BOARD OF INQUIRY INTO THE COVID-19 HOTEL QUARANTINE PROGRAM

WITNESS STATEMENT OF DR CLARE LOOKER

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Occupation: Senior Medical Advisor
Date: 5 September 2020

1. I make this statement to the Board of Inquiry in response to **NTP-123**, the Notice to produce a statement in writing (**Notice**). This statement has been prepared with the assistance of lawyers.

ROLES AND RESPONSIBILITIES

1. Please describe your relevant professional experience and qualifications.

2. I am a registered medical practitioner with the Australian Health Practitioner Regulation Agency. I work in Public Health Medicine and have completed my fellowship exam with the Australasian Faculty of Public Health Medicine.

3. I received a Bachelor of Medicine / Bachelor of Surgery / Bachelor of Medical Science from the University of Melbourne, 2005. I have a Master of Science (Epidemiology) from the London School of Hygiene and Tropical Medicine, and a Master of Public Health (International Health) from the University of Melbourne, 2009.

4. I am currently a Senior Medical Advisor employed by the Department of Health and Human Services (**Department**). This is a senior clinical role in the Department providing advice and leadership in supporting the Chief Health Officer (**CHO**) and staff in the Health Protection Branch and COVID-19 response. Typically, this role includes leadership of emergency management activities and coordination of prevention and response activities relating to public health incidents and outbreaks.

5. Prior to my current role, I was the Principal Public Health Medical Officer, at the Department from 2016-2019. In that role, I:

   (a) provided public health medical advice, information and direction to department staff, management, key stakeholders and members of the community;

   (b) was the public health medicine representative at multiple community information sessions, engagement sessions and 'open houses';

   (c) provided after hours medical officer cover of communicable disease notification, investigation and response service;

(d) provided public health medical support of environmental health incidents and issues; and

(e) coordinated and led public health medicine input to a number of Emergency Management plans and exercises.

6. During that time, I also acted for periods in the role of Senior Medical Advisor and Deputy Chief Health Officer (Environment).

7. Previously, I was a Public Health Registrar at the National Heart Foundation and VicHealth from 2014 to 2015.

8. Between 2011 and 2013, I worked as a Research Fellow (Epidemiology) at the London School of Hygiene and Tropical Medicine. My first role was at the Centre for Mathematical Modelling of Infectious Diseases working with a team examining tuberculosis transmission dynamics in South Africa and Zambia. Later, I worked with the Public and Environmental Health Research Unit analysing the relationship between community exposure to perflurooctanoic acid (PFOA) and a number of biomedical and clinical outcomes in a large cohort study.

9. In 2009-2010, I was a Project Manager in the Epidemiology Unit at the Victorian Infectious Disease and Reference Laboratory.

10. Prior to the above positions, I worked as a junior doctor predominantly at the Royal Melbourne Hospital and John James Hospital in Canberra.

11. I have made and contributed to a number of publications and presented at a number of conferences.

2. What is your role within the Department of Health and Human Services (the Department) and what are you ordinarily responsible for?

12. Prior to the COVID-19 response, I worked as a Senior Medical Advisor in the Communicable Diseases Section of the Health Protection Branch of the Department. I worked in this role part time, job sharing a single role with Dr Simon Crouch.

13. Presently, I am seconded on a fulltime basis to the COVID-19 Division as the Deputy Public Health Commander (**DPHC**), Case, Contact and Outbreak Management (**CCOM**). To

provide coverage of the role 24 hours a day and seven days a week. Dr Crouch and I both work full time.[1]

14. The DPHC (CCOM) is a member of the Department's COVID-19 Public Health Incident Management Team.

15. CCOM is responsible for the identification and management of individual cases and their contacts. The CCOM team also leads the management of outbreaks and complex cases associated with sensitive settings. Outbreaks are managed by an outbreak management team under the guidance of the DPHC (CCOM) and including members of other teams within the COVID-19 division such as the Intelligence team and other key stakeholders.

16. The DPHC (CCOM) is responsible for public health decision-making related to CCOM, and reports to the Public Health Commander and Chief Health Officer.

17. I provide high level authoritative public health medical and strategic advice. In addition, I prepare daily representation and briefing material on case, contact and outbreak management responses to the Minister for Health and others. I perform a role as a key liaison between government departments, industry and community stakeholders.

18. I am also responsible for overseeing operational matters related to the CCOM team. For those matters, I report to the Deputy Secretary of COVID-19 CCOM.

3. What role did you play in the Hotel Quarantine Program and what were your responsibilities in that role?

19. I do not play a regular or active role in the Hotel Quarantine Program and my interactions with the program have been incidental to my role as DPHC (CCOM).

20. In that capacity, as DPHC (CCOM), my interactions have been limited to those relating to hotel outbreak settings, namely at the Rydges Hotel Carlton (**Rydges**) and Stamford Plaza Hotel (**Stamford**); and providing discrete information or advice on request. For example, on 2 April 2020, I was asked about existing cleaning guidelines for COVID-19 by the State Emergency Management Centre and I responded by providing a link to the Commonwealth department's advice for cleaning specifications in hotels and copied in the Department' s infection prevention control consultant, indicating that she might have also been able to provide other resources that could guide the hotels.[2] Another example is on 29 May 2020, when I was asked to comment on whether the PPE Advice for hotel based security[3]

[1] We generally both work on Wednesdays. Dr Crouch remains in the DPHC (CCOM) role on Wednesdays and I generally resume this role on a Thursday (from when Dr Crouch is rostered off).

