COVID-19

Outbreak Management Plan

Version 1.0

Approved by Chief Health Officer

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VICTORIA State Government | Health and Human Services

Contents

Executive Summary

Purpose

The purpose of this document is to outline the key components of the Department of Health and Human Service's management of coronavirus disease (COVID-19) outbreaks in Victoria, including triggers for escalation, and current decision-making policies. It includes standardised lists of actions to be taken, descriptions of how key decisions will be made and by whom and prompts additional actions. It defines public health and emergency management roles and responsibilities and articulates concise and clear actions to ensure rapid and effective COVID-19 outbreak management in Victoria.

Context

COVID-19 is an infectious disease caused by a new coronavirus, SARS-CoV-2. COVID-19 was first identified in December 2019 and is currently causing a global pandemic. The first case of COVID-19 in Victoria was detected in January 2020. While travel restrictions and rapid public health responses have largely contained the spread of the virus in Victoria, outbreaks of COVID-19 have occurred and are likely to continue to occur as physical distancing restrictions are gradually lifted.

Outbreak Management

Rapid and effective outbreak management is critical to ensuring suppression of the COVID-19 pandemic in Victoria. Even with physical distancing measures, COVID-19 outbreaks will occur in facilities, workplaces and other settings that need to continue on-site operations with large numbers of individuals in close contact.

Outbreaks may occur in any setting but are of particular concern when they occur in sensitive settings, such as healthcare settings or residential aged care facilities. These are considered sensitive because of one or more factors that contribute to significant scale and severity of illness, including the vulnerability of those working or residing there; the risk of amplification of transmission due to close, frequent and multiple contacts; and environmental factors that can contribute to transmission. Other settings of note relate to critical infrastructure or essential services, with potential for broader impacts on the Victorian community. This plan sets out how COVID-19 outbreak management will occur in Victoria, including how all outbreaks will be managed rapidly and effectively.

Key Definitions

Outbreak of COVID-19

In Victoria, an outbreak of COVID-19 is defined as:

- A single confirmed case of COVID-19 in a resident or staff member of a residential care facility, OR
- Two or more epidemiologically linked cases outside of a household with symptom onset within 14 days.

Linked cases

To be considered linked (and therefore constitute an outbreak), cases should be linked in both time and place. Links may be inter-jurisdictional or international.

- Cases will be considered linked in **time** if symptom onset dates are within 14 days
    - Cases with symptom onsets which are within 28 days of each other should warrant further investigation but will not be considered an outbreak.
- Cases will be considered linked in **place** if they have a common geographical link. For example:
    - They work or reside in the same building or ward/wing of a facility
    - They live in the same household or neighbouring houses or in the same extended family or are linked by a common activity or location (e.g. school, health centre) in a rural Aboriginal community
    - They are patients or residents who have been cared for by the same staff member
    - They are cases in custodial or military settings attended by the same warden or supervisor
    - They reside in the same boarding school
    - They are aircraft passengers who were seated in the same row, or within the two rows in front of or behind another case on a flight of >2 hours duration
    - They attended the same event

Transmission within one household does not ordinarily constitute an outbreak.

For secondary and further transmission generations, cases must be identified as a close contact of, or have an epidemiological link to, a confirmed case linked to the outbreak in order to be included in the outbreak.

Other immediate control response cases

A single confirmed case of COVID-19 in another sensitive setting, or at a critical infrastructure and essential service, will require an immediate control response and active involvement of the Department of Health and Human Services (the department) and the State Control Team. The processes and procedures for an outbreak as contained in this plan may be applied to that case, as determined by the DPHC CCOM.

Acronyms and abbreviations

CCOM	case, contact and outbreak management
COVID-19	coronavirus disease 2019
IPC	infection prevention and control
KPI	key performance indicator
MDUPHL	Microbiological Diagnostic Unit Public Health Laboratory
PHC	public health commander
RACF	residential and aged care facilities
SARS-CoV-2	severe acute respiratory syndrome coronavirus 2
SCV	Safer Care Victoria
VAHI	the Victorian Agency for Health Information
VIDRL	Victorian Infectious Diseases Reference Laboratory

Glossary

Confirmed case	For COVID-19, a confirmed case is a person who tests positive to a validated SARS-CoV-2 nucleic acid test or has the virus identified by electron microscopy or viral culture
Contact	A person who has been in contact with a confirmed case during their infectious period. Contacts are typically defined as either close contacts or casual contacts
Close contact	A person 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)
Contact tracing	The process of identifying people who are close contacts of a case, and ensuring they are quarantined for the maximum incubation period (14 days) after last close contact with the case.
COVID-19	Coronavirus disease 2019 (the name of the disease). COVID-19 was initially referred to as “novel coronavirus” (2019-nCoV) and is sometimes referred to as just “coronavirus”
Critical Infrastructure and essential services	Defined as per the Infrastructure and Essential Services list held by Emergency Management Victoria (EMV)
Exposure site	A location or site to which an individual case or outbreak has been linked through attendance while infectious or during their acquisition period
Healthcare worker	Healthcare workers are people in close contact with patients or the patient space. For example, doctors and nurses and cleaners who enter the patient’s room or cubicle are included as healthcare workers. Staff who work in non-clinical areas who do not work with patients or enter patient rooms are not included as healthcare workers for this purpose.
Infectious period	The period during which an infected person can transmit an infectious agent to a susceptible person. Also known as the ‘communicable period’. The duration of the infectious period for COVID-19 is unknown. However, for the purposes of isolation and contact tracing, cases are considered to be infectious from 48 hours prior to the onset of symptoms, until they meet the criteria for release from isolation.
Isolation	The physical separation of ill people with a communicable disease (e.g. COVID-19) from those who are healthy.
Outbreak	The internationally accepted definition of an outbreak encompasses the occurrence of more cases of a disease than expected, or two or more linked cases. Tailored definitions for a COVID-19 outbreak are provided in this document.
Outbreak control squads	Multi-disciplinary public health teams formed to enable additional and rapid support at physical outbreak settings to facilitate outbreak control
Pandemic	Worldwide spread of a new disease

PPE	Personal protective equipment. This is clothing or equipment designed to be worn by someone to protect them from the risk of illness. For COVID-19, this usually means a mask, eye protection, gown and gloves.
Quarantine	The physical separation of people who are well but who may have been exposed with a communicable disease (e.g. contacts of a COVID-19 case) and are potentially infectious to see if they become ill.
Sensitive setting	Settings with a high risk of rapid transmission of COVID-19 and/or where there are vulnerable people who are at high risk of serious illness or death and/or high risk of significant impacts and broader consequences for communities.
SARS-CoV-2	Severe acute respiratory syndrome coronavirus 2 (the virus that causes COVID-19)

Governance

Overview

The Department of Health and Human Services is the Control Agency for the COVID-19 emergency response. The Chief Health Officer is the statutory officer under the *Public Health and Wellbeing Act 2008* for the public health management of the emergency and is responsible for public health outbreak governance.

The State Controller (Class 2) is responsible for the coordination of agencies in response to consequences of a COVID-19 outbreak that impact, or have the potential to impact, the broader community. The State Controller is responsible for ensuring the Joint Intelligence Unit is linked into the State Control Team to inform broader consequence management strategies.

Roles and Responsibilities in an outbreak

Outbreak Management Team

The Public Health Incident Management Team (PHIMT), led by the Public Health Commander, has responsibility for the public health management of COVID-19 cases and outbreaks. When an outbreak is identified, an Outbreak Management Team (OMT) will be constituted under the guidance of the Deputy Public Health Commander Case, Contact and Outbreak Management (DPHC CCOM). The OMT will include, at a minimum, the following representatives listed in the next section within and external to the PHIMT.

Core members of an Outbreak Management Team

Outbreak Lead

Generally a Public Health Physician or Infectious Diseases Physician and reporting to the Deputy Public Health Commander, Case, Contact and Outbreak Management (DPHC CCOM), the Outbreak Lead will coordinate the response to the outbreak for the duration of the outbreak. The lead will:

1. Chair Outbreak Management Team meetings.
2. Allocate tasks to other leads in the outbreak.
3. Undertake stakeholder management and engagement as required, including with agencies outside the department.
4. Escalate information and issues to relevant individuals.
5. For high profile or complex outbreaks, undertake the liaison role with the facility/setting, after discussion with the Case and Contact management lead.
6. Endorse any significant control measures, including closure, for approval by the DPHC CCOM.
7. Endorse proactive and reactive media lines, for approval by the DPHC CCOM, and ensure compliance with the exposure site naming policy.
8. Ensure the Outbreak Management Plan is being implemented.
9. Monitor outbreak management key performance indicators (KPIs) and escalate issues early where it is identified that additional resources may be required.
10. Identify recommendations for and updates to the Outbreak Management Plan following a hot debrief of the outbreak.

Case and Contact Management Lead

Generally an experienced Public Health Officer and reporting to the Outbreak Lead, the Case and Contact Management Lead will:

1. Ensure comprehensive, documented interviews with confirmed cases (or their next of kin or healthcare provider where relevant) are conducted to confirm the date and timing of symptom onset as well as their infectious period.
2. Implement case management to ensure no further risk to the public from infectious cases.
3. Identify contacts and ensure contact management occurs.
4. Identify required public health controls at the relevant setting(s), including closure of parts or all of a setting where required, and implement controls in consultation with the Outbreak Lead and DPHC CCOM.
5. Ensure high quality and complete data collection and documentation for cases and contacts is undertaken.
6. Consolidate information collected by the department with that obtained by the facility or setting.
7. Ensure information management of test results and clinical information of close contacts and confirmed cases in the Public Health Events Surveillance System (PHESS).
8. Nominate appropriate Public Health Officers to attend site visits with the Outbreak Squad if deemed necessary.
9. Coordinate liaison with:
    - Treating medical practitioners for all confirmed cases;
    - Nominated outbreak lead at the facility/site/setting to collect and update information;
    - Community stakeholders as required (i.e Aboriginal Community Controlled Health Organisation);
    - Laboratories.
10. Identify that escalation criteria have been met and implement subsequent actions.
11. Supervise other Public Health Officers assigned to the outbreak response.

Epidemiology Lead

An officer with training in epidemiology, preferably applied epidemiology, and reporting to the Outbreak Lead, the Epidemiology Lead will:

1. Ensure completeness and accuracy of data capture and management.
2. Analyse descriptive epidemiological data and undertake advanced analyses such as logistic regressions as required.
3. Provide epidemiological insight to assist with outbreak detection including:
    - Modelled transmission networks to flag possible missed connections between cases;
    - Other systems to assist with pattern recognition and outbreak detection.
4. Develop visualisation including:
    - Construction of epidemiological curves;
    - Transmission mapping;
    - Timeline mapping.
5. Write and maintain appropriate reports including:

- Outbreak summaries;
- Detailed outbreak reports;
- Case summaries;
- Morning briefings; and
- Genomic reports.

6. Nominate appropriate epidemiologist and/or information officers to attend site visits with Outbreak Squad if deemed necessary.
7. Consider the requirements for and initial proposals for analytical epidemiological studies to the Outbreak Lead.
8. Supervise other epidemiologists or data entry staff assigned to the outbreak.

