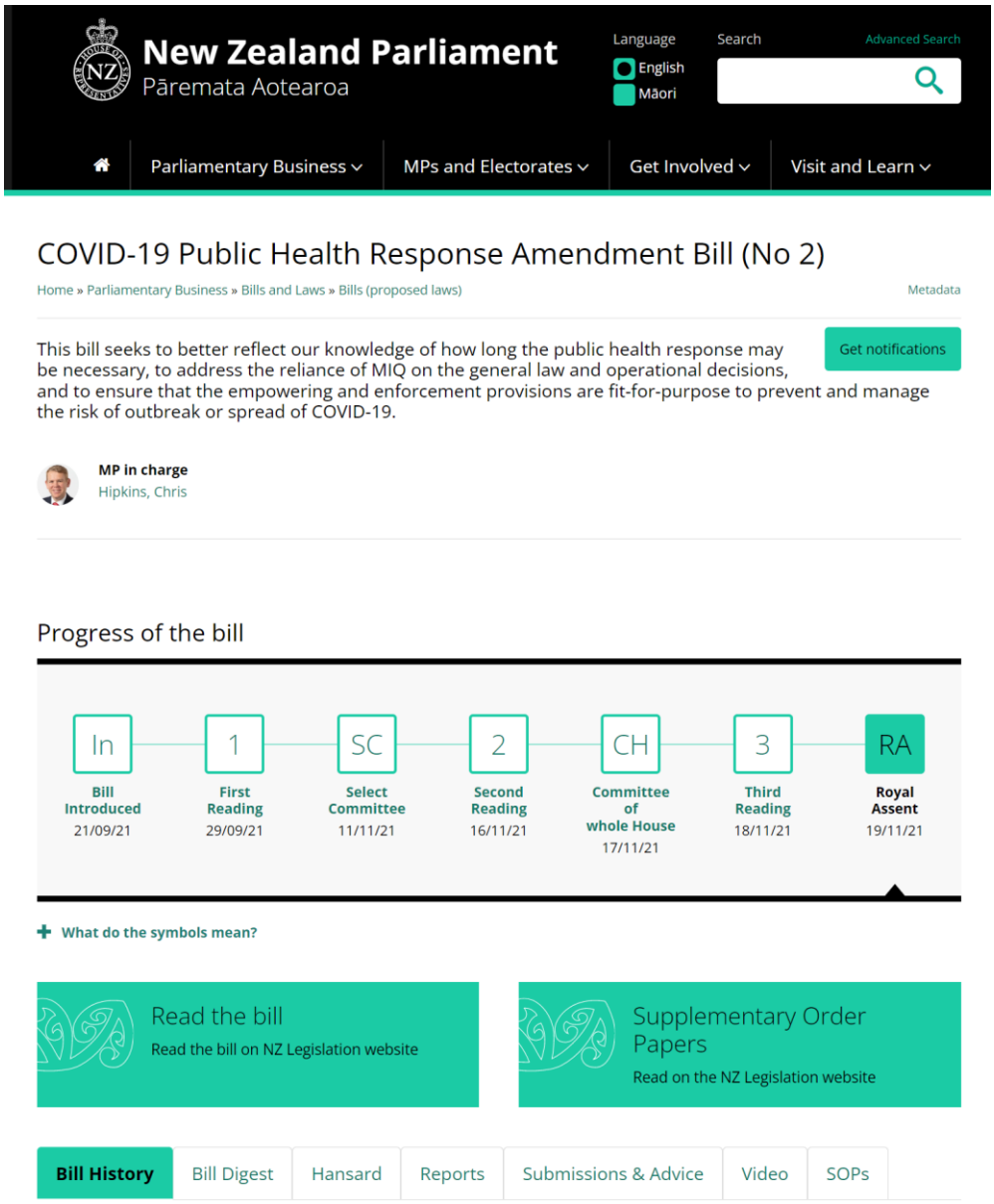

Figure 1. Screenshot, New Zealand Parliament website

The Hon Chris Hipkins was the MP in charge of the Bill, responsible for development of content, introduction, the entire process of getting the Bill through to receiving Royal Assent. The Bill itself (published here), the instrument (the information) the New Zealand public were granted permission to respond to – contained only a single reference to vaccines:

> Among other things, existing COVID-19 orders— require vaccination and regular testing of workers if they are to undertake certain work at borders or at managed isolation or quarantine (MIQ) facilities.

The public were limited to responding to the phrase 'testing of workers' -because these were the facts presented to them by the Hon Chris Hipkins.

The consultation to the Amendment Bill (No.2) was open between 30 Sept to Oct 11, when the rolling out of mandates was 'relatively' uncontroversial (discussed in the following section). Very few people at this time, had been required to be vaccinated in order to remain employed. There was no evidence that the general public, including the business community, would be expected to comply with an obligation to be vaccinated.

Following the 10 day public consultation (the longest consultation permitted to the public over COVID-19), the follow-up Health Committee report on 11 November 2021, discussed vaccines 6 times, with 5/6 times referring to the National Party view.

Despite some 15,000 submissions made over the course of 10 days, the public's input was not discussed. No other reports are held on the Parliament website appear to analyse or refer to public input to the bill.

The Attorney-General (A-G) in his earlier September 14 advice, assured the country that the proposed Amendment Bill would not impact the rights and freedoms of New Zealanders. It is noteworthy that the A-G did not discuss the implications of a duty of affected persons to be vaccinated.

Indeed, the A-G's release was drafted prior to the rapid expansion of mandates into the wider community. The A-G's assurance concerned freedom of expression, of peaceful assembly, association and of movement. Vaccines were not mentioned at all. As the A-G stated:

> 'The Bill provides for extensive limits on freedom of association, assembly and movement. However, in the context of a global pandemic, these powers reflect the significant risk that COVID-19 poses to the public health and wellbeing of individuals in New Zealand. The limitation on freedom of association, assembly and movement for a limited period is in due proportion to the public health response.'

Royal assent was granted November 11, 2021.

Mandate tsunami: COVID-19 Public Health Response (Vaccinations) Orders

COVID-19 Public Health Response (Vaccinations) Orders for workers were well under way from April 2021, as the versions and amendments list on the Parliamentary Counsel Office website demonstrates. The purpose of mandated vaccinations?:

> 'to prevent, and limit the risk of, the outbreak or spread of COVID-19 by requiring work at certain places to be carried out by affected persons who are vaccinated.'

It is evident a staged ratcheting effect (I would say, entrapment) was underway, drawing in greater and greater publics to a regime that coerced and required compliance with vaccinations and record keeping.

Note: The Hon Ayesha Verrall was Associate Minister of Health. Her signature is at the bottom of each document, this simply refers to the date that the first COVID-19 Public Health Response (Vaccinations) Order 2021was signed.

All Orders were made by the Minister for COVID-19 Response – predominantly and until June 2022, the Hon Chris Hipkins. Orders were made under section 11 of the COVID-19 Public Health Response Act 2020 in accordance with section 9 of that Act. (These sections are published in the **Appendix I**). On November 26, 2021 the heading of section 9 was altered; while the content in section 11 was substantially altered following the passing of the COVID-19 Response (Vaccinations) Legislation Act over 2 days (see **Appendix II**).