[2] Email from me to the Statement Emergency Centre, 2 April 2020, DHS.5000.0054.4766.

[3] PPE Advice for hotel Security, DHS.5000.0088.6479.

remained appropriate, I stated I was not aware of any evidence that it was not a valid approach, but stated that I thought the matter should be considered by the Department's Infection Prevention Control group and so referred the matter to them.[4]

INFECTION CONTROL MEASURES AT QUARANTINE HOTELS

4. Prior to any outbreak in connection with the Hotel Quarantine Program, what advice did you (or your team) provide regarding infection control measures at quarantine hotels (including in relation to cleaning)?

Please provide any relevant documents.

21. Other than on the occasions addressed in paragraph 20 above, it is generally not the function of the CCOM team to provide prevention advice regarding infection control measures. That responsibility for infection control measures falls under the responsibility of the DPHC – Pathology and IPC.

22. I am not aware of any other advice I provided, or my team provided to the hotel quarantine program prior to any outbreak in connection with the hotel quarantine program.

5. Prior to any outbreak in connection with the Hotel Quarantine Program, what plans were in place (if any) to respond to an outbreak at a quarantine hotel?

Please provide any relevant documents.

23. In early February 2020, the Public Health team commenced working within an incident management framework. Part of that framework involved the preparation and maintenance of an Incident Action Plan (**IAP**)[5], which is a document that is regularly updated to corral the work of the incident management team.

24. The IAP addressed very briefly outbreak management but did not prescribe a particular mode of operating to address outbreaks of COVID-19. Communicable disease outbreak management is a core activity of public health and the Department's Health Protection Branch. It is guided by a standard approach or framework. This approach is consistent with international and national best practice and includes case identification, the development of a case definition, key risk assessment steps, development of a working hypothesis and the key sets of control measures that should be considered relating to cases, close contacts and environmental exposures. This standard approach to outbreak management is reflected

[4] Email from me to the Commander, Operation Soteria, 29 May 2020, DHS.5000.0088.6471.

[5] For example, 2020 Novel CoV Incident Action Plan - 2 February 2020 (Version 1), DHS.5000.0056.3655.

throughout the Communicable Disease Network of Australia's Series of National Guidelines (**SONGs**) for a range of communicable diseases including COVID-19.

25. As the COVID-19 situation evolved, and after the declaration of the State of Emergency in mid-March 2020, a more detailed framework was developed to manage COVID-19 outbreaks and documented as the Outbreak Management Plan (**OMP**).[6]

26. The OMP framework was used by the CCOM team from the 14 May 2020. During the period from 14 May 2020 to the final approval of version 1 of the OMP by the Chief Health Officer (**CHO**) on 5 June 2020[7], revisions were made to the draft OMP based on experiences operating within its framework. However, the general process documented in the approved OMP remained substantially unchanged.

27. The OMP describes the key elements of the Department's response to an outbreak. It outlines how decisions related to outbreak management should be made and key escalation points. It includes the roles and responsibilities of those involved in the public health and emergency management aspects of the outbreak management.

28. The COVID-19 Case and Contact Management Guidelines for Health Services and General Practitioners (**CCOM Guidelines**)[8], describes the general approach to individual case management and contact tracing. This publicly available document is the Department's key resource for clinicians and health services. It is regularly updated to ensure that it aligns with the national Communicable Diseases Network Australia guidelines and international best practice. This resource is used alongside the OMP, when a case is being managed as part of a defined outbreak.

RESPONSE TO OUTBREAKS

6. When the Department became aware that people working at the Rydges Hotel in Carlton had contracted COVID-19, what steps were initially taken to contain the outbreak (that is, what steps were taken prior to 30 May)?

29. At the time that the first case was identified at Rydges, on Tuesday, 26 May 2020, I was not rostered on to work.

30. Dr Crouch and then Dr McGuinness, as Outbreak Lead, managed the response in the first two days. However, I am generally aware from my work arrangements with Dr Crouch, and subsequent involvement, of significant events that took place on 26 May 2020 to respond to and to control the Rydges outbreak.

[6] Outbreak Management Plan version 1, 5 June 2020, DHS.0001.0003.0046.

[7] Ibid.

[8] CCOM Guidelines, 5 April 2020, DHS.0001.0095.0001. At the time of the Rydges Outbreak, the CCOM Guidelines was at version 21 dated 24 May 2020, DHS.5000.0099.7008.