DHHS Agency Commander (Representing the State Controller - Health)

The DHHS Agency Commander, representing the State Controller - Health, will:

1. Consider the requirement for broader consequence management in relation to the outbreak.
2. Consider what support or relief (including accommodation) is required to assist in the management or control of the outbreak.
3. Work with the Joint Intelligence Lead and Outbreak Lead to provide regular contact with whole of Victorian Government (WoVG) or relevant agencies.
4. Consider, in conjunction with the outbreak lead and Joint Intelligence Lead, the requirement for Joint Outbreak Coordination Group to be activated to manage broader whole of government consequences (consequences of individual cases, the outbreak or of actions taken as part of outbreak management, as per Joint Intelligence Unit Operational Arrangements)
5. Nominate sector, regulator or other WoVG officers to attend site visits with Outbreak Squads if deemed necessary.
6. Liaise with department divisional leads (where relevant) to ensure linkage to local supports and networks.

State Joint Intelligence Lead (State Control Centre representative)

A representative from the Joint Intelligence Unit, the Joint Intelligence Lead will*:*

1. Manage the intelligence coordination across whole of government (WoVG) response agencies for the outbreak.
2. Support the identification of, and make contact with, appropriate contacts and conduits in relevant organisations, in collaboration with the Outbreak Lead.
3. Collect non-epidemiological intelligence regarding the outbreak or setting – for example regulatory requirements.
4. Support the OMT and SCT with regular updated intelligence in relation to the outbreak.
5. Consider, in conjunction with the outbreak lead and the DHHS Agency Commander, the requirement for Joint Outbreak Coordination Group to be activated to manage broader whole of government consequences (consequences of individual cases, the outbreak or of actions taken as part of outbreak management, as per Joint Intelligence Unit Operational Arrangements).

Communications and media lead

Reporting to the Outbreak Lead, the Communications and Media Lead will:

1. Coordinate all media responses.
2. Create proactive and reactive media lines relating to the outbreak.
3. Create all external or public facing communications relating to the outbreak – for example new fact sheets or workplace specific materials.
4. Update websites as required pertaining to the outbreak.
5. Ensure all communications are in line with the Communications policies for personal information.
6. Link with the State Control Centre Public Information Unit to support any whole of Victorian Government messaging, public information and warnings if required.

Outbreak Squad Coordinator

Reporting to the Outbreak Lead, the Outbreak Squad Coordinator is responsible for the coordination and logistics of any Outbreak Squad deployment of the relevant professionals who are required to undertake setting(s) visits as part of outbreak management. The Outbreak Squad Coordinator will attend all OMT meetings whether or not a Squad is deployed.

The Outbreak Squad Coordinator will:

1. Coordinate the logistics required to support the Outbreak Squad.
2. Source appropriate members of the Outbreak Squad in consultation with the OMT.
3. Ensure all members of the Outbreak Squad:
    a. are available and have appropriate resourcing/equipment;
    b. have appropriate qualifications, training and authorisations to be undertaking field work;
    c. are coordinated and able to undertake the relevant inspection, risk assessments, data collection, interviews, testing and other actions as determined to be necessary by the OMT at the initial meeting in a timely and efficient manner.
4. Ensure a safe working environment for Outbreak Squad members.

The Outbreak Squad Coordinator will also liaise with other relevant areas of the PHIMT and/or department to identify the appropriate people or resources required for any site visit such as:

1. Mobile or outreach testing through Health and Wellbeing Division;
2. Infection prevention team for Infection Prevention and Control Consultants;
3. Physical distancing team for occupational physicians;
4. Joint Intelligence lead for external agency requirements.

See Appendix 1 for further description of the remit of the Outbreak Squads.

Health and Wellbeing Division representative

The Health and Wellbeing Division representative will vary depending on the type and setting of the outbreak. This representative may be from any of the following areas:

- Ageing and Carers Branch – for aged care outbreaks
- Primary and Community Care – for community-based outbreaks which may need mobile testing or other community health input

- Commissioning Group – Metro or Regional
- Private Hospitals

The role of the Health and Wellbeing Division representative will also vary depending on the type and setting of the outbreak but will always include:

1. Determining, in conjunction with the OMT and others in their own division, which health services need to be notified of the outbreak in order to prepare for possible supportive actions or cases for admission
2. Notifying health services as above, using an agreed template
3. Liaising with health services and testing providers to arrange testing of cases and/or contacts in an appropriate location and a timely manner
4. Liaising with health services to provide other clinical supports as required for the outbreak – see Appendix 5 for examples of how health services may be involved in outbreak management
5. Assisting the Case and Contact lead if there are further care needs for cases, for example hospital in the home or other services.
6. Liaising with other relevant stakeholders (for example Aged Care Quality and Safety Commission, Commonwealth Department of Health (State Office and Aged Care Policy and Programs) or Community Health services

Administrative Support Officer

Reporting to the Outbreak Lead, the Administrative Support Officer will:

1. Coordinate OMT meetings, take minutes and document actions arising.
2. Create a central point for outbreak documentation and save all relevant documents there.
3. Support the Outbreak Lead and other OMT members with any other administrative tasks.

Additional roles might include a Laboratory Liaison lead and Environmental or Infection Prevention Control Lead, and potentially department divisional leads.

Potential additional members of an Outbreak Management Team

Other roles and representatives may be included in the OMT depending on the nature and setting of the outbreak, at the discretion of the DPHC CCOM. This will include the Aged Care Quality and Safety Commission, Commonwealth Department of Health (State Office and Aged Care Policy and Programs), Ageing and Carers Branch (DHHS) for outbreaks in residential aged care; representation from Health and Wellbeing Division when liaison with health services is required; a pathology lead (e.g. liaison with testing laboratories) or environmental lead (e.g. coordinating environmental risk assessment); other departmental stakeholders (e.g. regulators and commissioning groups); and external representatives of other departments where relevant, such as with an outbreak in a prison setting.

Outbreak Briefings

The following meeting will take place as a regular briefing:

- Daily outbreak briefing with Minister
    - Chaired by Minister.
    - Meeting involving Deputy PHC CCOM, Public Health Commander, Chief Health Officer Outbreak Squad Operations and Coordination Director and the Public Health Emergency Operations and Coordination Deputy Secretary (or the Assistant Deputy Secretary).
    - Briefing to discuss new and currently active outbreaks and complex cases or exposure sites which may create media attention

Key elements of the outbreak response

Identifying an outbreak

Early identification and rapid management of outbreaks is critical to interrupt transmission.

The responsibility for recognising an outbreak depends on the setting. In some settings, including many sensitive settings, prompt recognition of an outbreak is a joint responsibility between a facility and the department.

In most cases, however, identifying an outbreak is a responsibility of the department. Multiple mechanisms exist to identify outbreaks, including to identify linked cases, including:

- COVID-19 Clusters spreadsheet on Teams site (COVID-19-Outbreaks-DHHS-GRP).
- Epidemiological insights into data by the Intelligence team (e.g. modelled transmission networks to flag possible missed connections between cases, other systems to assists with pattern recognition and outbreak detection)
- Analysis of genomic data by the Microbiological Diagnostic Unit Public Health Laboratory (MDUPHL) – see Appendix 2 for further detail on genomics
- Case/s notified to CCOM team via investigations.
- Cases identified via communication with contacts.

When cases are identified that clearly meet the definition of an outbreak (a single case in an aged care facility or two cases in the same workplaces) an OMT will be immediately established in consultation with CCOM Operations Lead and the DPHC CCOM to determine membership of the OMT. A Problem Assessment Group will **not** be required.

Problem Assessment Group (PAG)

A problem assessment group should be convened when any member of the Public Health Incident Management team identifies any of the following:

- Potentially linked cases that warrant further investigation.
- A single case in a sensitive setting (other than an aged care facility) or a critical infrastructure or essential service.
- A high risk case.

The group should include the DPHC CCOM (or alternative DPHC/PHC who is a public health physician pending immediate availability), the CCOM Operations lead and the Public Health Intelligence Operations lead for that day.

The PAG should determine:

- If an OMT is needed.
- Which available officers should be appointed to the OMT based on relevant experience and seniority determined by the complexity of the initial analysis.
- If there are any additional members of the OMT to the core group listed above required.
- Any complexities with the situation that may require additional actions prior to the OMT meeting.

A PAG is not a substitute for an OMT. The PAG's primary purpose is to identify whether an OMT is needed and to rapidly ensure that group comes together if needed.

An Outbreak Management Team should be formed immediately if the PAG assesses this is required.

Initial Notification

The decision to form an OMT and the outcomes from the initial investigation and OMT meeting should be sent from the DPHC CCOM in an email summary to the Public Health Commander, DHHS Agency Commander, Chief Health Officer, Outbreak Squad Operations and Coordination Director, Deputy Secretary Public Health Operations and Coordination (or Assistant Deputy Secretary), State Controller-Health, Secretary's Office and the Minister's Office within two hours of the Outbreak Management Team convening. The summary will include initial actions undertaken.

Initial investigation and response activities are undertaken as part of routine case and contact management and are likely to be completed or commenced prior to the OMT (table 1). A delay in completing these activities, however, should not delay convening a PAG or OMT.

Table 1. Initial investigation and response steps prior to/concurrent with OMT

Investigation step	**Responsible**
Cases - Complete case interviews - Confirm infectious periods - Confirm incubation periods - Confirm acquisition period	Case and contact lead
Contacts - Identify all contacts - Identify high risk contacts/vulnerable contacts	Case and contact lead
Exposure sites (upstream and downstream) - Identify all exposure sites for each case - Document/create exposure sites on PHESS	Case and contact lead Epidemiology lead
Response step	**Responsible**
Cases - Notify cases in writing of their obligations - Ensure appropriate treatment and isolation is occurring - Ensure appropriate education has been received, including regarding any legal directions pertaining to isolation requirements - Ensure appropriate isolation is able to be undertaken in available accommodation, arrange alternative accommodation if necessary	Case and contact lead

Contacts - Notify close contacts in writing of their obligations - Ensure appropriate quarantine is being undertaken - Ensure appropriate education has been received, including regarding any legal directions pertaining to isolation requirements - Ensure appropriate quarantine is able to be undertaken in available accommodation, arrange alternative accommodation if necessary	Case and contact lead
Exposure sites - Notify exposure sites in writing of their obligations, provide with relevant cleaning and/or disinfection information - Ensure appropriate PPE and other infection control procedures are being undertaken	Case and contact lead
Initial notification step	**Responsible**
Internal notification - Ensure a brief summary of key information is provided to OMT members.	Outbreak Lead

Outbreak Management Team

An Outbreak Management Team (OMT) will be established for each identified outbreak (as per the outbreak definition) and will coordinate the full outbreak response. Many initial responses will occur concurrently as part of routine case and contact management processes, however, the OMT should ensure all of these are documented as part of outbreak reporting processes.

The outcome of the first OMT meeting will be agreed decisions on the initial assessment, control measures and communications priority tasks to enable a bespoke Outbreak Management Plan for that outbreak to be drafted. This plan will be updated daily prior to the morning OMT meeting with actions updated after that meeting. See Appendix 3 for an example template of this plan.

The OMT will meet at least daily while the outbreak is being actively managed.

The DPHC CCOM will brief the DHHS Agency Commander, Public Health Commander, Chief Health Officer, Deputy Secretary Public Health Operations and Coordination (or Assistant Deputy Secretary), State Controller-Health, Secretary's Office, the Minister's Office and OMT members daily on the outbreak, providing a daily summary outbreak report. Escalation will occur as per the below escalation criteria.