The Orders are administered by the Ministry of Health. There is no line of sight for those that might seek to identify how and why they were constructed, the Officials that were responsible for drafting, and the evidence supporting the construction of the Orders.

The regime appears to have been deployed tactically, as the releases of the Orders were disconnected (or decoupled) from to evidence steadily expanding in the scientific and regulatory literature, that directly related to vaccine efficacy and safety of the novel product. Throughout April and May 2021 scientists (here, here and here) expressed concern about the risk of the mRNA gene therapy, and it the U.S. Food and Drug Administration were presented with information that following the December 2020 release of the mRNA vaccines, 1223 people had died following in injection by April 2021. Historic protocols for vaccine safety would have conventionally resulted in the mRNA products being pulled due to safety reasons.

Schedule of Orders:

1. April 28, 2021, into force April 30. Duties of PCBUs (person conducting a business or undertaking) to be vaccinated and to maintain records within 35 days. Schedule 2 contains lists of affected persons. Hon Dr Ayesha Verrall.
2. July 14, 2021. Schedule 2 list of affected persons expanded who must receive first vaccination by before the close of 26 August 2021, and second injection no later than 35 days after their first injection.
3. August 12, 2021. Amendments including service workers must have first injection before the close of 26 August 2021; and affected persons who are not service workers before the close of 30 September 2021.

(Note: The COVID-19 Response (Vaccinations) Legislation Bill was released 7 working days, after this time. Therefore, it could not be a reference for which the public could respond to.

However, at this stage the scientific literature was demonstrating that not only were mRNA gene therapy injections showing higher rates of harm than conventional vaccines, but that there was waning and breakthrough – the novel 'vaccines' were not sterile. A colleague and I presented this information to the Health Select Committee (at 1hr 25min) during the consultation to the Amendment Bill (No.2).)

4. October 17, 2021. Amendments include Schedule 3, list of vaccines.
5. October 25, 2021. Amendments include expansion of affected workers to include healthcare workers, prison staff, and '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)' including home-based education and care service. Workers must have first injection by close of 15 November 2021; and second injection by January 1, 2022.
6. November 6, 2021. This Order appears to consolidate Orders.
7. November 7, 2021. Amendments include adding Part 4, as transitional provisions for police who just have first injection by 29 November 2021, and second injection by 14 January 2022.
8. November 12, 2021. Amendment includes Part 5, transitional provisions for fire services (FENZ) who just have first injection by 29 November 2021, and second injection by 14 January 2022.
9. November 20, 2021. This Order appears to consolidate Orders.
10. November 26, 2021. Amended to revoke 9B(12) definition of specified COVID-19 vaccination exemption criteria; replacing this in (4) Interpretation, to mean 'a COVID-19 vaccination exemption granted by the Director-General under clause 9B'.

Note: In addition to (10) above, on November 25, the COVID-19 Response (Vaccinations) Legislation Bill received Royal Assent with no public consultation. The Minister in Charge was the Hon Chris Hipkins. The Bill introduced November 23, COVID-19 Response (Vaccinations) Legislation Act 2021 received Royal Assent two days later. The Bill comment stated that 'This amendments in this omnibus bill make vaccination a more prominent part of New Zealand's COVID-19 response framework.'

The November 26 version of the COVID-19 Public Health Response Act 2020 which established rules which privilege COVID-19 vaccination status, and required the public to submit a COVID-19 vaccination certificate for entry to premises, resulted from the enactment of the COVID-19 Response (Vaccinations) Legislation Act 2021.

11. November 29, 2021. Amended to redefine vaccine to Pfizer/BioNTech COVID-19 vaccine. Schedule 3 which contained the list of approved vaccines/vaccinations was significantly expanded.
12. December 1, 2021. Amended to insert: *Clause 9A* Director-General may authorise affected persons not fully vaccinated to carry out certain work; *Clause 11A* Duties of relevant PCBUs of affected persons belonging to groups specified in Part 7, item 8.2 of Part 8, or Part 9 of Schedule 2: vaccination records. *Clause 12A* Power of Minister to grant exemptions.

Director-General register of records of COVID-19 vaccinations of affected persons expanded from Parts 1 to 6 of the table in Schedule 2 to Persons in part 8.

13. December 3, 2021. Amended to include new definitions, close-proximity business or service; CVC (COVID-19 vaccination certificate); food and drink business or service; gym; permitted event; tertiary education premises; tertiary education provider. Nurses can apply to Director-General for an exemption for individuals in 'belongs to a group specified in Part 6, 7, 8, 9, or 10 of the table in Schedule 2. Clause 11A to include vaccination record keeping of people in Parts 9 or 10 of Schedule 2. Part 7 introduced: Part 7 Provisions relating to COVID-19 Public Health Response (Vaccinations) Amendment Order (No 6) 2021 – where a CVC is required in order to enter a place or receive a service. This set in place transitional provisions where Schedule 2 added Part 10 *Groups in relation to settings where CVC required for persons to enter place or receive service* – food and drink premises, gyms, close-proximity businesses and tertiary education providers. Part 7 of Schedule 1 required these people to have received their second injection by 17 January 2022.
14. December 4, 2021. Amended to categorize infringement offences to low, medium and high.
15. December 16, 2021. Amended Clause 10(1AAA) to include staff members of corrections prisons. Changed name Part 10 to Groups in relation to settings where CVC may be required for persons to enter place or receive service.
16. January 1, 2022. Amended to revoke exemptions for people working in essential supply chains and the essential operations of corrections prisons.
17. January 23, 2022. Amended to expand purpose and definitions to include booster doses for over 18-year-olds. Schedule 1 Part 8 inserted to require booster doses. For workers in part 1-7 of Schedule 2 before 15 February 2022; Part 8 or 9 before 1 March 2022; and then booster doses are required every 183 days (6 months).
18. February 14, 2022. Amended Clause 15 to remove Schedule 2 Part 7 affected persons groups in the health and disability sector and then insert 15A and include the obligation to receive a booster dose before 25 February.
19. March 25 2022. Amended to expand of Schedule 3 list of vaccines.
20. April 4, 2022. Amended to revoke fire services and education personnel.

In addition, from 2022, the Hon Chris Hipkins, and later the Hon Ayesha Verrall released several Amendment Orders:

- COVID-19 Public Health Response (Vaccinations) Amendment Order (No 2) 2021 *14th Feb 2022.* Insert 15A transitional provisions for group in Part 7 for booster dose.

- COVID-19 Public Health Response (Vaccinations) Amendment Order (No 3) 2021 *22nd March.* Massively expanding Schedule which lists available vaccines.

- COVID-19 Public Health Response (Vaccinations) Amendment Order (No 4) 2021 *10th May 2022* Inserts 7A concerning boosters and defines, authorised rapid antigen test; definitive laboratory evidence; and nucleic acid amplification test (NAAT) for COVID-19.

- COVID-19 Public Health Response (Vaccinations) Amendment Order (No 5) 2022. *7th July 2022*. Amends Clause 5 to redefine/alter interpretations and remove requirement for certain border workers and corrections prisons staff from having to be boostered.