Tuesday, 26 May 2020

31. I am aware that a hotel staff member became unwell on 25 May 2020 and tested positive for COVID-19 on 26 May 2020. The Department was notified of the case on 26 May 2020. I was copied into Dr Crouch's email to the Public Health Commander (**PHC**) and CHO briefing them on the case and proposed actions.[9] Dr Crouch' s email outlined the following recommendations and plan:

    (a) the case was interviewed and was advised to immediately isolate. All identified close contacts were to be told to quarantine for 14 days from their last contact with the case (close contacts were identified as persons who has had greater than 15 minutes face-to-face contact (cumulative) or who has shared a closed space for more than two hours with a confirmed case during their infectious period without recommended personal protective equipment (PPE));[10]

    (b) further investigations by the CCOM team into the specific workplace activities of the first case were to occur on the evening of 26 May and continue on 27 May 2020;

    (c) all staff who worked shifts coinciding with the first positive case, during RE acquisition period, were to be tested (and this testing started on 27 May 2020);

    (d) areas where the case worked were to be cleaned;

    (e) a visit from the Outbreak Squad's Infection Prevention Control Nurses (**IPCON**) was arranged for 27 May 2020;

    (f) confirmation was sought that staff had been informed of the case. (A letter was provided for Operation Soteria to send to staff late on 27 May 2020); and

    (g) an OMT meeting for 28 May 2020 was arranged.

32. On 26 May 2020, I was also copied into an email sent by the Case Contact and Outbreak Lead to Operation Soteria EOC requesting information to enable a risk assessment to be undertaken and for advice to be developed for staff.[11]

Wednesday, 27 May 2020

33. I worked alongside Dr Crouch on 27 May 2020, who was in the role of DPHC (CCOM). (Dr Crouch and I have an overlapping day each week.)

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[9] Email from DPHC (Dr Crouch) to CHO, 26 May 2020, DHS.5000.0036.5306.

[10] Outbreak Management Plan version 1, 5 June 2020, DHS.0001.0003.0046 (page 7).

[11] Email from Case Contact and Outbreak Lead to the Operation Soteria EOC dated 26 May 2020 seeking information (including case 1's duties, roster information for others and information on the cleaning regime at the hotel) and requesting that a full clean of all common areas and the cases' direct work areas, DHS.5000.0015.3873.

34. Dr Crouch and Dr McGuinness remained the key leads in CCOM but I received a handover and was aware that the following events took place that day:

(a) Case 2 was notified to the Department. A case interview and contact tracing were immediately undertaken;[12]

(b) in response to CCOM's request on 26 May 2020, we received information from Rydges about the duties of the first positive case, the details of RE shifts, the staff with overlapping shifts to RE and details of RE movements in the hotel. We were also informed that all hotel staff work only at that hotel (in response to our question as to whether they might also work at other premises);[13]

(c) all staff who had been on site for 30 minutes or more from 11 May 2020 (14 days prior to symptom onset of Cases 1 and 2) were notified and asked to undergo testing (i.e. such staff did not meet the definition of close contact but we considered it appropriate to include them acquisition testing); and

(d) a request was made to the Department of Jobs, Precincts and Regions to arrange a commercial 'deep clean' of all common areas in the hotel visited by the two cases.[14]

35. I am also aware that the IPCON nurses visited Rydges on 27 May 2020 and prepared a report into their findings. Their report did not come to me on 27 May 2020 but I was aware of their findings. For example, I was aware that on their visit, the squad noted that a 'deep clean' with an appropriate disinfectant agent had not been carried out; there were inconsistencies in staff use of PPE and issues with inappropriate use of PPE. It was also noted that the duties of the first case included the cleaning of common areas and the lift that was used to transport COVID-19 cases.

Thursday, 28 May 2020

36. On 28 May 2020, I worked as DPHC (CCOM) and attended the outbreak management team meeting chaired by Dr McGuinness. Events at that meeting included:[15]

(a) the Outbreak Squad were tasked by the OMT to prepare materials (video and written) on proper hygiene and use of PPE to be distributed to staffing agency leadership via Operation Soteria command; and

[12] Email from Dr McGuinness to me, 27 May 2020, DHS.5000.0105.8087.

[13] I was copied to an email on 27 May 2020 at 2.59pm which forwarded an email sent by the Rydges GM responding to an earlier request for information, DHS.5000.0016.5468.

[14] I was copied to Dr Crouch's Outbreak Summaries email, 27 May 2020, DHS.5000.0036.4829 which includes an overview of actions undertaken.

[15] Minutes of OMT Meeting, 28 May 2020, DHS.5000.0105.7824.

(b) follow up discussions between Operation Soteria EOC and the Case and Contacts Lead to ensure that communications from CCOM were being sent to appropriate stakeholders, and also for assistance to procure contact details and complete rosters.

37. On the evening of 28 May 2020, Dr McGuinness reported to me by email that 78 staff had tested negative with some tests pending, and that a full commercial clean of relevant areas had been performed that evening.[16]

Friday, 29 May 2020

38. On 29 May 2020, the following events occurred.

39. The fourth meeting of the OMT was held. Agreed actions included:[17]

(a) hand hygiene and PPE education were to be provided to security firm management by IPCON;

(b) the Operation Soteria EOC representative was to procure Rydges staff contact details and to investigate standard cleaning arrangements at the hotel and report back to team;

(c) the Case and Contacts Lead was to organise and conduct a case and contact interview with a third staff case, and report back details to the team as soon as possible.

40. Alternative accommodation was arranged for Case 3.

41. In the afternoon, I received a report from Dr McGuinness that a 4th COVID-19 positive case has been linked to Rydges, being an asymptomatic security guard.