An initial outbreak meeting agenda is in Appendix 4.

Outbreak Squads

Single point source outbreaks at fixed facilities will require at least a single visit from an Outbreak Squad. Continuing common source settings may require ongoing input.

The number of attendances and composition of the Outbreak Squad will be based on a range of factors including:

- Level of sensitivity of outbreak setting;
- Capacity of outbreak setting to implement required controls;
- Concerns on the part of the department or evidence over lack of compliance to required measures;
- High case numbers at initial presentation of outbreak, indicating that ongoing transmission has been taking place for an extended period of time.

An Outbreak Squad Coordinator will attend all OMTs and the OMT will give consideration to the composition of the squad to be deployed.

The decision on timing and number of site visits to the outbreak setting will be made by the Outbreak Lead, based on ongoing assessment of the outbreak, and coordinated by the Squad Lead.

The Outbreak Squad will be operational within the OMT with the Squad Lead reporting to the Outbreak Lead until the outbreak is declared over. Additional information about Outbreak Squads is in Appendix 1.

Daily Activities

The department will maintain active involvement in each outbreak throughout the course of the outbreak. This includes continuing regular daily activities. The outcomes of these activities determine whether further actions or investigations are required.

Step	Responsible	Documentation
Outbreak management team meetings	Outbreak Lead	Action notes from meeting recorded in TRIM
Daily contact with cases and close contacts. Clearance from isolation or release from quarantine when appropriate. Note: the role of a facility or setting depends on the type and reliability. This might range from being asked to provide data, to actually doing the contact tracing themselves. This will be determined by the OMT and based on predetermined criteria.	Case and Contact Management Lead	PHESS file note for each case and contact.
Daily contact with the facility or setting while the outbreak is 'active' - Checking that actions being undertaken - Appropriate communications to staff etc	As nominated by OMT – pending regular visits or not, dependent on type of facility and major components of DHHS input (e.g. infection control, or occupational medicine or case management)	Written evidence of contact in TRIM file (e.g. email to facility lead)
Site visit reports for all Outbreak Squad visits	Outbreak Squad Coordinator	Squad report saved on TRIM

Daily outbreak report updates with review of epidemiology curve, hypothesis and other information (e.g. genomics)	Epidemiology Lead	Recorded in the individual outbreak management plan and saved on TRIM
Daily review of support and relief requirements, and risk and consequences	DHHS Agency Commander	Recorded in the individual outbreak management plan and saved on TRIM
Briefing Public Health Command team, the Chief Health Officer, DHHS Agency Commander, State Controller – Health, Deputy Secretary Public Health Operations and Coordination (or Assistant Deputy Secretary), the Secretary's Office and the Minister's Office	DPHC CCOM	Daily email summary, saved on TRIM.
Targeted exposure site/sector/stakeholder communications and responses	As determined by OMT - Outbreak Squad - Joint intelligence Unit - Case and Contact Management - Communications and Media	Formal written communication (e.g. by email). Saved on TRIM.

Points of Escalation

Escalation is the process of involving higher levels of governance for two reasons: first to share information to enable awareness (which might prompt a different course of action but may not necessarily), or second to move the management of a particular risk to a higher level of governance, due to the complexity / risk / consequences and accountability for the decision.

Tier 1

In the following situations there should be information escalated to the DPHC CCOM, the Public Health Commander, Chief Health Officer, DHHS Agency Commander, State Controller – Health, Deputy Secretary Public Health Operations and Coordination (or Assistant Deputy Secretary), the Secretary's Office and the Minister's Office:

- A death associated with an outbreak.
- An outbreak that is likely to attract significant media attention.
- Where there are potential or actual impacts with broader consequences for communities.

Tier 2

In the following situations there should be information escalated to the DPHC CCOM and then the Public Health Commander (who will determine if it requires further immediate escalation):

- A confirmed case in a sensitive setting
- A significant increase in the number of cases in any one day.
- A case linked to an outbreak that exposes a secondary site (potentially generating a second outbreak location).
- An outbreak involving individuals or organisations where there is evidence of non-compliance with DHHS legal directions.
- An outbreak where there are two or more generations of cases (outside of household transmission) after the first case was identified and notified to DHHS, i.e. initial evidence of potentially non-effective control measures.
- Where there are concerns regarding preparedness activities as requested by DHHS or other regulators.
- Where there are potential or actual impacts with broader consequences for communities.

Where the above information relates to an existing outbreak, it will be included in the relevant daily outbreak summary provided to key stakeholders.

Closure of an outbreak

An outbreak is declared over (no longer active) after two full incubation periods (28 days) since the day the last case is effectively isolated.

Step	Responsible	Documentation
Determining that the outbreak meets above criteria for being declared over	DPHC CCOM	Recorded in the Outbreak Management Plan
Closure of outbreak on PHESS	Epidemiology Lead	Recorded on PHESS
Finalise Outbreak Report	Epidemiology Lead	Final Outbreak Report saved on TRIM
Evaluation/discussion	Determined by DPHC CCOM. Every outbreak should have a final debrief meeting documented, including a rapid evaluation of the work of the OMT and any on-site work by the Outbreak Squad.	Evaluation documented and saved on TRIM.

Outbreaks in Sensitive Settings

Sensitive Settings

Sensitive settings are defined as settings where there is a high risk of rapid transmission of COVID-19 and/or where there are vulnerable people who are at high risk of serious illness or death. Put another way, a sensitive setting is a setting where factors come together that cause high attack rates amongst people at the setting, and potentially increased morbidity and mortality from COVID-19 if there is transmission.

Early detection and rapid management of suspected or confirmed cases in these settings is critical to limit the spread of the virus and reduce the potential for severe illness or death.

The following are considered sensitive settings:

- Residential and Aged Care Facilities (RACF)
- Healthcare and mental health settings
- Prison/Justice settings (correctional facilities, detention centres)
- Aboriginal rural and remote communities
- Accommodation with shared facilities
- Defence force operational settings
- Boarding schools and other group residential settings
- Schools
- Childcare centres
- Remote industrial sites with accommodation (e.g. mine sites)
- Certain high-risk work sites where workers are unable to undertake physical distancing or where outbreaks have been identified in the past:
    - Meat processing or other manufacturing plants
    - Restaurants/industrial kitchens
    - Workplaces with highly casualised workforces (who may be less likely to report symptoms)
- Settings with high-risk potential or actual impacts and broader consequences for communities, where physical distancing cannot be undertaken, and in critical infrastructure and essential services workplaces, including:
    - Banking and finance (banks, insurance, payroll, accounting)
    - Communications (telecommunications and data centres)
    - Energy (power generation, fuel supply and transmission)
    - Food and grocery logistics (processing, manufacturing and supply)
    - Government (frontline and critical services)
    - Transport (airports, transport maintenance and operations)
    - Water (supply and disposal facilities)
    - Emergency services (police, fire, ambulance)

See Reference materials for further guidance on sensitive settings

Outbreak Briefings and Reports

Summary of outbreak briefings, plans and reports

- Initial notification of an Outbreak
    - Email sent by DPHC CCOM to Public Health Commander, Chief Health Officer, DHHS Agency Commander, State Controller-Health, Outbreak Squad Operations and Coordination Director, Public Health Emergency Operations and Coordination Deputy Secretary (or Assistant Deputy Secretary), the Secretary's Office and the Minister's Office.
- Daily COVID-19 Intelligence Morning Briefing
    - Email sent by PH Intelligence to Public Health Command and CCOM/Intelligence Leads, DHHS Agency Commander and State Controller-Health, Outbreak Squad Operations and Coordination Director, Public Health Emergency Operations and Coordination Deputy Secretary (or Assistant Deputy Secretary) in the mornings
    - Includes summary statistics and background on currently active outbreaks.
- Individual Outbreak Management Plan
    - This plan will be created after the first OMT meeting and will be updated daily prior to each OMT meeting with actions added immediately after the meeting.
- Daily Outbreak email summary – bullet points for each active outbreak
    - Sent by DPHC CCOM to Public Health Commander, Chief Health Officer, DHHS Agency Commander, State Controller-Health, Outbreak Squad Operations and Coordination Director, Public Health Emergency Operations and Coordination Deputy Secretary (or Assistant Deputy Secretary), the Secretary's Office and the Minister's Office.
- Outbreak Report – finalised upon closure of the outbreak
    - The outbreak report will be a finalised version of the Individual Outbreak Management Plan.
    - Sent by DPHC CCOM to Public Health Commander, Chief Health Officer, DHHS Agency Commander and State Controller-Health, Outbreak Squad Operations and Coordination Director and Public Health Emergency Operations and Coordination Deputy Secretary (or Assistant Deputy Secretary) within 2 weeks of outbreak closing

Business rules for distribution of outbreak reports and data requests

Additional requests for outbreak reporting products (or more detailed outputs, e.g. underlying line lists) may occur over the course of the pandemic. For each request, the relevant data custodian will determine the appropriateness of response and will need to seek approval for provision of information from the DPHC CCOM on a case-by-case basis.

Requests for support or additional Joint Intelligence Unit products should be forwarded to the State Controller–Health for assessment sccvic.sctrl.health@scc.vic.gov.au, cc: sccvic.stratintel@scc.vic.gov.au.

Evaluation

Key Performance Indicators (KPIs)

Following the decision to establish an Outbreak Management Team:

Within 2 hours

- Outbreak Management Team convened, and first meeting occurred [responsibility of designated Outbreak Lead].
- Construct a working case definition.
- Determine logistics for site visit.
- Determine external stakeholders who require to be notified.
- Provide initial notification to the Public Health Commander, the Chief Health Officer, DHHS Agency Commander, State Controller – Health, Deputy Secretary Public Health Operations and Coordination (or Assistant Deputy Secretary), the Secretary's Office and the Minister's Office [responsibility of DPHC CCOM]

Within 12 hours– 50 Lonsdale St

- Make contact with the setting and commence a risk assessment.
- Initial notified case interviews and exposure sites entered into PHESS.
- Determine support or relief requirements.
- Commence contact tracing of identified contacts.
- First draft of Outbreak Management Plan completed.

Within 24 hours –50 Lonsdale St and site visit requirements

- Form an Outbreak Squad.
- Determine if any other agency personnel are required to attend the site.
- Attend the site.
- Complete a risk assessment to determine whether a closure of the facility / workplace / setting is required or not (if relevant) and provide this information to the OMT lead, Public Health Commander, DHHS Agency Commander, Deputy Public Health Commander Case Contact and Outbreak Management, Outbreak Squad Operations and Coordination Director.
- Request a list of close contacts and all attendees within risk period in writing from manager / relevant contact person if not already completed.
- Advise of need and associated requirements for closure in writing (if Deputy Public Health Commander, Case Contact and Outbreak Management determines this is required).
- Advise on immediate environmental controls including in writing if closure is not warranted
- Ensure cleaning and disinfection requirements have been completed.
- Send formal letter to setting manager indicating presence of an outbreak and stating plan/recommendations of the department.
- Escalate request for details of all attendees or close contacts in period of risk if not yet received.
- Determine which contacts require testing to be undertaken as part of outbreak investigation or upstream contact tracing and arrange for testing to be undertaken

Within 48 hours – on site actions

- Within the OMT:
    - Review closure decision (if not closed: reconsideration of closure made).
    - Aim to have contacted all close contacts / attendees identified within 48 hours of receipt of initial list, including provision of quarantine/test advice in writing.
    - Initial literature review on specific controls for that setting tasked to Intelligence if new setting.
    - Formal report established by Intelligence and specific KPIs established for the outbreak (1-2 based on specific things that work in that setting from literature).
    - Aim to have all identified contacts who require testing to be confirmed as having had samples taken
- In relation to onsite:
    - Ensure definitive environmental cleaning and disinfection review commenced (IPC lead) or controls expectation provided in writing.
    - Site specific plan created as part of outbreak management to determine reopen requirements, return to work/school/facility testing requirements for staff/attendees
    - Initial plan (above) agreed by and communicated to both site management and OMT members for consistent messaging and management

Closure of the outbreak

- Final outbreak report completed.
- Debrief documented.
- Lessons learnt incorporated into outbreak management plan.