- COVID-19 Public Health Response (Vaccinations) Order 2021. Principal order As at July 7. Slight amendments to Schedule 2, groups of affected persons which must be boostered.

November 25, 2021 - COVID-19 Response (Vaccinations) Legislation Act.

As I noted above, 12 days later – *7 working days* after the COVID-19 Public Health Response Amendment Bill (No 2) received Royal Assent, this monster was released by the Hon Chris Hipkins:

COVID-19 Response (Vaccinations) Legislation Bill. *No public consultation.* The Bill was introduced November 23, Royal Assent was received November 25 2021. The Hon Chris Hipkins was the Minister in Charge.

> 'This amendments in this omnibus bill make vaccination a more prominent part of New Zealand's COVID-19 response framework.'

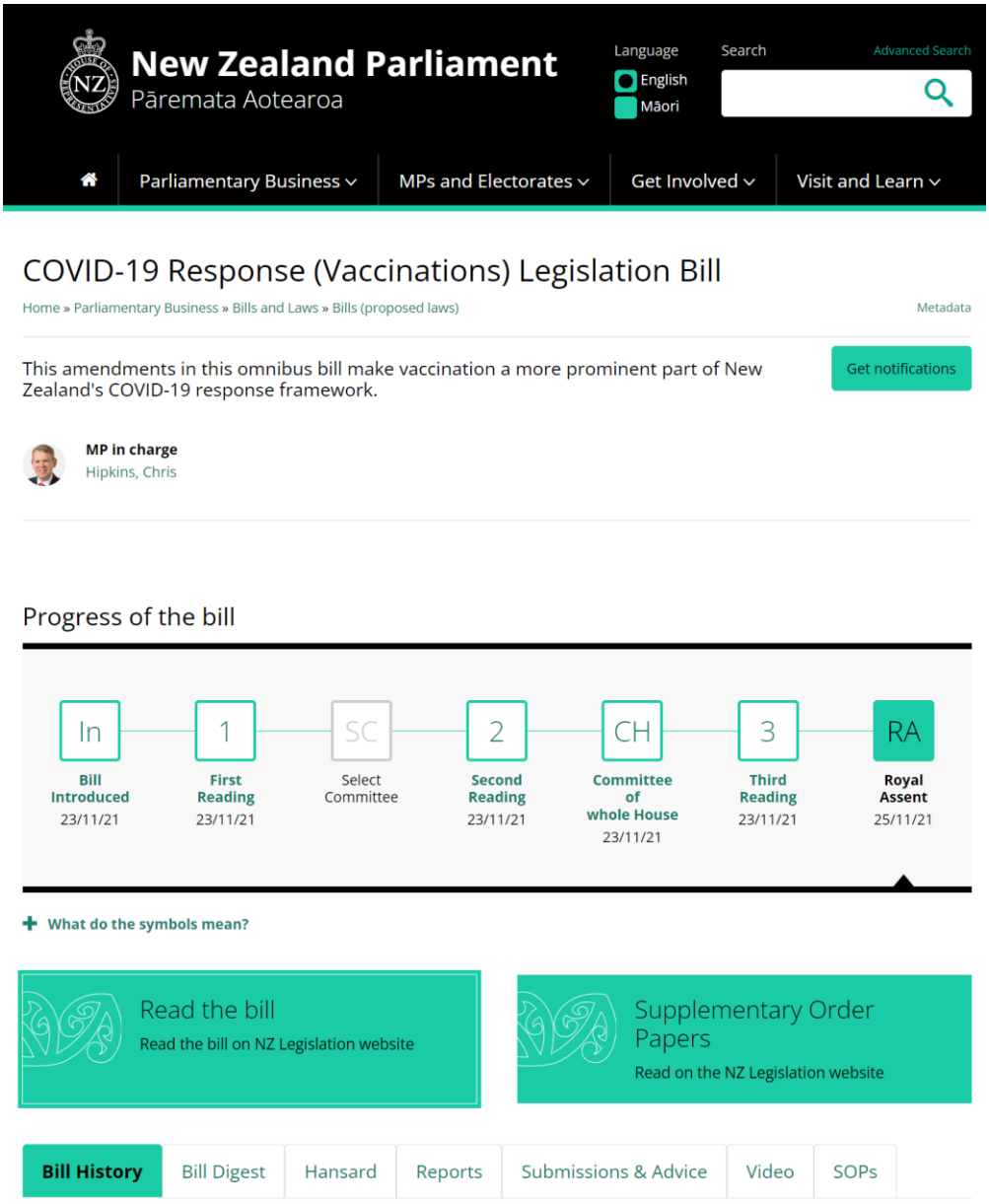

Figure 2 Screenshot, the New Zealand Parliament website

It would be strange if the Hon Chris Hipkins did not know that widespread mandates for public life were about to be introduced during the public consultation. That the government was going to control access to social, public and economic life for all citizens, based on receipt of a novel gene therapy, that, it was known, by October, 2021, was never designed to prevent transmission and infection.

It was the power to make democratically unaccountable Orders that enabled Ministers and officials to have such control over the process.

Section 11 was significantly altered by the passing of this Act. (See Appendix II)

Ethics and Accountability.

This is where one of the many the ethical blackboxes appear. There was no bioethics committee convened over the COVID-19 pandemic. I can find no release of reviews of the scientific literature, and no doubt was ever expressed over the safety and efficacy of the novel vaccine. Shouldn't this occur in a dynamic event, particularly when the technology deployed at scale was novel and remains under provisional consent?

(It quite boggles the mind if one contemplates how profoundly uninterested the Wellington and Auckland public law academics have been regarding such matters.)

Health Act 1956 – drawn on for powers but not obligations to protect?

Inconsistent application of the Health Act 1956 in COVID-19 legislation arose from early 2020 Orders that derived their powers from that Act. I'm attempting to put this into historic context and hope it makes some sense.

The Health Act 1956 appears to be have been deployed over COVID-19 to expand powers of government officials, but health protective or precautionary provisions appear to have been excluded. This can be observed in the consistent harnessing of the powers and provisions of the Health Act for lockdowns, but no requirement or obligation that sets moral or ethical boundaries to protect health and prevent harm.

The Prime Minister's March 24 2020 Epidemic Preparedness notice was based on the understanding that the Prime Minister was *'satisfied that the effects of the outbreak of COVID-19 are likely to disrupt or continue to disrupt essential governmental and business activity in New Zealand significantly.'*
The Notice was one of the ways the special powers under section 70, 71 and 74 of the Health Act were activated. The protection of health was not referred to.

On **April 24 2020** Director General Dr Ashley Bloomfield drew on the powers of the Health Act to declare the Health Act (COVID-19 Alert Level 3) Order 2020 which came into force on 11.59 pm on 27 April 2020. It was issued under the authority of the Legislation Act 2012. It drew on the Health Act to undertake New Zealand's first COVID-19 lockdown

'Pursuant to section 70(1)(f) and (m) of the Health Act 1956, for the purpose of preventing the outbreak or spread of COVID-19.'