42. Dr McGuinness and I met with the Public Health Commander to discuss the hypothesis that there was potential environmental transmission at the Rydges. The key evidence considered included: the role the first case played in cleaning duties (including in the lift that was known to transport COVID-19 cases); the use of non-standard PPE and lack of adequate training in hand hygiene and PPE use; the lack of routine cleaning and disinfection with antiviral cleaning agents in areas where hotel staff worked; and the lack of reported contact of the staff cases with any other known confirmed cases. With increased case numbers and increasing evidence that the source of infection could be contaminated surfaces or infectious waste, Dr McGuinness proposed four alternative approaches to the management of other staff at the hotel:

"Stage 1 – active monitoring only

[16] Email from Dr McGuinness – draft Outbreak Summaries, 28 May 2020, DHS.5000.0106.2903.

[17] Minutes of OMT Meeting, 29 May 2020, DHS.5000.0072.7622.

Stage 2 – test everyone but do not enforce restrictions

Stage 3 – testing PLUS cohorting of staff (i.e. say they can't work elsewhere for now) +/- designate certain people (e.g. overlapping shifts with a case during their infectious period) as close contacts

Stage 4 – designate everyone as close contacts and get in an entirely new workforce."[18]

43. We also learnt that the three positive COVID-19 staff cases had all worked on 23 May 2020, but on different shifts.[19]

44. It was decided that we would adopt a conservative but proportionate approach to the management of the outbreak, pursuant to "stage 3" as proposed by Dr McGuinness. This reflected the concerns we had about the risk of environmental transmission from exposure to the site. This decision was made to balance the need to manage the public health risk with the impact of the measures, which in this case, would have resulted in the hotel no longer being able to operate and the need to rapidly relocate a large number of hotel guests with confirmed COVID-19. The sudden movement of a large number of positive cases through a hotel also poses a transmission risk. We formed the view that the 'stage 3' approach was appropriately cautious and proportionate to the evidence available at the time.

45. As part of the approach, described as stage 3, testing was recommended for all staff who had worked at Rydges since 11 May 2020 (14 days before symptom onset in the first case) and all staff were cohorted (required not to work elsewhere), unless they had not been on site in the preceding 14 days (i.e. since 15 May 2020) and had a negative swab. A subgroup of staff who had worked an overlapping shift with one of the positive cases during the case's infectious period were also designated as close contacts. These staff were required to quarantine for a full 14 days from their last date of exposure to a case.[20]

46. Given the concerns about environmental transmission and inadequacy of current cleaning practices, CCOM advised Operation Soteria of the need for Rydges to undertake at least once daily cleaning and disinfection of all common areas and high touch surfaces. DHHS guidelines for cleaning and disinfection were provided.

47. Later on the evening of the 29th, we learnt that there were two further cases that had tested positive to COVID-19 (bringing the total to six cases). I advised Operation Soteria of the two new cases and directed that the following immediate actions take place:

[18] Email from Dr McGuinness, 29 May 2020, DHS.5000.0105.5936.

[19] Email from Case and Contact Management Lead, 29 May 2020, DHS.5000.0105.5928.
[20] I sent an email to the Secretary, CHO and others that evening recording the decision: email sent by me, 29 May 2020, DHS.5000.0114.7238.

(a) no staff who worked at the hotel since 11 May 2020 should work elsewhere unless they had not been on site for 14 days and tested negative;

(b) daily commercial cleaning should be implemented;

(c) there should be no further admissions to the hotel;

(d) movement of returned travellers outside their rooms should be minimised; and

(e) there was to be no movement of staff between hotel sites (including health staff, AOs, team leaders, support staff, DJPR team leaders, security and hotel staff).[21]

Due to the new information, identified in paragraph 43, we commenced working on an additional set of controls on the basis that a larger group of staff may have been exposed to an environmental risk.

48. These actions and those which followed are set out in the Outbreak Management Report for the Rydges Outbreak, including where they are recorded in the minutes for the OMT meetings.[22]

7. At that time, did you consider that those steps were adequate and appropriate? With hindsight, do you consider that those steps were adequate and appropriate?

49. At the time, I did consider the steps undertaken were adequate and appropriate. A thorough risk assessment and management process was undertaken that aligned closely with the OMP.

50. With the benefit of hindsight, I still believe that the steps taken were proportionate to the risk assessment and available evidence at the time.

[21] Email to Commander, Operation Soteria and others, 29 May 2020, DHS.5000.0016.5676.

[22] COVID-19 Outbreak Management Report Rydges on Swanston, 13 July 2020; DHS.0001.0036.0145, from page 18.

8. When the Department became aware that people working at the Stamford Plaza Hotel had contracted COVID-19, what steps were initially taken to contain the outbreak (that is, what steps were taken within the first three days of the Department becoming aware of transmission)? Were there any material differences between that initial response and the initial response to the outbreak at the Rydges Hotel?

51. The initial responses to the Rydges and Stamford Hotel outbreaks were undertaken under the OMP and were similar.

52. The initial actions undertaken involved:

    (a) a case interview and gathering of information such as rosters to enable contact tracing;

    (b) the identification and contacting of close contacts;

    (c) the identification of the relevant infectious and acquisition periods to determine who should be considered close contacts or possible sources of the infection;

    (d) the formation of a multidisciplinary OMT;

    (e) the development of a case definition, close contact definition and hypothesis;

    (f) an onsite visit by the Outbreak Squad.