Reference Documents/Guidelines

Document	Internal / External	Link to Document
Outbreak specific documentation		
COVID-19 Outbreak management plan (this document)	External	
COVID-19 Outbreak management protocol	Internal	
COVID-19 Outbreak management guidelines for residential care facilities	External	
COVID-19 Outbreak management guidelines for sensitive settings	External	
COVID-19 Outbreak management standard operating procedure	Internal	
COVID-19 PHESS – Cluster Quick Entry Guide	Internal	Link
COVID-19 Outbreak action plan template	Internal	
COVID-19 Intelligence Team Outbreak Plan	Internal	
COVID-19 Public Naming Policy	Internal	
Supporting documentation		
Case Questionnaire COVID-19 (Novel Coronavirus)	Internal	Link
Case and Contact Management Guidelines	Internal	
COVID-19 Guidelines for Health Services and General Practitioners	External	
Healthcare worker PPE guidance	External	Link
Managing upset, angry, confused or challenging callers	Internal	Link
New Cases Standard Operating Procedures	Internal	
New Contact Cases Standard Operating Procedures	Internal	
PHESS Summary Notes	Internal	
Screening of visitors for COVID-19 - Advice for sensitive settings	External	Link
State Emergency Relief Plan for COVID-19	External	

Factsheets

Factsheet	Audience	SharePoint Link
Confirmed Case	External	Link
Suspected Case	External	Link
Close Contact	External	Link
Telephone Interpreter Service	External	Link

System Requirements

1. PHESS
2. TRIM/EDRM
3. DHHS Intranet
4. Microsoft Teams/SharePoint
5. PureCloud Telephony

Appendix 1 – Outbreak Control Squads

Public Health Outbreak Control Squads

Role and focus

A Public Health Outbreak Control Squad function (squads) has been established in DHHS to ensure the rapid deployment of public health outbreak control squads to sites of COVID-19 outbreaks.

Squads will facilitate rapid testing, infection prevention and control, isolation of close contacts and support and relief to ensure effective containment of public health risks. The squads will deliver a dedicated focus to ensuring testing, contact tracing and deep cleaning is carried out as soon as a potential outbreak is identified. That includes delivering rapid mobile testing at outbreak sites.

The squads provide rapid response mobile expertise of infection prevention and control specialists, nurses, environmental hygienists and others as required to respond to the circumstances of the outbreak.

In addition to the outbreak control squads, the public health team will increase infection prevention and control activities in relation to COVID-19, including a workforce of infection control outreach nurses employed to focus on both infection prevention and control preparedness in high risk settings.

The squads will work within each OMT.

Pre-deployment briefing

A pre-deployment briefing must take place that provides a situation update on cases and contacts, and information on the setting to date. Roles and responsibilities are expected to be as follows but must be confirmed before deployment:

Roles and responsibilities

A squad may be deployed involving as few as two persons, and potentially a wider number of the roles below.

Squad member	Roles and responsibilities
Outbreak Squad coordinator	Management of the squad Logistics Health and Safety
Case and contact management	Interview cases and identified close contacts Contact management
Intelligence	Data collection and analysis to inform to inform outbreak characterisation and ascertain transmission dynamics
Infection control outreach nurse	Review infection control plans and procedures in place On the ground inspection of facility adherence to infection control guidance Review of PPE use and staff donning/doffing procedures if

	relevant Make recommendations for improved infection control, e.g. physical barriers and cohorting
Environmental Health Officer	Advise on site set up, systems, environmental cleaning
Emergency Management Officer	Assess support and relief needs Links to Local services, support and trusted networks
Mobile testing unit	Testing of facility staff/residents if appropriate

Informing the outbreak setting of squad deployment

The Outbreak Squad Coordinator will contact the identified outbreak setting manager/liaison and inform them of the planned deployment of the outbreak control squad to their location. An explanation should be given outlining the reason for the activation and deployment, the legislative environment that supports these activities, an explanation of what the squad intends to do on site, and what the objective is of the visit. Their full cooperation, support and assistance should be sought.

Documentation

The following should be documented by the Outbreak Squad Coordinator and provided to the Outbreak Management Team to form a section of the outbreak report:

- Rationale and decision to stand up outbreak control squad;
- Composition of squad including presence of authorised officer (AO);
- Date(s) squad deployed to outbreak site;
- Form for site assessment – site report
    - Case and contact management
    - Physical distancing
    - Infection control processes
    - Environmental measures including cleaning
    - Data collection
- Recommendations from site visit
- OHS requirements for site visits, including travel arrangements
- Records management processes

Appendix 2 – Use of Genomics

Use of Genomics

Microbiological Diagnostic Unit (MDU) Public Health Laboratory

MDU is currently engaged with the department in a COVID-19 Genomics Collaboration that seeks to improve COVID-19 surveillance through integration of COVID-19 genomic data (obtained by MDU) with epidemiological data (obtained during case investigation by the department). Combined epidemiological and genomic sequence data will be added to an integrated data visualisation tool (named SeeSARS-2) to visualise relationships between SARS-CoV-2 sequences.

The degree to which genomic relatedness between sequences can be used to infer transmission networks for SARS-CoV-2 is not yet known. Interpretation of clusters of infection will be dependent on both epidemiologic and genomic data.

MDU epidemiologists and bioinformaticians will:

- Perform genome sequencing on all SARS-CoV-2 positive samples received at VIDRL or MDU.
- Within 24 hours of availability, add sequence data to the SeeSARS-2 integrated data visualisation tool to visualise relationships between SARS-CoV-2 sequences.
- Examine the combined data to identify additional genomic clusters and, where possible, answer questions posed by the department.
- Allocate a 'genomic cluster ID' to sequences where the degree of genomic relatedness is consistent (supports the existence of a cluster) and provide this information back to the department.
- Upload sequences without metadata to public viral sequence databases (GISAID and NCBI).

Clusters of interest and other related topics at a weekly meeting involving representatives of department, MDU and VIDRL.

The Outbreak Intelligence member of the Outbreak Squad is the designated departmental liaison with MDU. Any requests for genomic information from people working on COVID-19 outbreaks should be sent via email to REDACTED by 12pm on Mondays to allow representatives from MDU sufficient time to comment, including the following information:

- Question being asked of the data (e.g. is Case X genomically linked to Cluster Y).
- Relevant PHESS numbers.
- Brief statement on priority/rationale (e.g. name of cluster, level of risk/sensitivity, whether it is in a healthcare setting).

Outbreaks in sensitive settings (with a clear question that can reasonably be answered by the genomic data, given the limitations) will be given the highest priority. Outbreaks involving health care workers and/or healthcare settings will also be given priority.

Documents pertaining to Genomics will be stored in the PUBLIC HEALTH – HEALTH PROTECTION – MDU genomic sequencing folder on TRIM (IIEF/20/1215). This includes:

- Protocol documents
- Meeting minutes

- Genomic data requests
- Genomic reports

Information delineated from genomic investigation will be shared with the department for integration with epidemiological data and use in public health control of COVID-19 under the *Public Health and Wellbeing Act 2008*. Further dissemination, reporting or publication of genomic or epidemiological data will only be performed in collaboration with the department. No data to come from genomic investigation under this project will be shared with external parties without the written permission of the department. The department retains the right to veto publication of genomic information obtained through this project.

Appendix 3 – Outbreak Management Plan template

Purpose

[Insert general purpose and statement relating to use of the report in OMT meetings]

Governance

Outbreak Management team

Functional role	Name:	Mobile No:	Email:
Outbreak Lead			
Case and Contact Lead			
Epidemiology Lead			
Joint Intelligence Lead			
Communications and Media Lead			
Outbreak Squad Coordinator			
DHHS Agency Commander			
Administrative Support Officer			

Outbreak Management Team meeting dates

Situation

[Insert overview of the situation]

Epidemiological and clinical investigation

COVID-19 in Victoria

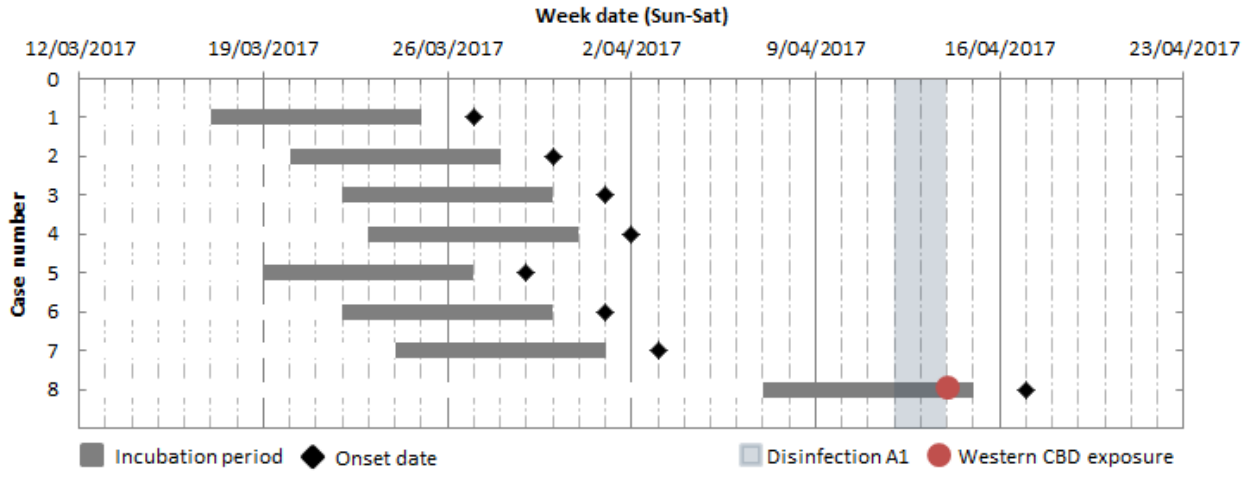
[Insert background epidemiology]

Epicurve

[Insert epidemiology curve. Include at least one incubation period before first confirmed/suspected outbreak case]

[Consider inserting timeline for each case – example for a legionella outbreak is included here]

Figure X [EXAMPLE]: Onset date and incubation period for confirmed and probable cases. Melbourne CBD legionellosis outbreak, as at 5pm 15 May 2017.