The Order outlined the brief history of government activities from March 2020:

'On 24 March 2020, the Prime Minister, with the agreement of the Minister of Health, gave a notice under section 5 of the Epidemic Preparedness Act 2006. The epidemic notice allows the use of special powers by the Medical Officer of Health in accordance with section 70 of the Health Act 1956 for the purpose of preventing the outbreak or spread of COVID-19.'

- *A state of national emergency was declared under the Civil Defence Emergency Management Act 2002, with effect from 12.21pm on 25 March 2020.*
- *From 25 March 2020, an order under section 70(1)(m) of the Health Act 1956 required that premises be closed and forbade congregation in outdoor places of amusement or recreation.*
- *From 31 March 2020, an order under section 70(1)(f) of the Health Act 1956 applied to arrivals into New Zealand providing certain isolation or quarantining requirements.*
- *From 3 April 2020, an order under section 70(1)(f) of the Health Act 1956 applied to all persons in New Zealand providing certain isolation or quarantining requirements.*
- *From 9 April 2020, an order under section 70(1)(e), (ea), and (f) of the Health Act 1956 applied to arrivals by air into New Zealand providing further isolation or quarantining requirements.*

Early days. May 13, 2020. The COVID-19 Public Health Response Bill

As I have mentioned previously, the Attorney General David Parker introduced the COVID-19 Public Health Response Act, with one day to signing and deployment. This signature legislation that has provided the legislative backbone to all further legislative amendments and the production of new Orders. He was central therefore to the construction of the purpose of the Act, that would guide all future legislation.

The COVID-19 Public Health Response Act 2020 purpose includes the principles which inform subsequent secondary legislation emphasised outbreak and infection:

> **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
> (d) has enforceable measures, in addition to the relevant voluntary measures and public health and other guidance that also support that response.

The May 13 2020 COVID-19 Public Health Response Act 2020 demonstrated that much was drawn from the Health Act 1956. However these appeared to be cherrypicked in such a way that increased control without imposing protective clauses. For example, definitions in prospective Orders (as new secondary or delegated legislation that did not require public oversight) did not have to be consistent with the Health Act 1956 (S.13); and persons acting under the authority of the act would be protected, just like the Health Act (S.34).

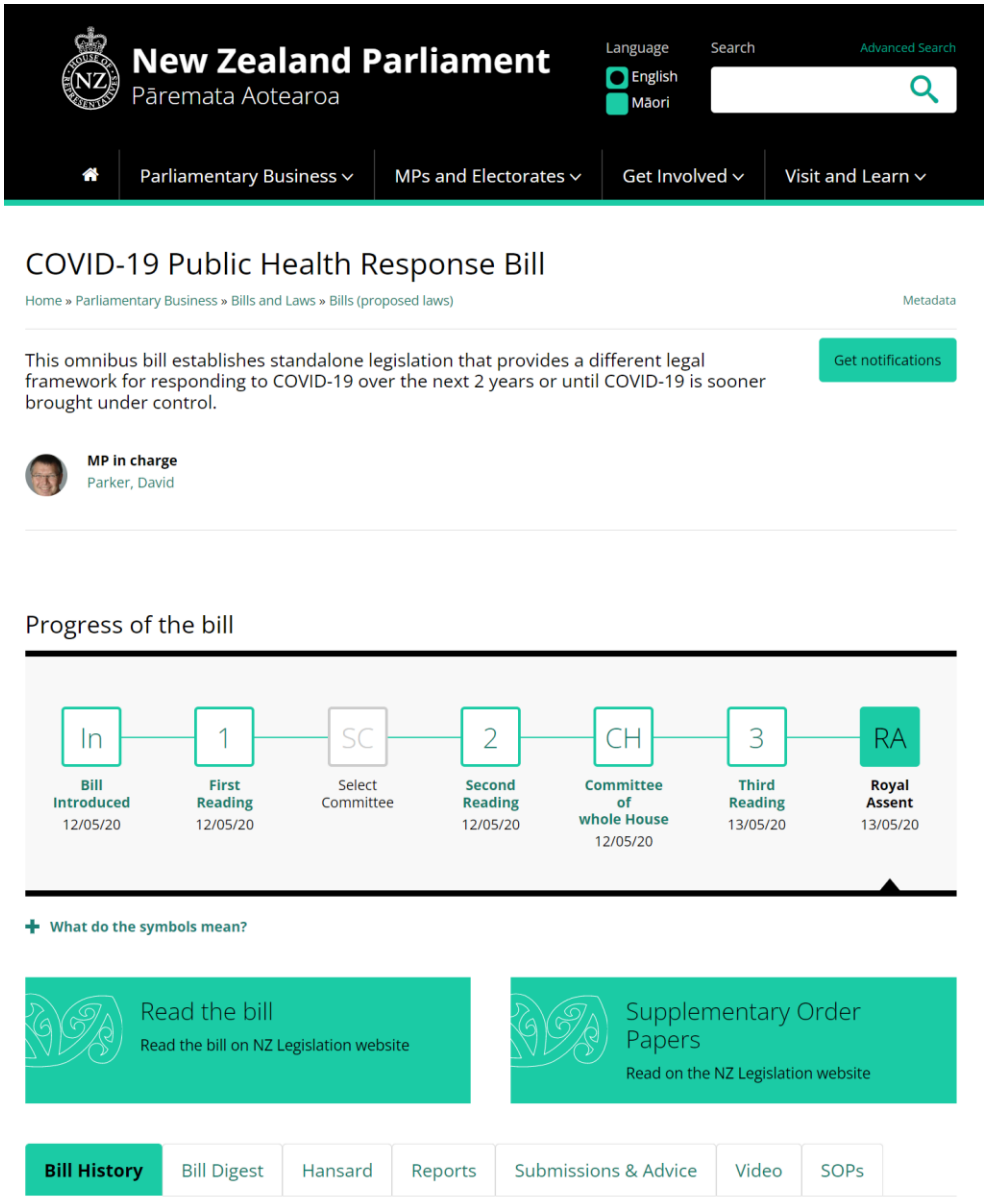

Figure 3 Screenshot, New Zealand Parliament website

The purposes of the Health Act?

I consider it is important to reflect back on the Health Act 1956, which defined the Ministry's' function:

> **3A Function of Ministry in relation to public health**
> Without limiting any other enactment or rule of law, and without limiting any other functions of the Ministry or of any other person or body, the Ministry shall have the function of improving, promoting, and protecting public health.

Consider this - improving, promoting and protecting public health has been enshrined at the top of our health legislation for nearly 70 years. Then – decisions that were taken outside the public domain, with practically no public consultation, swept the focus aside in order to achieve the narrow purpose of tracking down a coronavirus.

At this stage it was known that not all people were at risk, and that coronaviruses rapidly mutate. It was also known that conventionally, as viruses mutate, they become more infectious and less pathogenic (harmful).

Early days. May 14th, 2020. The first Order

The COVID-19 Public Health Response (Alert Level 2) Order 2020, the first Order to come out of the came into force on the 14 of May, the purpose was to

> 'limit the risk of, the outbreak or spread of COVID-19.'