53. The experience of the Rydges outbreak ensured a very conservative approach was immediately taken to the determination of close contacts amongst other staff who worked at the hotel. In my view, otherwise the responses were not different in any material way.

54. Below I discuss the steps taken to control the Outbreak in the first three days of the Department becoming aware of the index case at the Stamford (the **Stamford Outbreak**).[23]

Tuesday, 16 June 2020

55. On 16 June 2020, the Department was notified that a security guard working at the Stamford Plaza had tested positive for COVID-19.

56. I was not working that day but at 10.58pm, I received an email from Dr Crouch sent to the Public Health Commander and copied to me (and others) which provided a report about a complex case relating to Stamford and the events that took place at an OMT meeting that day. I read that email that night.

[23] Outbreak Management Report - Stamford Plaza Outbreak 19 July 2020, DHS.0001.0036.0203, page 10.

57. Dr Crouch's email includes the following information:

(a) the case was notified to the Department on the evening of 16 June 2020, having become unwell on 15 June 2020 and tested that same day (the results became available on 16 June 2020);

(b) the case was a security guard at the Stamford Plaza and had worked during their infectious period between [redacted] and [redacted] June 2020;

(c) an OMT meeting was convened that evening (16 June 2020) and received a report from the Outbreak Squad following their visit that day to Stamford and the following actions were agreed (as stated in Dr Crouch's email):

> *"1. Full clean of the hotel as soon as possible tomorrow – it was agreed that only staff who have worked in the past three days will be allowed on site to supervise the clean in order to minimise any ongoing risk. Following the clean all staff who have worked since 7 June [this date was revised to 1 June that evening] will be stood down in the first instance and only new staff will be allowed to staff the hotel. This period will be reviewed tomorrow.* [Operation Soteria] *to obtain all staff lists and rosters for this period. All identified close contacts of the case will be quarantined.*
>
> *2. Arrange testing for all staff who have worked since 1 June – [the Department's testing team] to support this tomorrow.*
>
> *3. Provide a letter for all staff who have worked at the hotel since 1 June – Simon Crouch to provide letter to* [Operation Soteria] *for further dissemination. The letter will need to go to all DJPR staff, all DHHS staff, all hotel staff, all nursing/medical staff and all security staff.*
>
> *4. The outbreak squad will revisit the hotel tomorrow* – [Outbreak squad lead] *to arrange.*
>
> *5.* [Operation Soteira] *to inform DJPR tonight. …*
>
> *7. Media lines to be prepared.*
>
> *8. Communications for residents of the hotel to be developed in the morning (to go out before any media)*
>
> *9. Further investigation of the case, [redacted] movements, close contacts and exposures tomorrow.*

Additional actions – we will ensure that the case's [family] *are quarantined, tested and provide with appropriate support. The case has been offered a room at a hotel following discharge from hospital tomorrow."*[24]

58. On 16 June 2020 at 11.42pm, Dr Crouch emailed a letter to the Commander, Operation Soteria,[25] to be provided to all staff who had worked at the Stamford since 1 June 2020. Although I did not receive that email, I am familiar with the letter that was sent, and am aware that Operation Soteria actioned Dr Crouch's request and also informed DJPR, as stated in Dr Crouch's email.

Wednesday, 17 June 2020

59. On 17 June 2020, Dr McGuinness copied me into an email which consolidated information that had been provided to CCOM at that time as part of the outbreak management response. Her email outlines contact details for key contacts and other relevant information for CCOM's Case and Contacts staff in relation to contractors and staff groups operating at the Stamford. The email also attached a letter approved by Dr Crouch to be provided to relevant individuals recommending that all staff who had been on site for 30 minutes or longer on or after the 1 June 2020 seek testing.

60. Dr McGuinness reported that she had already dispatched the letter to some organisations and provided a copy to me.[26] Dr McGuinness also provided some of the rosters that had been obtained at that time.

61. On 17 June 2020, I was aware that the main stakeholders responsible for the different staff groups at the hotel had been identified and they included the security contractor, contractor nurse agencies, Alfred Health, Hotel Management and DHHS.[27]

62. I am aware that the IPCON visited Stamford on 17 June 2020 and reported back to Dr McGuinness as Outbreaks Squad Lead, reporting to her their observations and recommendations from attending the hotel that that day.[28] Their recommendations, which were accepted by the OMT, included that the Outbreak Squad conduct PPE and hygiene training and education for security staff and hotel staff and for supporting materials to be developed in languages other than English. An action item from the second OMT meeting was for that material to be prepared.

[24] Email from Dr Crouch to PHC and me, 16 June 2020, DHS.5000.0036.3558.

[25] Email chain ending in email from the Commander, Operation Soteria, 17 June 2020, DHS.5000.0001.6825. Letter to Staff, 16 June 2020, DHS.5000.0008.3634.

[26] Email from Dr McGuinness copied to me, 17 June 2020, DHS.5000.0106.2824 attaching various attachments including letter providing advice on testing, DHS.5000.0106.2827.

[27] PHESS Notes – Stamford, DHS.0001.0026.0013.