Case definitions

Current department case definition

[Include current departmental general case definitions for confirmed cases and testing criteria]

Outbreak case definitions

Confirmed case – outbreak

[Agree a confirmed case definition for the outbreak that incorporates person, place and time]

Suspected case – outbreak

[Agree a suspected case definition for the outbreak that incorporates person, place and time]

Person under investigation – outbreak

[Agree a description of a person under investigation for the outbreak that incorporates person, place and time]

Rejected case

[Insert relevant criteria based on epidemiological, clinical and/or laboratory evidence]

Case follow-up

[Describe case follow-up procedures for both business hours and after hours follow-up

Case finding

[Describe active case finding activities]

Case summary

Total confirmed cases	
Sex distribution	
Age (median, range)	
Date of first notification	
Date of first symptom onset	
Total hospitalisations	
Current hospitalisations	
Total ICU admissions	
Current ICU admissions	
Deaths	

Line list

[Include a line list of each case – can be an attachment if necessary]

Environmental investigation

[Include details of any relevant environmental investigations – eg activities at a given setting, abattoir]

Hypothesis

[Develop a hypothesis for the outbreak that can be tested using epidemiological analysis if necessary]

Control measures

[Describe any control measures taken]

Stakeholder mapping

[List identified stakeholders]

Risk communication

Key events

[Include information on internal communication, including briefings and communication with the Minister's Officer. Detail when media releases and press conference are released/take place]

Escalation point	Date of escalation
Deputy Public Health Commander CCOM	
Public Health Commander	
State Controller-Health	
Chief Health Officer	
Minister's Office	

Communication with exposed settings

[Add dates and details of any communication with workplace/health facility/aged care facility/school etc.]

Chief Health Officer Alert

[Link to CHO alert if developed and issued]

Key messages – health professionals

[Develop and record key messages]

Key messages – general public

Develop and record key messages]

Outbreak Management Team meeting actions list

Action	Due date	Responsible person

Timeline of outbreak

Date	Action

Appendix 4 – Initial Outbreak Management Team Agenda

Step	Responsible
Welcome and introductions	Outbreak Lead
Overall situation report, - confirmation of cases and current epidemiological information - proposed case definition for the outbreak in time, person, place	Epidemiology Lead
Case and contact management actions to date	Case & Contact Management Lead
Risk assessment to determine: - Further information required regarding cases? o Expedite genomics if required - Further information required regarding contacts? o Broaden or change definition? - Further information required regarding exposure site/s? o Site maps o Rosters o Sampling o Plans and procedures o Infection control/hygiene/social distancing plans o Critical/essential service o Workplace demographics - Whether site visit is necessary at one or more sites by an outbreak squad?	All – a decision about the composition of the Outbreak Squad.
Hypothesis for transmission	All – guided by Epidemiology Lead
Control measures - Isolation of cases - Quarantining of close contacts - Environmental measures in place - Setting closure considered - Active case finding strategy discussed (including screening)	

- Sector specific responses	
Support and Relief requirements	DHHS Agency Commander
Identification of relevant stakeholders and agencies to contact/seek details for - Government – internal and external - Industry - Regulators - Unions - Media - Exposure sites	Outbreak Lead supported by Joint Intelligence Lead and other members
Risk communication - Agree reporting requirements, including outbreak reports, TRIM file etc - Media and communications plan and immediate requirements. (including briefing the facility if decision made to name in the media) - Ensure that representatives from relevant areas brief up to their Ministers as appropriate	Epidemiology Lead Communications and Media Lead
Actions and agreed timelines	Outbreak Lead

Appendix 5 – Health Services and Outbreaks

Health Services potential roles in outbreaks

- Mobile testing and referral of COVID suspected and positive individuals
- On-site testing and referral of suspected or confirmed cases and contacts (in particular where large scale testing is required as part of outbreak investigations or upstream contact-tracing)
- Provision of specialist clinicians (ID consultants and nurses) to support outbreak control squad
- Community support including:
  - Links and referrals to health and community services; and
  - Long term follow-up of COVID positive individuals, including health and psychosocial support
- Communications support for affected communities and organisations – for example
  - Cultural liaison or support workers
  - Interpreting services
- Support contact tracing where required by DHHS (potentially within emergency health command)
- Provision of clinical decision making and specialist support as required for the COVID and non-COVID clinical needs of residents in residential aged care or other residential facilities.
- Mental health and psychosocial support for those impacted by protracted quarantine requirements
- Provision of clinical advice to sites impacted by outbreaks, such as schools, business, residential facilities.

RE: Attention Operations - Required accommodation

From: "Simon Crouch (DHHS)" REDACTED
To: REDACTED REDACTED >, "Jodie Geissler (DHHS)" REDACTED 'Braedan Hogan (DHHS)"
Cc: REDACTED REDACTED >, "Brett Sutton (DHHS)"
Date: Mon, 06 Jul 2020 14:20:15 +1000

REDACTED

Might be tricky to get me on the phone for a little while – teleconferences.

From a public health perspective it is very important that cases from the public housing be offered alternative accommodation to minimise the risk of spread to household members – I note that one of the cases in a house of 10 people who should be given the opportunity to be protected.

A confirmed case from the housing estate poses no different risk to a confirmed case from any other setting if moving into the hotel.

Happy to chat later if needed but it would be great to move quickly to get these positive cases alternative accommodation as soon as possible to minimise risk to their households.

Thanks
Simon

Dr Simon Crouch BA MBBS MA MPH PhD FAFPHM
COVID-19 Deputy Public Health Commander (Case, Contact and Outbreak Management)
Health Protection Branch | Regulation, Health Protection and Emergency Management
Department of Health and Human Services | 50 Lonsdale Street, Melbourne, Victoria 3000
t. REDACTED | REDACTED
w. www.dhhs.vic.gov.au | he/

From: REDACTED @dhhs.vic.gov.au>
Sent: Monday, 6 July 2020 2:13 PM
To: Jodie Geissler (DHHS) <REDACTED; Braedan Hogan (DHHS) REDACTED
Cc: Simon Crouch (DHHS) <REDACTED
Subject: RE: Attention Operations - Required accommodation

Sure – Simon I will call you soon.?

REDACTED

Senior Executive Officer
CO-VID Accomodation and Enforcement
Department of Health and Human Services
REDACTED REDACTED

From: Jodie Geissler (DHHS) REDACTED
Sent: Monday, 6 July 2020 2:10 PM
To: Braedan Hogan (DHHS) RE EDACTED REDACTED
REDACTED

Cc: Simon Crouch (DHHS) REDACTED
Subject: RE: Attention Operations - Required accommodation

Thanks Braedan – I have sought advice from Kym. It will be a public health decision as to the merits of removing people from these arrangements. RE, do you mind calling Simon, thanks.

From: Braedan Hogan (DHHS) REDACTED
Sent: Monday, 6 July 2020 1:54 PM
To: REDACTED REDACTED Jodie Geissler (DHHS)
REDACTED
Cc: Simon Crouch (DHHS) REDACTED
Subject: FW: Attention Operations - Required accommodation

Afternoon both,

See below the requests for alternate accommodation of positive cases out of the locked down towers – which have not been accepted.

As we don't oversee accommodation for positive cases can this issue please be discussed with Public Health Command – Simon is DC-CCOM today.

Regards,
Braedan

Braedan Hogan | DHHS Agency Commander

Deputy Director, Strategy and Policy
Emergency Management Branch | Regulation, Health Protection and Emergency Management
Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
REDACTED REDACTED
www.dhhs.vic.gov.au

From: REDACTED REDACTED
Sent: Monday, 6 July 2020 1:25 PM
To: Braedan Hogan (DHHS) REDACTED
Cc: REDACTED REDACTED
Subject: RE: Attention Operations - Required accomodation

Hi Braedan,

I have two more accommodation requests that have been sent back to me from Op Soteria (attached).

I wanted to seek your guidance on what to do with these two cases.

Thanks, REDACTED

REDACTED
State Duty Officer
Emergency Management Branch | Regulation, Health Protection and Emergency Management Division
Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
w. www.dhhs.vic.gov.au

The Department of Health and Human Services respectfully acknowledges the Traditional Owners of Country throughout Victoria and pays its respect to the ongoing living cultures of Aboriginal peoples.

From: Braedan Hogan (DHHS) REDACTED
Sent: Monday, 6 July 2020 12:20 PM
To: REDACTED REDACTED REDACTED

REDACTED REDACTED ; StateEmergencyManagementCentre SEMC (DHHS) <semc@health.vic.gov.au>REDACTED REDACTED
Cc: Public Health Operations <publichealth.operations@dhhs.vic.gov.au>;REDACTED REDACTED REDACTED ; Simon Crouch (DHHS) <Simon.Crouch@dhhs.vic.gov.au>;REDACTED REDACTED REDACTED >; Annaliese Van Diemen (DHHS) <REDACTED
Subject: RE: Attention Operations - Required accomdation

This is a matter for Op Soteria not SEMC.

Including Rowena.

Braedan

Braedan Hogan | DHHS Agency Commander

Deputy Director, Strategy and Policy
Emergency Management Branch | Regulation, Health Protection and Emergency Management
Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
m.REDACTED e.REDACTED
www.dhhs.vic.gov.au

From:REDACTED
Sent: Monday, 6 July 2020 12:17 PM
To:REDACTED >; StateEmergencyManagementCentre SEMC (DHHS) <semc@health.vic.gov.au>; Braedan Hogan (DHHS) <REDACTED
Cc: Public Health Operations <publichealth.operations@dhhs.vic.gov.au>;REDACTED REDACTED ; Simon Crouch (DHHS)REDACTED REDACTED REDACTED REDACTED >; Annaliese Van Diemen (DHHS) <REDACTED
Subject: RE: Attention Operations - Required accomdation

Hi Team

Can you please clarify the comment below?

Our information from the Op Benessere EMT meeting yesterday was that we could still access relief accommodation for those in high rise buildings that could not effectively isolate away from their family. If this isn't arranged through SEMC for the public housing estate can you shed light on where we should direct these requests?

As you can appreciate having a family with a confirmed case in a small apartment would put other family members at greater risk of being expose irrespective of if they are in lockdown or not. This will lead to increase cases within the housing block which is all the more reason that we should not stop relief accommodation for this cohort.

thanks

Kind Regards,

REDACTED
COVID-19 Public Health Operations Lead | Case, Contact and Outbreak Management

(Manager - Investigation and Response | Communicable Disease Prevention and Control)
Health Protection Branch | Regulation, Health Protection and Emergency Management Division
Department of Health & Human Services | 50 Lonsdale Street, Melbourne, Victoria, 3000
REDACTED | e. publichealth.operations@dhhs.vic.gov.au
w. www.dhhs.vic.gov.au

From: Public Health Operations <publichealth.operations@dhhs.vic.gov.au>
Sent: Monday, 6 July 2020 12:07 PM
To:REDACTED (DHHS) REDACTED REDACTED
REDACTED

Subject: FW: Attention Operations - Required accomdation
Importance: High

Hi both,

See below – it is indicating that people cannot be moved out of the towers?

For your clarification please.

Thanks,

REDACTED – Operations Information Lead
Public Health Operations | Novel Coronavirus (COVID-19) Response
Health Protection Branch | Regulation, Health Protection and Emergency Management Division
Department of Health & Human Services | 50 Lonsdale Street, Melbourne, Victoria, 3000
REDACTED e. publichealth.operations@dhhs.vic.gov.au
w. www.dhhs.vic.gov.au

From: REDACTED
Sent: Monday, 6 July 2020 12:04 PM
To: Public Health Operations <publichealth.operations@dhhs.vic.gov.au>
Cc: StateEmergencyManagementCentre SEMC (DHHS) <semc@health.vic.gov.au>
Subject: FW: Attention Operations - Required accomdation

Good Afternoon,

Please be advised we are unable to book accommodation for this case as they currently reside in one of the high rise buildings that is currently locked down.