The COVID-19 Response (Further Management Measures) Legislation Bill which received Royal Assent May 15, 2020, drew upon the Health Act 1956 in Report of the Epidemic Response Committee discussion in its' reasoning. The Hon Chris Hipkins was the Minister in Charge. The Act emphasised that 'COVID-19 lockdown period means the period during which any order or other restriction is in force under section 70(1)(f), (g), (h), (i), (la), or (m) of the Health Act 1956, or section 11 of the COVID-19 Public Health Response Act 2020'.

However higher purposes of the Health Act that required that health was protected were never included.

None of the higher purposes of the Health Act were not embedded in any COVID-19 legislation, requiring that the Ministry of Health Ministry 'shall have the function of improving, promoting, and protecting public health.' This has been excluded from all COVID-19 legislation.

In addition, and somewhat strangely, the overarching principles of infectious disease management (Part 3A of the Health Act 1956) that were not reflected in any COVID-19 legislation, most disturbingly, (S.92B) which included a requirement that the paramount consideration would be the protection of public health.

As civil society understands, instead of a paramount consideration that health would be protected, the paramount consideration throughout COVID-19 appears to have revolved around the notion that powers from the overriding Acts would be granted to civil servants ***to prevent, and limit the risk of, the outbreak or spread of COVID-19.***

Therefore, for the COVID-19 Response Ministers Hipkins (November 2020-June 2022) and Verrall (from June 2022), in carrying out your duties under COVID-19 legislation, have no stated requirement under COVID-19 legislation to protect health. The legislation placed no direct obligation these Ministers of the Crown, to undertake all reasonable action to dedicate resources to, and understand how risk for hospitalisation and death was stratified by age and health status in a respiratory infectious disease outbreak.

The only possible obligation might come from (b) avoids, mitigates, or remedies the actual or potential adverse effects of the COVID-19 outbreak (whether direct or indirect);

It was understood from March 2020, that risk was stratified to the elderly and infirm and those with complex comorbid conditions.

The legislation placed no direct obligation on Ministers to ensure that the interventions applied did not harm disproportionately harm populations who were not at risk of hospitalisation and death.

Guidance for officials

Civic education, and civic knowledge is poor. It's easily whitewashed, and it's easily dulled down, or technocratised into something boring and instrumental. However, the bedrock of democratic life is based on accountability and transparency, it's based on acting in good faith to steward our country and protect future generations.

There has been a decline in our capacity to talk about ethics, get to the guts of what judgement means in complex, nuanced and highly uncertain environments. Our centres of excellence don't have capacity to bring to public attention how closely intertwined our governance systems are with large, powerful institutions with financial and political interests. Yet these arrangements alter the way decisions are calculated and made.

These are socio-cultural and ethical beliefs and understandings that infiltrate and inform our thinking, often unknowingly, and intuitively. Often, we can't articulate them, we 'just know' they are there. They inform judgement when there are multiple issues at stake.

Of course, the drivers of this are intensely complex, stemming from socio-historic, economic, and institutional shifts towards public-private partnerships, as well as the expansion of power, the endless monopoly game of the key industries across technology and digital, food; media; pharmaceutical; and the resource and industrial feedstock sectors. Such work scaled up with new communications technologies, from the development of the fax machine, to email, social media, video conferencing et al.

However, a democratic rule of law only works if there is a culture to ensure that judgement can be made in the interest of civil society. I consider that it is evident in the laws that have driven the COVID-19, that more nuanced ethics-based obligations have been kept outside regulatory and informational arenas. Instead, it was technocratic - focussing on a fast mutating, respiratory virus. From the start, the case rate terror, and the eliminate narrative was locked in.

I consider that is because the relationship of our governing bodies have shifted ever-closer to firmer and contractual alliances and 'partnerships' with commercial partners. This socio-industrial pressure, or asymmetrical power, has shifted the obligation away from a webbed matrix with the public - to a deeper webbed matrix with powerful institutions, in a perpetual feedback loop.

And yes, we have always had the Crown, and Māori have long felt the brunt of the Crown's racist, extractive and at times tyrannical power. However, when the power of the Crown is fused with the power of concentrated, offshore financial or political interests, the balance tips.

But the individual Official, what can they do? In the face of pervasive institutional power, family commitments (and at times, NDA's - non-disclosure agreements), it is all too easy to default to wilful blindness (and here).

The consequence has been - in this pandemic - insane, unethical and anti-democratic.

Yet there are breadcrumbs in the governance literature which demonstrate that officials do have obligations.

The Cabinet Manual

Officials are required to

> 'inform Ministers promptly of matters of significance within their portfolio responsibilities, particularly where these matters may be controversial or may become the subject of public debate.'

Officials in the public service are guided by principles of public service, they are expected to engage in conduct that is fair, impartial, responsible and trustworthy. In addition:

> 'Advice given to Ministers must be honest and impartial, and include all relevant information. It must also be responsive to the priorities determined by the government of the day. Advice must be free and frank, and acknowledge any key information gaps, assumptions, risks, or connections to other matters. This will allow Ministers to take decisions based on the best available evidence and an appreciation of all the options and issues. Once policy decisions have been taken, departments are responsible for their effective implementation.'

Yet such information has not appeared to have been collated and forwarded by officials in published records, despite constitutional principles that oblige officials to provide free and frank advice to Ministers and others in positions of authority.

Controversial information over COVID-19 is scientific, it involves data. Such information directly impacts policy – it should (theoretically) be a *significant policy issue*. But from what I understand none of the Ministers hold scientific information or data. It appears from Cabinet papers that the Minister of Health was not briefed on risks relating to novel vaccine efficacy and safety. Efficacy risks, which included risk of waning and breakthrough, and safety risks, of disability and death following injection, were steadily aggregating in the literature by August 2021. New Zealand modelling scenarios relating to national uptake of the mRNA gene therapies did not include risk of waning and breakthrough.

How can Ministers be 'informed about matters of public interest, importance, or controversy' if such a process did not occur - or - can be demonstrated not to have occur through actions by Ministers and agencies to refuse Official Information Act requests, or divert attention in request responses to information that is not temporally related to the enactment of policy?

The Cabinet Manuel highlights again and again, the need for significant or potentially controversial matters to be consulted on – but this seems never to have happened, in Ardern's lockstep authoritarianism.

However, it feels that the mechanisms in the machinery of government that should enable challenges to government actions - where there is a failure to consider all relevant issues - have been withdrawn, eroded or underfunded.

These gaps have occurred where Commissioners, State Services Commission and Governor General are strangely muted, and the Attorney General politically invested in the policy outcome. We know that release of documents containing legal advice must be approved by the Attorney-General. How

does this work when he put in place the overriding legislation? Many of us have witnessed a refusal to respond to OIA requests through the fact that there is no data – or the handballing to another agency, and the incapacity of a backlogged Ombudsman and more. Judges have been unable to exercise discretion and judgement to recognise the difference between science selectively provided by an agency set on enforcing rights-limiting and policies that inversely harm not-at-risk-of COVID-19 populations (i.e. the greater majority of New Zealanders), with the evidence provided by a scientist who has published over 600 peer reviewed papers with an h-index of around 95.