[28] Email from Outbreak Squad Coordinator, 17 June 2020, DHS.0001.0004.1679.

63. I am also aware that a clean was undertaken at Stamford in the afternoon of 17 June 2020 starting at 1pm.[29]

64. On 17 June 2020, the OMT held its second meeting. This meeting was attended by Dr McGuinness and Dr Crouch but I was briefed by them both and have seen the minutes.[30] The minutes record the complicated circumstances relating to the index case's family situation. Relief services were arranged to ensure adequate support for the case and RE family to safely isolate.

65. The OMT minutes also record that at the time of the meeting, the security roster had not yet been received and that only first names of these staff had been provided to the CCOM team at that point, preventing contact being made with those people.

Thursday, 18 June 2020

66. I attended the third OMT meeting on 18 June 2020 and the minutes of the OMT record a number of actions from the second meeting had been completed. The minutes also record that the IPCON had observed, on a visit on 17 June 2020, that cleaning was not to the required standard and that the IPCON had remained on site to perform cleaning tasks themselves to ensure that communal areas were appropriately clean for hotel staff.[31]

67. As at 18 June 2020, CCOM had identified approximately 48 close contacts, comprising nursing staff and AOs who had worked onsite. At the time of the meeting, the details of hotel staff were outstanding.[32]

68. In the afternoon on 18 June 2020, the security contractor at Stamford provided its staffing lists. The Case and Contacts team identified from the lists provided that one of the security guards was linked to another outbreak referred to as the 'Hallam' Outbreak and had worked while infectious. The person had previously told the Case and Contacts team that they did not have paid employment and had had very minimal contact outside of the home. That information was subsequently found to be inaccurate.

69. As a consequence of that new information coming to hand, the decision was made to require all staff who worked from 8 June 2020 to go into immediate quarantine.[33]

70. The minutes also record that a letter had been prepared for Stamford guests on 17 June 2020 for approval, and subsequently approved on 18 June 2020. This information was given to the hotel for distribution to the guests.[34]

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[29] Minutes of OMT Meeting, 17 June 2020, DHS.5000.0093.7360.

[30] Minutes of OMT Meeting, 17 June 2020, DHS.5000.0093.7360.

[31] Minutes of OMT Meeting, 18 June 2020, DHS.5000.0105.5646.

[32] PHESS Notes – Stamford Outbreak, DHS.0001.0026.0011.

[33] Email from Dr van Diemen to Prof. Sutton and others, 18 June 2020, DHS.5000.0036.6031.

9.In the longer-term, what steps were taken to contain the:

(a) Rydges Hotel outbreak; and

(b) Stamford Plaza Hotel outbreak.

Rydges

71. On 30 May 2020, there was an OMT meeting to address the additional 2 cases identified on the evening of 29 May 2020 and an additional case, bring the total to 7 cases. In the OMT meeting on 30 May 2020, we discussed the hypothesis of environmental transmission being supported by preliminary genomic results received that day.

72. The actions following those meetings are summarised in an email from Dr McGuinness and include:

    (a) frequent cleaning on at least a daily basis and preferably twice daily;

    (b) PPE training for security company management, embedded IPC at the hotel;

    (c) restrictions on guests' movements until a second environmental clean was undertaken, blocking further admissions to the hotel and quarantining all staff who attended site for more than 30 minutes between 18 May 2020 and 28 May 2020 for 14 days from the date of their last attendance at the site.[35]

73. The number of staff affected by this extended quarantine period necessitated Rydges closing. Returned travellers who were quarantining at the hotel were removed and transferred to another hotel.

74. After 30 May 2020, the steps undertaken to control the Rydges Outbreak were mostly an extension of steps already in train from the initial outbreak response and those mentioned above and included:

    (a) continued case identification and contact tracing;

    (b) testing arrangements for close contacts on day 11;

    (c) measures intended to control the environmental risk at the Rydges site. While a full clean had occurred on 28 May 2020, given the hypothesis of potential environmental contamination, the OMT recommended regular cleaning and disinfection at the site;

[34] Minutes of OMT Meeting, 18 June 2020, DHS.5000.0105.5646.

[35] These actions are recorded in Dr McGuinness notes of the OMT Meeting on 30 May 2020, and her handover note that same day, both contained in an email chain I was copied to on 30 May 2020, DHS.5000.0121.2374.

(d) prevention measures including the IPCON providing PPE, IPC and hand hygiene training material to staff including security; and

(e) investigations into the potential transmission event, including taking steps to obtain information from Rydges including CCTV footage.

Stamford

75. The particular steps taken to control the Stamford Outbreak are recorded in the OMT minutes and the Outbreak Management Report for the Stamford. Notable events during the period 19 June 2020 to 1 July 2020 include:

(a) on 19 June 2020: fresh air breaks were suspended at the hotel, other than special arrangements for mental health reasons; and following a third visit to the site, the IPCON note ongoing issues with cleaning, PPE use and IPC practices;[36]

(b) on 22 June 2020: following the identification of a positive case in a security guard who had worked one shift at Park Royal Hotel during their infectious period (prior to being identified as a close contact of the Stamford outbreak and prior to showing any symptoms), further contact tracing and deep cleaning was undertaken at the Park Royal.[37] 150 close contacts were identified from the Park Royal exposure and quarantined.[38]

10. Are you:

(a) aware of; and

(b) familiar with,

the relevant contact tracing (including epidemiological and genomic) evidence regarding the Rydges and Stamford Plaza outbreaks?