Could you please re-refer the case if accommodation is required once the lockdown has been lifted, thanks, REDACTED

REDACTED
State Duty Officer
Emergency Management Branch | Regulation, Health Protection and Emergency Management Division
Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
w. www.dhhs.vic.gov.au

The Department of Health and Human Services respectfully acknowledges the Traditional Owners of Country throughout Victoria and pays its respect to the ongoing living cultures of Aboriginal peoples.

From: DHHSOpSoteriaEOC <DHHSOpSoteriaEOC@dhhs.vic.gov.au>
Sent: Sunday, 5 July 2020 6:45 PM
To: REDACTED
Subject: RE: Attention Operations - Required accomdation

Hi REDACTED
As this guest is residing in the Flemington public housing estate which is currently under hard lockdown, I have contacted REDACTED to advise that we are unable to relocate REDACTED to self isolate in a hotel at the moment.

Kind regards

REDACTED
DHHS Op Soteria EOC

From: REDACTED
Sent: Sunday, 5 July 2020 3:58 PM
To: DHHSOpSoteriaEOC <DHHSOpSoteriaEOC@dhhs.vic.gov.au>
Cc: StateEmergencyManagementCentre SEMC (DHHS) <semc@health.vic.gov.au>; Public Health Operations <publichealth.operations@dhhs.vic.gov.au>
Subject: Attention Operations - Required accomdation

Hi Ops team,

Please find below a request for accommodation for a positive case,

If you require any further information, please feel free to contact me, REDA

Kinds regards,

REDACTED
State Duty Officer | Emergency Management Branch

Emergency Management Branch | Regulation, Health Protection and Emergency Management Division

From: SEMC <semc@dhhs.vic.gov.au>
Sent: Sunday, 5 July 2020 3:52 PM
To: REDACTED
Subject: Fwd: Required accomdation

--------- Forwarded message ---------
From: REDACTED (Northern Sydney LHD)"
Date: 05/07/2020 15:43
Subject: Required accomdation
To: "StateEmergencyManagementCentre SEMC (DHHS)"

Hello,

REDACTED

Positive case
Case lives with REDACTED one child symptomatic they only have three bedrooms and one bathroom.
Isolation starts today

Kind Regards,
REDACTED
NSLHD PHU

Cleaning and disinfecting to reduce COVID-19 transmission

Tips for non-healthcare settings
20 March 2020

Purpose

The current outbreak of coronavirus disease 2019 (COVID-19) has been declared a pandemic. The Victorian government is working with health services, agencies and businesses to keep the Victorian community safe.

As more people are diagnosed with COVID-19, practicing good personal hygiene will be critical to help prevent the spread of this disease. It will also be important to clean and disinfect premises, including non-healthcare settings, where cases worked or studied.

This guide aims to provide advice on cleaning and disinfecting to reduce the risk of COVID-19 transmission in all non-healthcare settings in Victoria. The principles in this guide apply equally to domestic settings, office buildings, small retail businesses, social venues and all other non-healthcare settings.

How COVID-19 is transmitted

- COVID-19 spreads through close contact with an infected person and is typically transmitted via respiratory droplets (produced when an infected person coughs or sneezes). It may also be possible for a person to acquire the disease by touching a surface or object that has the virus on it and then touching their own mouth, nose or eyes, but this is not thought to be the main way that the virus is spreading in this pandemic.
- Current evidence suggests the virus causing COVID-19 may remain viable on surfaces for many hours and potentially for some days. The length of time that COVID-19 survives on inanimate surfaces will vary depending on factors such as the amount of contaminated body fluid (e.g. respiratory droplets) present, and environmental temperature and humidity. In general, coronaviruses are unlikely to survive for long once droplets produced by coughing or sneezing dry out.

Cleaning and disinfection

- **Cleaning** means physically removing germs, dirt and organic matter from surfaces. Cleaning alone does not kill germs, but by reducing the numbers of germs on surfaces, cleaning helps to reduce the risk of spreading infection.
- **Disinfection** means using chemicals to kill germs on surfaces. This process does not necessarily clean dirty surfaces or remove germs, but by killing germs that remain on surfaces after cleaning, disinfection further reduces the risk of spreading infection. Cleaning before disinfection is very important as organic matter and dirt can reduce the ability of disinfectants to kill germs.
- Transmission or spread of coronavirus occurs much more commonly through direct contact with respiratory droplets than through contaminated objects and surfaces. The risk of catching coronavirus when cleaning is substantially lower than any risk from being face-to-face without appropriate personal protective equipment with a confirmed case of COVID-19 who may be coughing or sneezing.

Importance of cleaning your hands regularly

- Soap and water should be used for hand hygiene when hands are visibly soiled. Use an alcohol-based hand rub at other times (for example, when hands have been contaminated from contact with environmental surfaces).
- Cleaning hands also helps to reduce contamination of surfaces and objects that may be touched by other people.
- Avoid touching your face, especially their mouth, nose, and eyes when cleaning.

VICTORIA State Government | Health and Human Services

- Always wash your hands with soap and water or use alcohol-based hand rub before putting on and after removing gloves used for cleaning.

Cleaning and disinfection

Routine cleaning and disinfection

Households, workplaces and schools should routinely (at least daily) clean frequently touched surfaces (for example, tabletops, door handles, light switches, desks, toilets, taps, TV remotes, kitchen surfaces and cupboard handles). Also, clean surfaces and fittings when visibly soiled and immediately after any spillage. Where available, a disinfectant may be used following thorough cleaning. See below for choice, preparation and use of disinfectants.

What to clean and disinfect and when

Clean and disinfect all areas (for example, offices, bathrooms and common areas) that were used by the suspected or confirmed case of COVID-19. Close off the affected area before cleaning and disinfection. Open outside doors and windows to increase air circulation and then commence cleaning and disinfection.

In situations where a suspected or confirmed case remains in a facility that houses people overnight (for example, a boarding house or hotel), focus on cleaning and disinfection of common areas. To minimise any risk of exposure to staff, only clean or disinfect bedrooms/bathrooms used exclusively by suspected or confirmed case as needed.

In household settings where there is an suspected or confirmed case, dedicate a bedroom (and bathroom if possible) for their exclusive use. Clean or disinfect the ill person's bedroom/bathroom as needed (at least daily). If a separate bathroom is not available, the bathroom should be cleaned and disinfected after each use by the ill person.

How to clean and disinfect

1. Wear gloves when cleaning and disinfecting. Gloves should be discarded after each clean. If it is necessary to use reusable gloves, gloves should only be used for COVID-19 related cleaning and disinfection and should not be used for other purposes. Wash reusable gloves with soap and water after use and leave to dry. Clean hands immediately after removing gloves.
2. Thoroughly clean surfaces using detergent (soap) and water.
3. Apply disinfectant to surfaces using disposable paper towel or a disposable cloth. If non-disposable cloths are used, ensure they are laundered and dried before reusing.
4. Ensure surfaces remain wet for the period of time required to kill the virus (contact time) as specified by the manufacturer. If no time is specified, leave for 10 minutes.

A one-step detergent/disinfectant product may be used as long as the manufacturer's instructions are followed regarding dilution, use and contact times for disinfection (that is, how long the product must remain on the surface to ensure disinfection takes place).

Cleaning and disinfection of items that cannot withstand bleach

Soft furnishings or fabric covered items (for example, fabric covered chairs or car seats) that cannot withstand the use of bleach or other disinfectants or be washed in a washing machine, should be cleaned with warm water and detergent to remove any soil or dirt then steam cleaned. Use steam cleaners that release steam under pressure to ensure appropriate disinfection.

Use of personal protective equipment (PPE) when cleaning

Gloves are recommended when cleaning and disinfecting. Use of eye protection, masks and gowns is not required when undertaking routine cleaning.

Always follow the manufacturer's advice regarding use of PPE when using disinfectants.

For cleaning and disinfection for suspected and confirmed cases, when available, a surgical mask and eye protection may provide a barrier against inadvertently touching your face with contaminated hands and fingers, whether gloved or not.

For cleaning and disinfection for suspected and confirmed cases, wear a full-length disposable gown in addition to the surgical mask, eye protection and gloves if there is visible contamination with respiratory secretions or other body fluid. Get advice from your work health and safety consultants on correct procedures for wearing PPE.

Choice, preparation and use of disinfectants

- Where possible, use a disinfectant for which the manufacturer claims antiviral activity (meaning it can kill viruses). Chlorine-based (bleach) disinfectants are one product that is commonly used. Other options include common household disinfectants or alcohol solutions with at least 70% alcohol (for example, methylated spirits).
- Follow the manufacturer's instructions for appropriate dilution and use. Table 1 below provides dilution instructions when using bleach solutions.

Chlorine dilutions calculator

Household bleach comes in a variety of strengths. The concentration of active ingredient — hypochlorous acid — can be found on the product label.

Table 1. Recipes to achieve a 1000 ppm (0.1%) bleach solution

Original strength of bleach		Disinfectant recipe		Volume in standard 10L bucket
%	Parts per million	Parts of bleach	Parts of water	
1	10,000	1	9	1000 mL
2	20,000	1	19	500 mL
3	30,000	1	29	333 mL
4	40,000	1	39	250 mL
5	50,000	1	49	200 mL

For other concentrations of chlorine-based sanitisers not listed in the table above, a dilutions calculator can be found on the department's website <https://www2.health.vic.gov.au/public-health/infectious-diseases/infection-control-guidelines/chlorine-dilutions-calculator>.

Management of linen, crockery and cutlery

If items can be laundered, lauder them in accordance with the manufacturer's instructions using the warmest setting possible. Dry items completely. Do not shake dirty laundry as this may disperse the virus through the air.

Wash crockery and cutlery in a dishwasher on the highest setting possible. If a dishwasher is not available, hand wash in hot soapy water.

Reducing the risk of transmission in social contact settings

Social contact settings or environments include (but are not limited to), transport vehicles, shopping centres and private businesses.

To reduce the risk of spreading COVID-19 in these settings:

- Promote cough etiquette and respiratory hygiene.
- Routinely clean frequently touched hard surfaces with detergent/disinfectant solution/wipe.
- Provide adequate alcohol-based hand rub for staff and consumers to use. Alcohol-based hand rub stations should be available, especially in areas where food is on display and frequent touching of produce occurs.
- Train staff on use of alcohol-based hand rub.
- Consider signs to ask shoppers to only touch what they intend to purchase.

Vehicle air-conditioning should be set to fresh air ☒  ☑ 

COVID-19

Outbreak Management Plan

Version 1.0

Approved by Chief Health Officer

27 May 2020

VICTORIA State Government | Health and Human Services

Contents

Executive Summary

Purpose

The purpose of this document is to outline the key components of the Department of Health and Human Service's management of coronavirus disease (COVID-19) outbreaks in Victoria, including triggers for escalation, and current decision-making policies. It includes standardised lists of actions to be taken, descriptions of how key decisions will be made and by whom and provides prompts additional actions. It defines public health and emergency management roles and responsibilities and articulates concise and clear actions to ensure rapid and effective COVID-19 outbreak management in Victoria.