Palmer and Butler noted in 2018 in *Towards Democratic Renewal* that 'the New Zealand style of government is already authoritarian.' When the mechanisms, that uphold democratic life are impotent, what have we left?

I'm just a layman, however I understand that legislation must be fit for purpose, it should be defined early and robustly tested. Was there any challenge in the drafting process to the exclusion of the Health Act obligation to protect health, and the infectious disease principles?

The Legislation Design and Advisory Committee Legislation Guidelines 2021 Edition

> 'Legislation should be fit for purpose…. Legislation should be designed to provide certainty as to rights and obligations but also build in sufficient flexibility to enable them to last. Legislation should be comprehensive enough to deal with likely scenarios.' (Page 9.)

And this

> Legislation should be constitutionally sound—Legislation should be consistent with the Treaty of Waitangi and should reflect the fundamental values and principles of a democratic society, including in the processes by which it is made.

And this

> Legislation should be accessible for users—legislation should be able to be easily found by citizens, easy to navigate, and understand. (Page 9.)

Do you consider that the purposes of the overriding Act could respond to this highly emergent environment? That the legislation was and is, constitutionally sound? Does the legislation reflect the fundamental values and principles of a democratic society?

Was the legislation designed to be sufficiently flexible, to respond to the fact that the infectious disease never posed a risk to most of the population? The changing evidence in the government and science literature on prior to mass mandates? The potential for not at-risk populations to be harmed by mandates? How was it possible to address such issues if the legislation was based around stewarding all over 12's to take up a novel gene therapy, that had none of the qualities of classic vaccines, such as the smallpox vaccine.

And of course, those who signed the deal with Pfizer knew this. They understood that the endpoints in the clinical trials were not prevention of transmission of infection, nor prevention of death. Because they had access to the clinical trials.

Legislation that shepherded the whole of the adult population towards an injection that did not prevent transmission of infection, and that also caused harm, I would suggest, was not fit for purpose.

Was the principle of legality set aside?

From pages 23-24 of the guidelines:

Legislation should be consistent with the dignity of the individual and the presumption in favour of liberty.

All law is made (and, when enacted, will be construed by courts) against a matrix of values and principles that are regarded as fundamentally important to our legal system. These values and principles can be expressed at differing levels of abstraction. Fundamentally, they concern human dignity and liberty but these terms embrace a broader set of rights and freedoms that include:

- the right not to be deprived of life;
- physical integrity of one's body, including freedom from medical treatment or scientific experimentation without consent;
- freedom from torture, or cruel, degrading, or disproportionately severe treatment or punishment;
- freedom from discrimination based on immutable characteristics;
- physical liberty, in the sense of freedom from arbitrary arrest or restraint;
- freedom of conscience, religion, expression, association, assembly, and movement;
- liberty, in the sense of freedom to make fundamental personal choices as to how one lives one's life; and
- procedural fairness, often referred to as natural justice.

The expectation is that legislation will be construed and applied in light of these abiding values. This has been called the "principle of legality".

Most of these fundamental rights and freedoms have, since 1990, been affirmed in NZBORA. Section 7 of that Act requires, as part of the process of law making, that the Attorney-General advise the House of Representatives if any provision in a bill appears to be inconsistent with rights and freedoms in NZBORA.
The government never convened bioethics panels to discuss whether COVID-19 legislation would impact the rights affirmed by NZBORA. The decisions were made by Hons Andrew Little and David Parker.
The rights affirmed by NZBORA can be grouped into six categories (page 32):

- life and security of the person;
- democratic and civil rights;
- non-discrimination and minority rights;
- search, arrest, and detention rights;
- criminal procedure rights; and
- rights to justice

Was the failure to disclose that the novel vaccine would not prevent transmission, that this was evident in the scientific literature; a failure to provide informed consent, while distributing large sums to communities with the condition that they would promote a novel vaccine (rather than protect, for example, immune health), misleading and deceptive conduct which contradicted the principles of the Treaty of Waitangi?

The primary consideration of Māori that were not at risk of COVID-19 to take the injection, was to protect whanau. But this exposed those not at risk to risk from the provisionally consented injection, it also ignored the fact that those with immunosuppressive and complex conditions might have fared better on other treatments.

As I have discussed, the Attorney General (A-G) advised that an amendment to an Act *he set in place* would not be inconsistent with the rights and freedoms in BORA. The A-G could be said to have a vested or predetermined interest in an outcome that aligned with his earlier purpose – to reduce infection and transmission, not to prevent hospitalisation, death nor protect health.

When the A-G was giving consideration to the justification for the Bill which would set aside peoples' rights, human rights and international conventions, the A-G must have known that there was to be exclusive adoption of forcing a novel vaccine onto much of the New Zealand public. This is because, his other responsibilities were to direct priorities within the parliamentary drafting office where preparations were already advanced for using the powers for the purpose of paving the way for vaccine mandates.

Considerations which should be the bedrock of government administration were not considered, nevertheless human rights were removed through process to facilitate this novel vaccine.

> 'An authority may unlawfully abdicate its statutory function by refusing or failing to act. A public body must not renounce its decision-making responsibility, nor preclude itself from inquiring into matters relevant to its inquiry.' Joseph, P.A., 4th Ed. 23.3.5.

Has something gone wrong?

Note: As this is a complex issue, please notify me of incorrect terms or misinterpreted information.

APPENDIX I

COVID-19 Public Health Response (Vaccinations) Order 2021

Sections 9 & 11 of the COVID-19 Public Health Response Act 2020 are where the powers to make the Orders are defined.

COVID-19 Public Health Response (Vaccinations) Order 2021

This order is made by the Minister for COVID-19 Response under **section 11** of the COVID-19 Public Health Response Act 2020 in accordance with **section 9** of that Act.
Minister responsible until June 2022: Hon Chris Hipkins.
(Original version as signed into force by Associate Health Minister Ayesha Verrall, 28 April 2021)

COVID-19 Public Health Response Act

Section 9 (as at April 28, 2021)

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 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.

Section 9 heading: amended, on 6 August 2020, by section 10 of the COVID-19 Public Health Response Amendment Act 2020 (2020 No 57).
Section 9(1): amended, on 6 August 2020, by section 10 of the COVID-19 Public Health Response Amendment Act 2020 (2020 No 57).
Section 9(1)(ba): inserted, on 6 August 2020, by section 6 of the COVID-19 Public Health Response Amendment Act 2020 (2020 No 57).
Section 9(1)(c): replaced, on 8 December 2020, by section 5 of the COVID-19 Public Health Response Amendment Act (No 2) 2020 (2020 No 64).

COVID-19 Public Health Response Act

Section 11 (as at April 28, 2021)

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:

(b) in relation to any places, premises, crafts, vehicles, animals, or other things, to require specified actions to be taken, require compliance with any specified measures, or impose specified prohibitions that contribute or are likely to contribute to preventing the risk of the outbreak or spread of COVID-19, including (without limitation) any of the following:

(i) Require things to be closed or only open if specified measures are complied with:

(ii) prohibit things from entering any port or place, or permit the entry of things into any port or place only if specified measures are complied with:

(iii) prohibit gatherings of any specified kind in any specified places or premises, or in any specified circumstances:

(iv) require things to be isolated, quarantined, or disinfected in any specified way or specified circumstances:

(v) require the testing of things in any specified way or specified circumstances.