If so, please detail what you understand that evidence demonstrates in respect of the chain of transmission of SAR-CoV-19 virus from returned travellers at each hotel and how it made its way into the community.

76. I am aware of and familiar with both the epidemiological and genomic evidence regarding the Rydges and Stamford Plaza outbreaks.

77. Epidemiological investigation and evidence are fundamental components of all outbreak management and were core to our management of both the Rydges and Stamford outbreaks.

[36] Minutes of OMT Meeting, 19 June 2020, DHS.5000.0093.5613.

[37] Minutes of OMT Meeting, 22 June 2020, DHS.5000.0094.2945.

[38] Outbreak Summaries, 24 June 2020, DHS.0001.0012.1054.

Epidemiological evidence is used to establish the existence of an outbreak, establish the case definition in order to count cases, relate the outbreak to time, place and person and to formulate an outbreak hypothesis. The OMP defines an COVID-19 outbreak as either a single case in a residential aged case setting or two or more epidemiologically linked cases outside a household with symptom onset within 14 days. To be considered linked, cases should be linked in both time and place. This evidence is gathered from the time a case is notified to the department. It is obtained from a range of sources including interviewing cases, through records relating to a particular setting (attendance logs, video footage etc), through direct observation of the setting, interviews of third parties and medical results. The data collection exercise is commonly referred to as 'contact tracing' but includes a broad suite of information sources. The collection and analysis of the data to inform interventions is generally understood as epidemiology.

78. In both the Rydges and Stamford Plaza outbreaks, staff were linked to a common work site and period of concern.

79. Genomic analysis is a separate investigation discipline to epidemiology but the outcome of genomic investigations can enhance epidemiological evidence by identifying links between cases or clusters of cases that were previously not known.

80. The genomic analysis linked the first cases in both outbreaks to returned travellers. Subsequently, it also linked the parent clusters (that is, Rydges and Stamford) to other clusters. However, the genomics does not allow for a conclusion to be made about the chain or direction of transmission. This is because genomics only proves the subjects have the same version of the virus. It does not establish how it was obtained or the order in which it was obtained.

81. I now know that both the Rydges cluster and the Stamford cluster have a genomic link with subsequent cases in the community and returned travellers. However, that link was not known at the time of the initial outbreak response.

82. In both cases, we investigated to see if a single, specific transmission event could be identified but were unable to do so. That is not unusual.

83. For the Rydges Outbreak, the tightly clustered symptom onset date for the first six cases, and the common work shift times supports a point source transmission event rather than a staggered person to person transmission, but the latter was not able to be ruled out. Usually, with person to person transmission there will be a sequence of cases over a number of days. With a point source exposure, all cases are exposed to the same single exposure source (usually at a similar point in time) and the cases then generally subsequently develop symptoms at a similar point in time.

84. The seventh case identified at the Stamford was linked to another outbreak. When interviewed, that person had informed the contact tracers that they had not worked and had

been confined to the home. That information was subsequently found to be incorrect and they had worked as a security guard at Stamford during their infectious period. The genomics subsequently linked this case with the other outbreak. Based on symptom onset and work shift overlaps, that person is probably a source case for other staff at the Stamford. However, as stated in the Outbreak Report for Stamford, the genomic analysis lends evidence to the hypothesis that there were two possible transmission events between returned travellers in hotel isolation and security staff at the hotel.

85. For both outbreaks, there were various household and social contacts that became infected. The genomic evidence that is presently available indicates a broader spread of the virus, most likely through unidentified infected cases from household or social contacts of cases.

86. In both the Rydges and Stamford Plaza outbreaks we know that there was further transmission from hotel staff to their household and social contacts. Many of these household cases had previously been identified by the staff member as close contacts, however it is likely that there were additional unrecognised transmission events from the staff cases to unidentified contacts or from these household and social contacts to other individuals. We are unable to definitively identify which cases contributed to the further spread that occurred into the community. A key limitation that arises in outbreak management is that the information relied on to inform actions depends on both the quality of information gathered from cases and the information about contacts that is available from other sources such as staff rosters. It is challenging for many individuals to recall all their activities and interactions during their infectious period. Furthermore, other factors can contribute to individuals being reluctant to fully disclose contacts that they are aware of, including the financial impact of not being able to work, or shame or anxiety about other household contacts becoming aware that an individual is a positive case. In a number of the households associated with these outbreaks, household members were not well known to each other and/or undertook shift work at different times of the day to each other. If accurate information is not able to be obtained then it can limit the ability to identify and act to control an outbreak. Control of an outbreak also requires people to behave in line with the instructions provided by the Department, including appropriate isolation or quarantine, and close contacts seeking testing if symptomatic. Many cases were identified in social and household contacts through day 11 testing. In some instances, close contacts who had been required to quarantine had not, and/or had developed symptoms but had not informed us or sought testing when earlier asked.