Context

COVID-19 is an infectious disease caused by a new coronavirus, SARS-CoV-2. COVID-19 was first identified in December 2019 and is currently causing a global pandemic. The first case of COVID-19 in Victoria was detected in January 2020. While travel restrictions and rapid public health responses have largely contained the spread of the virus in Victoria, outbreaks of COVID-19 have occurred and are likely to continue to occur as physical distancing restrictions are gradually lifted.

Outbreak Management

Rapid and effective outbreak management is critical to ensuring suppression of the COVID-19 pandemic in Victoria. Even with physical distancing measures, COVID-19 outbreaks will occur in facilities, workplaces and other settings that need to continue on-site operations with large numbers of individuals in close contact.

Outbreaks may occur in any setting but are of particular concern when they occur in sensitive settings, such as healthcare settings or residential aged care facilities. These are considered sensitive because of one or more factors that contribute to significant scale and severity of illness, including the vulnerability of those working or residing there; the risk of amplification of transmission due to close, frequent and multiple contacts; and environmental factors that can contribute to transmission. Other settings of note relate to critical infrastructure or essential services, with potential for broader impacts on the Victorian community. This plan sets out how COVID-19 outbreak management will occur in Victoria, including how all outbreaks will be managed rapidly and effectively.

Key Definitions

Outbreak of COVID-19

In Victoria, an outbreak of COVID-19 is defined as:

- A single confirmed case of COVID-19 in a resident or staff member of a residential care facility, OR
- Two or more epidemiologically linked cases outside of a household with symptom onset within 14 days.

In sensitive settings other than residential care facilities (see below for examples), or critical infrastructure and essential services, a single confirmed case of COVID-19 will require an immediate control response and active involvement of the Department of Health and Human Services (the department) and the State Control Team and may be classified as an outbreak at the discretion of the Public Health Commander. It is expected that notifications in people from sensitive settings or who work in critical infrastructure and essential services will be discussed by a problem assessment group (described below).

Transmission within one household does not constitute an outbreak but will become part of an outbreak response if linked to a high priority setting.

Linked cases

To be considered linked (and therefore constitute an outbreak), cases should be linked in both time and place. Links may be inter-jurisdictional or international.

- Cases will be considered linked in **time** if symptom onset dates are within 14 days
    - Cases with symptom onsets which are within 28 days of each other should warrant further investigation but will not be considered an outbreak.
- Cases will be considered linked in **place** if they have a common geographical link. For example:
    - They work or reside in the same building or ward/wing of a facility
    - They live in the same household or neighbouring houses or in the same extended family or are linked by a common activity or location (e.g. school, health centre) in a rural Aboriginal community
    - They are patients or residents who have been cared for by the same staff member
    - They are cases in custodial or military settings attended by the same warden or supervisor
    - They reside in the same boarding school
    - They are aircraft passengers who were seated in the same row, or within the two rows in front of or behind another case on a flight of >2 hours duration
    - They attended the same event

For secondary and further transmission generations, cases must be identified as a close contact of, or have an epidemiological link to, a confirmed case linked to the outbreak in order to be included in the outbreak.

Acronyms and abbreviations

CCOM	case, contact and outbreak management
COVID-19	coronavirus disease 2019
IPC	infection prevention and control
KPI	key performance indicator
MDUPHL	Microbiological Diagnostic Unit Public Health Laboratory
PHC	public health commander
RACF	residential and aged care facilities
SARS-CoV-2	severe acute respiratory syndrome coronavirus 2
SCV	Safer Care Victoria
VAHI	the Victorian Agency for Health Information
VIDRL	Victorian Infectious Diseases Reference Laboratory

Glossary

Confirmed case	A person who meets the confirmed case definition. For COVID-19, a confirmed case is a person who tests positive to a validated SARS-CoV-2 nucleic acid test or has the virus identified by electron microscopy or viral culture
Contact	A person who has been in contact with a confirmed case during their infectious period. Contacts are typically defined as either close contacts or casual contacts
Close contact	A person 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)
Contact tracing	The process of identifying people who are close contacts of a case, and ensuring they are quarantined for the maximum incubation period (14 days) after last close contact with the case.
COVID-19	Coronavirus disease 2019 (the name of the disease). COVID-19 was initially referred to as “novel coronavirus” (2019-nCoV) and is sometimes referred to as just “coronavirus”
Critical Infrastructure and essential services	Defined as per the Infrastructure and Essential Services list held by Emergency Management Victoria (EMV)
Exposure site	A location or site to which an outbreak has been linked
Healthcare worker	Healthcare workers are people in close contact with patients or the patient space. For example, doctors and nurses and cleaners who enter the patient’s room or cubicle are included as healthcare workers. Staff who work in non-clinical areas who do not enter patient rooms are not included as healthcare workers for this purpose.

Infectious period	The period during which an infected person can transmit an infectious agent to a susceptible person. Also known as the 'communicable period'. The duration of the infectious period for COVID-19 is unknown. However, for the purposes of isolation and contact tracing, cases are considered to be infectious from 48 hours prior to the onset of symptoms, until they meet criteria for release from isolation.
Isolation	The physical separation of ill people with a communicable disease (e.g. COVID-19) from those who are healthy.
Outbreak	Occurrence of more cases of a disease than expected. Specific definitions for a COVID-19 outbreak are provided in this document.
Outbreak control squads	Multi-disciplinary public health teams formed to enable additional and rapid support at physical outbreak settings to facilitate outbreak control
Pandemic	Worldwide spread of a new disease
PPE	Personal protective equipment. This is clothing or equipment designed to be worn by someone to protect them from the risk of illness. For COVID-19, this usually means a mask, eye protection, gown and gloves.
Quarantine	The physical separation of people who are well but who may have been exposed with a communicable disease (e.g. contacts of a COVID-19 case) and are potentially infectious to see if they become ill.
Sensitive setting	Settings with a high risk of rapid transmission of COVID-19 and/or where there are vulnerable people who are at high risk of serious illness or death and/or high risk of significant impacts and broader consequences for communities.
SARS-CoV-2	Severe acute respiratory syndrome coronavirus 2 (the virus that causes COVID-19)

Governance

Overview

The Department of Health and Human Services is the Control Agency for the COVID-19 emergency response. The Chief Health Officer is the statutory officer under the *Public Health and Wellbeing Act 2008* for the public health management of the emergency and is responsible for public health outbreak governance.

The State Controller (Class 2) is responsible for the coordination of agencies in response to consequences of a COVID-19 outbreak that impact, or have the potential to impact, the broader community. The State Controller is responsible for ensuring the Joint Intelligence Unit is linked into the State Control Team to inform broader consequence management strategies.

Roles and Responsibilities in an outbreak

Outbreak Management Team

The Public Health Incident Management Team (PHIMT), led by the Public Health Commander, has responsibility for the public health management of COVID-19 cases and outbreaks. When an outbreak is identified, an Outbreak Management Team (OMT) will be constituted under the guidance of the Deputy Public Health Commander Case, Contact and Outbreak Management (DPHC CCOM). The OMT will include, at a minimum, the following representatives listed in the next section within and external to the PHIMT.

Core members of an Outbreak Management Team

Outbreak Lead

Generally a Public Health Physician or Infectious Diseases Physician and reporting to the Deputy Public Health Commander, Case, Contact and Outbreak Management (DPHC CCOM), the Outbreak Lead will coordinate the response to the outbreak for the duration of the outbreak. The lead will:

1. Chair Outbreak Management Team meetings.
2. Allocate tasks to other leads in the outbreak.
3. Undertake stakeholder management and engagement as required, including with agencies outside the department.
4. Escalate information and issues to relevant individuals.
5. For high profile or complex outbreaks, undertake the liaison role with the facility/setting, after discussion with the Case and Contact management lead.
6. Endorse any significant control measures, including closure, for approval by the DPHC CCOM.
7. Endorse proactive and reactive media lines, for approval by the DPHC CCOM.
8. Ensure the Outbreak Management Plan is being implemented.
9. Monitor outbreak management key performance indicates (KPIs) and escalate issues early where it is identified that additional resources may be required.
10. Identify recommendations for and updates to the Outbreak Management Plan following a hot debrief of the outbreak.

Case and Contact Management Lead

Generally an experienced Public Health Officer and reporting to the Outbreak Lead, the Case and Contact Management Lead will:

1. Ensure comprehensive, documented interviews with confirmed cases (or their next of kin or healthcare provider where relevant) are conducted to confirm the date and timing of symptom onset as well as their infectious period.
2. Implement case management to ensure no further risk to the public from infectious cases.
3. Identify contacts and ensure contact management occurs.
4. Identify required public health controls at the relevant setting(s), including closure of parts or all of a setting where required, and implement controls in consultation with the Outbreak Lead and DPHC CCOM.
5. Ensure high quality and complete data collection and documentation for cases and contacts is undertaken.
6. Consolidate information collected by the department with that obtained by the facility or setting.
7. Ensure information management of test results and clinical information of close contacts and confirmed cases in the Public Health Events Surveillance System (PHESS).
8. Nominate appropriate Public Health Officers to attend site visits with the Outbreak Squad if deemed necessary.
9. Coordinate liaison with:
    - Treating medical practitioners for all confirmed cases;
    - Nominated outbreak lead at the facility/site/setting to collect and update information;
    - Community stakeholders as required (i.e Aboriginal Community Controlled Health Organisation);
    - Laboratories.
10. Identify that escalation criteria have been met and implement subsequent actions.
11. Supervise other Public Health Officers assigned to the outbreak response.

Epidemiology Lead

An officer with training in epidemiology, preferably applied epidemiology, and reporting to the Outbreak Lead, the Epidemiology Lead will:

1. Ensure completeness and accuracy of data capture and management.
2. Analyse descriptive epidemiological data and undertake advanced analyses such as logistic regressions as required.
3. Provide epidemiological insight to assist with outbreak detection including:
    - Modelled transmission networks to flag possible missed connections between cases;
    - Other systems to assist with pattern recognition and outbreak detection.
4. Develop visualisation including:
    - Construction of epidemiological curves;
    - Transmission mapping;
    - Timeline mapping.
5. Write and maintain appropriate reports including:

- Outbreak summaries;
- Detailed outbreak reports;
- Case summaries;
- Morning briefings; and
- Genomic reports.

6. Nominate appropriate epidemiologist and/or information officers to attend site visits with Outbreak Squad if deemed necessary.
7. Consider the requirements for and initial proposals for analytical epidemiological studies to the Outbreak Lead.
8. Supervise other epidemiologists or data entry staff assigned to the outbreak.

DHHS Agency Commander (Representing the State Controller - Health)

The DHHS Agency Commander, representing the State Controller - Health, will:

1. Consider the requirement for broader consequence management in relation to the outbreak.
2. Consider what support or relief (including accommodation) is required to assist in the management or control of the outbreak.
3. Work with the Joint Intelligence Lead and Outbreak Lead to provide regular contact with whole of Victorian Government (WoVG) or relevant agencies.
4. Nominate sector, regulator or other WoVG officers to attend site visits with Outbreak Squads if deemed necessary.
5. Liaise with department divisional leads (where relevant) to ensure linkage to local supports and networks.