(2) An order made by the Minister may specify which breaches of an order made by the Minister or the Director-General are infringement offences for the purposes of section 26(3).

(3) For the purpose of this section and section 12, things means any things mentioned in subsection (1)(b), including places, premises, ports, crafts, vehicles, and animals.

Section 11(1): amended, on 6 August 2020, by section 7(1) of the COVID-19 Public Health Response Amendment Act 2020 (2020 No 57).
Section 11(1)(a)(viii): replaced, on 6 August 2020, by section 7(2) of the COVID-19 Public Health Response Amendment Act 2020 (2020 No 57).
Section 11(1)(a)(x): inserted, on 6 August 2020, by section 7(3) of the COVID-19 Public Health Response Amendment Act 2020 (2020 No 57).

APPENDIX II

FROM NOVEMBER 26, 2021.

COVID-19 Response (Vaccinations) Legislation Act

COVID-19 Public Health Response Act, amended following COVID-19 Response (Vaccinations) Legislation Act. *No public consultation.*
Bill introduced November 23, the Act received Royal Assent *November 25 2021*.
Minister in Charge: Hipkins

COVID-19 Public Health Response Act

Section 9. (as at November 26, 2021)

9 Requirements for making COVID-19 orders under section 11
(1) The Minister may make a COVID-19 order under section 11 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 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.
Section 9 heading: replaced, on 26 November 2021, by section 5(1) of the COVID-19 Response (Vaccinations) Legislation Act 2021 (2021 No 51).

Section 9(1): amended, on 26 November 2021, by section 5(2) of the COVID-19 Response (Vaccinations) Legislation Act 2021 (2021 No 51).

Section 9(1): amended, on 6 August 2020, by section 10 of the COVID-19 Public Health Response Amendment Act 2020 (2020 No 57).

Section 9(1)(ba): inserted, on 6 August 2020, by section 6 of the COVID-19 Public Health Response Amendment Act 2020 (2020 No 57).

Section 9(1)(c): replaced, on 8 December 2020, by section 5 of the COVID-19 Public Health Response Amendment Act (No 2) 2020 (2020 No 64).

COVID-19 Public Health Response Act

Section 11. (as at November 26, 2021)

11 Orders that can be made under this Act

(1) The Minister or the 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 or to take any specified actions, or comply with any specified measures, so as to contribute or be likely to contribute to either or both of the following:

(i) preventing, containing, reducing, controlling, managing, eliminating, or limiting the risk of the outbreak or spread of COVID-19:

(ii) avoiding, mitigating, or remedying the actual or potential adverse public health effects of the outbreak of COVID-19 (whether direct or indirect):

(b) by way of example under paragraph (a), requiring persons to do any of the following:

(i) stay in any specified area, place, or premises or refrain from going to any specified area, place, or premises (including in specified circumstances or unless in compliance with specified measures):

(ia) permit entry to any specified areas, places, or premises only in specified circumstances or in compliance with specified measures:

(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 or place, or refrain from travelling to or from any specified area or place in specified circumstances or unless in compliance with specified measures (for example, refrain from leaving an area unless the person has a COVID-19 vaccination certificate):

(v) refrain from carrying out specified activities (for example, business activities involving close personal contact) or carry out specified activities 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:

(c) in relation to an MIQF, other place of isolation or quarantine, or a place of self-isolation or quarantine, to require specified actions to be taken, or require compliance with any specified measures, for the purpose of managing the movement of people to, from, and within the MIQF, other place of isolation or quarantine, or place of self-isolation or quarantine, including (without limitation) any of the following:

(i) giving directions that relate to the movement of people to, from, and within the MIQF, other place of isolation or quarantine, or place of self-isolation or quarantine:

(ii) imposing restrictions and conditions that relate to the movement of people to, from, and within the MIQF, other place of isolation or quarantine, or place of self-isolation or quarantine:

(iii) permitting people to leave their rooms in the MIQF, other place of isolation or quarantine, or place of self-isolation or quarantine in accordance with any requirements or conditions specified in the order:

(d) in relation to any places, premises, craft, vehicles, or other things, to require specified actions to be taken, require compliance with any specified measures, or impose specified prohibitions, so as to contribute or be likely to contribute to either or both of the following:

(i) preventing, containing, reducing, controlling, managing, eliminating, or limiting the risk of the outbreak or spread of COVID-19:

(ii) avoiding, mitigating, or remedying the actual or potential adverse public health effects of the outbreak of COVID-19 (whether direct or indirect):

(e) by way of example under paragraph (d), doing any of the following:

(i) requiring any places, premises, craft, vehicles, or other things to be closed or only open if specified measures are complied with:

(ii) prohibiting any craft, vehicles, or other things from entering any port or place, or permitting the entry of any craft, vehicles, or other things into any port or place only if specified measures are complied with:

(iii) prohibiting gatherings of any specified kind in any specified places or premises, or in any specified circumstances:

(iv) requiring any places, premises, craft, vehicles, or other things to be isolated, quarantined, or disinfected in any specified way or specified circumstances:

(v) requiring the testing of any places, premises, craft, vehicles, or other things in any specified way or specified circumstances:

(f) in relation to laboratories that undertake COVID-19 testing, by—

(i) setting quality control measures and minimum standards:

(ii) requiring COVID-19 test results to be reported to the Director-General's public health national testing repository:

(iii) managing the supply of testing consumables (such as reagents and swabs) used by the laboratories:

(iv) providing differently for different classes of testing laboratories (for example, different provisions for laboratories depending on whether they are funded publicly or privately):

(g) requiring the owner or any person in charge of a specified laboratory that undertakes COVID-19 testing to—

(i) deliver or use, in accordance with directions given under the order, specified quantities of COVID-19 testing consumables that the Minister considers necessary for the purposes of the public health response to COVID-19:

(ii) undertake COVID-19 testing solely for the purposes of the public health response to COVID-19 while subject to the order, whether or not the laboratory is contracted by the Crown for that purpose:

(h) requiring persons to permit individuals to enter a place or receive a service whether or not those individuals are vaccinated, have a COVID-19 vaccination certificate, or are otherwise able to produce evidence of their vaccination status:

(i) specifying the evidence that may be required to be produced, and the person to whom the evidence may be required to be produced to, to demonstrate compliance with a specified measure (for example, specifying that a COVID-19 vaccination certificate is required to be

produced to enter certain premises) and providing for any prohibitions or duties that apply in respect of the use or production of that evidence:

(j) specifying, for the purposes of a COVID-19 vaccination, the required doses for each COVID-19 vaccine or combination of COVID-19 vaccines:

(k) in relation to COVID-19 vaccination certificates,—

(i) specifying who is eligible to be issued with a COVID-19 vaccination certificate:

(ii) specifying how an application for a COVID-19 vaccination certificate must be made, and the information required to accompany that application:

(iii) providing for the issue, renewal, and extension of COVID-19 vaccination certificates by the Director-General or by the use of automated electronic systems (which certificates are to be treated as if they were issued, renewed, or extended by the Director-General):

(iv) providing for the form and content of COVID-19 vaccination certificates to be determined by the Director-General:

(v) specifying the period for which COVID-19 vaccination certificates are valid, or the conditions under which COVID-19 vaccination certificates may expire.