11. When, and to what extent, did the information provided in response to the previous answer inform the Department's attempts to contain the:

(a) Rydges Hotel outbreak; and

(b) Stamford Plaza Hotel outbreak?

87. Each outbreak response is driven by epidemiological evidence. The core control measures implemented for each outbreak were based on the information relating to it. The actions and decisions of the OMT were based on the then available information. Generally, a conservative position was adopted in each outbreak.

88. For each outbreak, both person to person transmission and environmental transmission were considered and appropriate control measures for each transmission route were implemented. The OMT kept an open mind that the source of infection at Rydges and Stamford could have been from a staff member. Given the acknowledged sensitivities of the setting, the high density of staff and the high risk associated with large volumes of cases being in the hotels, a conservative approach was adopted throughout.

89. A number of efforts were made to address the particular needs and vulnerabilities of the staff cohort. Education and information was provided using interpreters and translated materials. Relief accommodation was offered to any case or contact who was unable to safely or easily isolate at home.

RESERVATIONS AND CONCERNS?

12. Did you have any reservations about any aspect of the Hotel Quarantine Program? If so, what were those reservations and to whom did you convey them? What was their response?

90. In the early months of the pandemic, a significant number of new COVID-19 cases in Victoria were in returned travellers. There were multiple examples of these returned travellers unknowingly infecting other contacts and seeding outbreaks. At the commencement of the hotel quarantine program, I had some private caution about the unintended effects of detaining people and whether the removal of people's liberty was proportionate to the risk the returned travellers posed. I did not share these concerns broadly. In hindsight, we better understand the high risk of asymptomatic and mildly symptomatic infection. We have seen international examples of unsuccessful voluntary quarantine programs for returned travellers and the subsequent impact that this has on the course of an epidemic.

91. I was also aware that there had been logistical challenges relating to guest movements and testing at the hotels but those logistical issues were worked through and did not cause me to have significant reservations about the program more broadly.

13. Did you have any concerns about the use of PPE by:

(a) private security contractors;

(b) Authorised Officers

(c) nursing staff and medical staff;

working in the Hotel Quarantine Program?

If so, what were those concerns; when did you form them; to whom did you relay them; and what response, if any, was there to your expressing those views?

92. I did not have visibility of the arrangement for PPE use at the hotels prior to the outbreaks and had no reason for specific concerns.

93. Following the visits of the IPCON to Rydges and Stamford Plaza, I was made aware of concerns regarding the IPC practices and use of PPE by staff and security guards at the hotels. These issues were considered by the OMTs in both outbreaks as part of the outbreak response. The OMT's actions included arranging education and training for security and hotel staff. These concerns were raised in the OMT forum which included a number of stakeholders involved in the running of the hotel quarantine program. The concerns were also highlighting in our briefings to the PHC and CHO and in our outbreak reports.

14. What, if anything, do you consider that:

(a) the Department;

(b) other government departments or private organisations;

(c) those working with the Hotel Quarantine Program;

(d) you,

should have done differently, in relation to the Hotel Quarantine Program?

94. Both Rydges and Stamford Outbreaks were managed in accordance with the OMP and I do not consider I would have done anything differently. The decisions made by me (including in consultation with my colleagues) were made on the evidence and information we had available to us at the time.

95. With the benefit of hindsight, it is apparent that the use of private security guards may have contributed to the outbreaks. In both outbreaks, the IPC outbreak nurses observed PPE and hand hygiene practices below the appropriate standard. In addition, the contact tracing efforts were impeded by a workforce that often worked in multiple jobs and many cases lived in large or dense housing. Social and health vulnerabilities in the security guard cohort meant that many of our usual outbreak control measures were more difficult to implement and have success with. For example, many cases that were guards lived in crowded, dense accommodation and were reluctant to accept our offers of alternative accommodation. This reluctance was not immediately apparent to us and was only realised when we learnt that cases were in fact sharing living spaces. The workforce was also largely casual and so many had and were required to have more than one job to sustain themselves and/or their families. They were also a young, fit and socially active cohort and tended not to seek testing even if symptomatic until it was required on day 11 of their quarantine period. By that time, there were some cases that had by then transmitted within their household. In addition, there were language issues and at times a distrust or caution about government services generally. Broadly, this was a group with complex needs and from whom it was challenging to obtain accurate information.

96. It is also possible to see, again with the benefit of hindsight, that more robust practices needed to be deployed on the ground at hotels to ensure compliance with appropriate PPE, IPC and cleaning practices.

97. The use of multiple contractors for functions also created a complicated environment for contract tracers. Usually, there is a single source for information relating to a site, typically at a workplace, it is the employer. However, in hotel quarantine there were a number of stakeholders including the hotels, security companies, contracted nurses and doctors, guests and multiple government departments. The increased numbers of stakeholders caused additional work for contract tracers and some delays were experienced obtaining information, such as rosters during the course of the response.

98. That being said, there also must be a recognition that the hotel program was set up at pace. It is also important to bear in mind that the understanding of COVID-19 has moved forward since March. What is now understood about the virus and how best to manage it has developed since March, and continues to evolve.

FURTHER INFORMATION

15. If you wish to include any additional information in your witness statement, please set it out below.

99. No.

Signed at Melbourne

in the State of Victoria

on 5 September 2020

Dr Clare Looker