(2) *[Not in force]*

(3) For the purposes of this section and section 12, **things** includes animals, goods, businesses, records, equipment, and supplies.

(4) All goods prohibited from import under a COVID-19 order are deemed to be included among goods prohibited from import under section 96 of the Customs and Excise Act 2018, and the provisions of that Act apply to those goods accordingly.

(5) A COVID-19 order made under this section is secondary legislation (*see* Part 3 of the Legislation Act 2019 for publication requirements).

(6) If a COVID-19 order authorises the Director-General or chief executive to do anything specified in section 12(1)(d) by notice,—

(a) the notice is secondary legislation (*see* Part 3 of the Legislation Act 2019 for publication requirements), unless it applies only to 1 or more named persons or things; and

(b) the order must contain a statement to that effect.

Legislation Act 2019 requirements for secondary legislation referred to in subsection (5)

Publication	PCO must publish it on the legislation website and notify it in the *Gazette*	LA19 s 69(1)(c)
Presentation	The Minister must present it to the House of Representatives	LA19 s 114
Disallowance	It may be disallowed by the House of Representatives	LA19 ss 115, 116

This note is not part of the Act.

Legislation Act 2019 requirements for secondary legislation referred to in subsection (6)(a)

Publication	The maker must publish it in accordance with the Legislation (Publication) Regulations 2021, unless it is published by PCO	LA19 ss 69, 73, 74(1)(aa)
Presentation	The Minister must present it to the House of Representatives, unless it is excluded by section 114(2) of the Legislation Act 2019	LA19 s 114
Disallowance	It may be disallowed by the House of Representatives, unless it is excluded by section 115 of the Legislation Act 2019	LA19 ss 115, 116

This note is not part of the Act.

Section 11: replaced, on 20 November 2021, by section 7 of the COVID-19 Public Health Response Amendment Act 2021 (2021 No 48).

Section 11(1)(b)(i): replaced, on 26 November 2021, by section 6(1) of the COVID-19 Response (Vaccinations) Legislation Act 2021 (2021 No 51).

Section 11(1)(b)(ia): inserted, on 26 November 2021, by section 6(1) of the COVID-19 Response (Vaccinations) Legislation Act 2021 (2021 No 51).

Section 11(1)(b)(iv): replaced, on 26 November 2021, by section 6(2) of the COVID-19 Response (Vaccinations) Legislation Act 2021 (2021 No 51).

Section 11(1)(h): inserted, on 26 November 2021, by section 6(3) of the COVID-19 Response (Vaccinations) Legislation Act 2021 (2021 No 51).

Section 11(1)(i): inserted, on 26 November 2021, by section 6(3) of the COVID-19 Response (Vaccinations) Legislation Act 2021 (2021 No 51).

Section 11(1)(j): inserted, on 26 November 2021, by section 6(3) of the COVID-19 Response (Vaccinations) Legislation Act 2021 (2021 No 51).

Section 11(1)(k): inserted, on 26 November 2021, by section 6(3) of the COVID-19 Response (Vaccinations) Legislation Act 2021 (2021 No 51).

Section 11(5): amended, on 26 November 2021, by section 6(4) of the COVID-19 Response (Vaccinations) Legislation Act 2021 (2021 No 51).

11ACompensation or payment relating to requisitions

(1) This section applies if an order is made under section 11(1)(g).

(2) The owner of a testing laboratory injuriously affected by the requisitioning of testing consumables is entitled to receive compensation from the Crown at the market rate for the consumables requisitioned.

(3) The owner of a testing laboratory required to undertake COVID-19 testing solely for the purposes of the public health response to COVID-19 is entitled to be paid by the Crown for its services at the market rate for those services.

(4) All questions and disputes relating to claims for compensation or payment under this section must be heard and determined by the District Court, whose decision is final.

Section 11A: inserted, on 20 November 2021, by section 8 of the COVID-19 Public Health Response Amendment Act 2021 (2021 No 48).

11AARequirements for making COVID-19 orders under section 11AB

(1) The Minister may make a COVID-19 order under section 11AB in accordance with the following provisions:

(a) 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

(b) the Minister—

(i) must have consulted the Prime Minister, the Minister for COVID-19 Response, the Minister of Justice, and the Minister of Health; and

(ii) may have consulted any other Minister as the Minister thinks fit; and

(c) before making the order, the Minister—

(i) may consult the Director-General; and

(ii) must be satisfied that the order is in the public interest and is appropriate to achieve the purpose of this Act.

(2) For the purposes of subsection (1)(c)(ii), **public interest** includes (without limitation)—

(a) ensuring continuity of services that are essential for public safety, national defence, or crisis response:
(b) supporting the continued provision of lifeline utilities or other essential services:
(c) maintaining trust in public services:
(d) maintaining access to overseas markets.

Section 11AA: inserted, on 26 November 2021, by section 7 of the COVID-19 Response (Vaccinations) Legislation Act 2021 (2021 No 51).

11AB Orders that can be made under this Act relating to specified work

(1) The Minister may, in accordance with section 11AA, make an order for 1 or more of the following purposes:
(a) specifying work, or classes of work, that may not be carried out by an affected worker unless the affected worker is vaccinated, an exempt person, or an authorised person:
(b) specifying work, or classes of work, that may not be carried out by an affected worker unless the affected worker reports for and undergoes medical examination or testing for COVID-19, or is otherwise permitted to do the work—
(i) at any specified place or time:
(ii) in any specified way or specified circumstances:
(c) imposing further duties or obligations relating to specified work carried out by affected workers:
(d) prescribing how duties imposed under subpart 2A or a COVID-19 order made under this section are to be performed:
(e) prescribing record-keeping requirements for the purposes of subpart 2A or a COVID-19 order made under this section, including the content of the records and the manner in which records must be kept.
(2) An order made under this section may specify which breaches of the order are infringement offences for the purposes of section 26(3), and may specify that a breach of an order is a particular class of infringement offence (with the corresponding penalties) for the purposes of regulations made under section 33(1)(b).
(3) To avoid doubt, nothing in this section limits the purposes for which an order may be made under section 11.
(4) If a conflict arises between an order made under this section and an order made under section 11, the order made under section 11 prevails unless specified otherwise in the order made under this section.
(5) A COVID-19 order made under this section is secondary legislation (*see* Part 3 of the Legislation Act 2019 for publication requirements).

Legislation Act 2019 requirements for secondary legislation made under this section

Publication	PCO must publish it on the legislation website and notify it in the *Gazette*	LA19 s 69(1)(c)
Presentation	The Minister must present it to the House of Representatives	LA19 s 114
Disallowance	It may be disallowed by the House of Representatives	LA19 ss 115, 116

This note is not part of the Act.

Section 11AB: inserted, on 26 November 2021, by section 7 of the COVID-19 Response (Vaccinations) Legislation Act 2021 (2021 No 51).