State Joint Intelligence Lead (State Control Centre representative)

A representative from the Joint Intelligence Unit, and reporting to the Outbreak Lead, the Joint Intelligence Lead will:

1. Manage the intelligence coordination across whole of government (WoVG) response agencies for the outbreak.
2. Support the identification of, and make contact with, appropriate contacts and conduits in relevant organisations, in collaboration with the Outbreak Lead.
3. Collect non-epidemiological intelligence regarding the outbreak or setting – for example regulatory requirements.
4. Support the OMT and SCT with regular updated intelligence in relation to the outbreak.

Communications and media lead

Reporting to the Outbreak Lead, the Communications and Media Lead will:

1. Coordinate all media responses.
2. Create proactive and reactive media lines relating to the outbreak.
3. Create all external or public facing communications relating to the outbreak – for example new fact sheets or workplace specific materials.
4. Update websites as required pertaining to the outbreak.

5. Ensuring all communications are in line with the Communications policies for personal information.
6. Link with the State Control Centre Public Information Unit to support any whole of Victorian Government messaging, public information and warnings if required.

Outbreak Squad Coordinator

Reporting to the Outbreak Lead, the Outbreak Squad Coordinator is responsible for the coordination and logistics of any Outbreak Squad deployment of the relevant professionals who are required to undertake setting(s) visits as part of outbreak management. The Outbreak Squad Coordinator will attend all OMT meetings whether or not a Squad is deployed.

The Outbreak Squad Coordinator will:

1. Coordinate the logistics required to support the Outbreak Squad.
2. Source appropriate members of the Outbreak Squad in consultation with the OMT.
3. Ensure all members of the Outbreak Squad:
    a. are available and have appropriate resourcing/equipment;
    b. have appropriate qualifications, training and authorisations to be undertaking field work;
    c. are coordinated and able to undertake the relevant inspection, risk assessments, data collection, interviews, testing and other actions as determined to be necessary by the OMT at the initial meeting in a timely and efficient manner.
4. Ensure a safe working environment for Outbreak Squad members.

The Outbreak Squad Coordinator will also liaise with other relevant areas of the PHIMT and/or department to identify the appropriate people or resources required for any site visit such as:

1. Mobile or outreach testing through Health and Wellbeing Division;
2. Infection prevention team for Infection Prevention and Control Consultants;
3. Physical distancing team for occupational physicians;
4. Joint Intelligence lead for external agency requirements.

See Appendix 1 for further description of the remit of the Outbreak Squads.

Administrative Support Officer

Reporting to the Outbreak Lead, the Administrative Support Officer will:

1. Coordinate OMT meetings, take minutes and document actions arising.
2. Create a central point for outbreak documentation and save all relevant documents there.
3. Support the Outbreak Lead and other OMT members with any other administrative tasks.

Additional roles might include a Laboratory Liaison lead and Environmental or Infection Prevention Control Lead, and potentially department divisional leads.

Potential additional members of an Outbreak Management Team

Other roles and representatives may be included in the OMT depending on the nature and setting of the outbreak, at the discretion of the DPHC CCOM. This will include the Aged Care Quality and Safety Commission, Commonwealth Department of Health (State Office and Aged Care Policy and Programs), Ageing and Carers Branch (DHHS) for outbreaks in residential aged care; representation from Health and Wellbeing Division when liaison with health services is required; a pathology lead (e.g. liaison with testing laboratories) or environmental lead (e.g. coordinating environmental risk assessment); other

departmental stakeholders (e.g. regulators and commissioning groups); and external representatives of other departments where relevant, such as with an outbreak in a prison setting.

Outbreak Meetings

The following meeting will take place as a regular briefing:

- Daily outbreak briefing (09:40h on Teams)
    - Chaired by the DPHC CCOM;
    - Meeting involving Outbreak Management Team leads, Public Health Commander, Deputy Public Health Commander, State Controller (or delegate), Outbreak Squad Operations and Coordination Director, Public Health Emergency Operations and Coordination Deputy Secretary and Assistant Deputy Secretary.
    - Operational discussions relating to new and currently active outbreaks.
    - Discussion of outbreaks of concern.

Key elements of the outbreak response

Identifying an outbreak

Early identification and rapid management of outbreaks is critical to interrupt transmission.

The responsibility for recognising an outbreak depends on the setting. In some settings, including many sensitive settings, prompt recognition of an outbreak is a joint responsibility between a facility and the department.

In most cases, however, identifying an outbreak is a responsibility of the department. Multiple mechanisms exist to identify outbreaks, including to identify linked cases, including:

- COVID-19 Clusters spreadsheet on Teams site (COVID-19-Outbreaks-DHHS-GRP).
- Epidemiological insights into data by the Intelligence team (e.g. modelled transmission networks to flag possible missed connections between cases, other systems to assists with pattern recognition and outbreak detection)
- Analysis of genomic data by the Microbiological Diagnostic Unit Public Health Laboratory (MDUPHL) – see Appendix 2 for further detail on genomics
- Case/s notified to CCOM team via investigations.
- Cases identified via communication with contacts.

When cases are identified that clearly meet the definition of an outbreak (a single case in an aged care facility or two cases in the same workplaces) an OMT can be immediately established in consultation with CCOM Operations Lead and the DPHC CCOM to determine membership of the OMT. In all other circumstances a Problem Assessment Group will be formed (see below).

Problem Assessment Group (PAG)

A problem assessment group should be convened when any member of the Public Health Incident Management team identifies any of the following:

- Potentially linked cases that warrant further investigation.
- A single case in a sensitive setting (other than an aged care facility, for example critical infrastructure or essential service).
- A high profile/high media risk case.

The group should include the DPHC CCOM (or alternative DPHC/PHC who is a public health physician pending immediate availability), the CCOM Operations lead and the Public Health Intelligence Operations lead for that day.

The PAG should determine:

- If an OMT is needed.
- Which available officers should be appointed to the OMT based on relevant experience and seniority determined by the complexity of the initial analysis.
- If there are any additional members of the OMT to the core group listed above required.
- Any complexities with the situation that may require additional actions prior to the OMT meeting.

A PAG should not try to substitute for an OMT. The PAG's primary purpose is to identify whether an OMT is needed and to rapidly ensure that group comes together if needed.

An Outbreak Management Team should be formed immediately if the PAG assesses this is required.

The decision to form an OMT should be sent from the DPHC CCOM in email summary to the Public Health Commander and DHHS Agency Commander within one hour. It is the responsibility of the Public Health Commander to inform the Chief Health Officer who will further inform the Deputy Secretary Public Health Operations and Coordination, State Controller- Health and the Minister's Office if they consider that there is sufficiently high risk and/or immediate media attention is anticipated. It is anticipated that the Public Health Commander will include in their briefing of the Chief Health Officer a recommendation as to which senior stakeholders should be informed by the Chief Health Officer of the institution of the OMT.

Initial investigation and response activities are undertaken as part of routine case and contact management and are likely to be completed or commenced prior to the OMT (table 1). A delay in completing these activities, however, should not delay convening a PAG or OMT.

Table 1. Initial investigation and response steps prior to/concurrent with OMT

Investigation step	**Responsible**
Cases - Complete case interviews - Confirm infectious periods - Confirm incubation periods - Confirm acquisition period	Case and contact lead
Contacts - Identify all contacts - Identify high risk contacts/vulnerable contacts	Case and contact lead
Exposure sites (upstream and downstream) - Identify all exposure sites for each case - Document/create exposure sites on PHESS	Case and contact lead Epidemiology lead
Response step	**Responsible**
Cases - Notify cases in writing of their obligations - Ensure appropriate treatment and isolation is occurring - Ensure appropriate education has been received, including regarding any legal directions pertaining to isolation requirements	Case and contact lead
Contacts - Notify close contacts in writing of their obligations Ensure appropriate quarantine is being undertaken - Ensure appropriate education has been received, including regarding any legal directions pertaining to isolation requirements	Case and contact lead
Exposure sites Notify exposure sites in writing of their obligations, provide with relevant cleaning and/or disinfection information - Ensure appropriate PPE and other infection control procedures are being undertaken	Case and contact lead
Initial notification step	**Responsible**
Internal notification - Ensure a brief summary of key information is provided to OMT members.	Outbreak Lead

Outbreak Management Team

An Outbreak Management Team (OMT) will be established for each identified outbreak (as per the outbreak definition) and will coordinate the full outbreak response. Many initial responses will occur concurrently as part of routine case and contact management processes, however, the OMT should ensure all of these are documented as part of outbreak reporting processes.

The outcome of the first OMT meeting will be agreed decisions on the initial assessment, control measures and communications priority tasks to enable a bespoke Outbreak Management Plan for that outbreak to be drafted. This plan will be updated daily prior to the morning OMT meeting with actions updated after that meeting. See Appendix 3 for an example template of this plan.

The OMT will meet at least daily while the outbreak is being actively managed and the Outbreak Lead will brief the DPHC CCOM and DHHS Agency Commander daily on the outbreak, providing a daily summary outbreak report. Escalation will occur as per the below escalation criteria.

An initial outbreak meeting agenda is in Appendix 4.

Outbreak Squads

Single point source outbreaks may need a single visit or no input at all from an Outbreak Squad, whereas continuing common source settings will almost always need a site visit, and possibly ongoing input.

Outbreak Squad deployment will be based on a range of factors including:

- Level of sensitivity of outbreak setting;
- Capacity of outbreak setting to implement required controls;
- Concerns on the part of the department or evidence over lack of compliance to required measures;
- High case numbers at initial presentation of outbreak, indicating that ongoing transmission has been taking place for an extended period of time.

An Outbreak Squad Coordinator will attend all OMTs and a decision will be made whether or not to deploy a squad.

If a site visit is necessary, consideration must be given to which team members need to go.

The decision on timing and number of site visits to the outbreak setting will be made by the Outbreak Lead, based on ongoing assessment of the outbreak, and coordinated by the Squad Lead.

The Outbreak Squad will be operational within the OMT with the Squad Lead reporting to the Outbreak Lead until the outbreak is declared over. Additional information about Outbreak Squads is in Appendix 1.

Daily Activities

The department will maintain active involvement in each outbreak throughout the course of the outbreak. This includes continuing regular daily activities. The outcomes of these activities determine whether further actions or investigations are required.

Step	Responsible	Documentation
Outbreak management team meetings	Outbreak Lead	Action notes from meeting recorded in TRIM
Daily contact with cases and close contacts. Clearance from isolation or release from quarantine when appropriate. Note: the role of a facility or setting depends	Case and Contact Management Lead	PHESS file note for each case and contact.

on the type and reliability. This might range from being asked to provide data, to actually doing the contact tracing themselves. This will be determined by the OMT and based on predetermined criteria.		
Daily contact with the facility or setting while the outbreak is 'active' - Checking that actions being undertaken - Appropriate communications to staff etc	As nominated by OMT – pending regular visits or not, dependent on type of facility and major components of DHHS input (e.g. infection control, or occupational medicine or case management)	Written evidence of contact in TRIM file (e.g. email to facility lead)
Site visit reports for all Outbreak Squad visits	Outbreak Squad Coordinator	Squad report saved on TRIM
Daily outbreak report updates with review of epidemiology curve, hypothesis and other information (e.g. genomics)	Epidemiology Lead	Recorded in the individual outbreak management plan and saved on TRIM
Daily review of support and relief requirements, and risk and consequences	DHHS Agency Commander	Recorded in the individual outbreak management plan and saved on TRIM
Briefing Public Health Command team, the CHO and the Minister for Health	DPHC CCOM	Daily email summary, saved on TRIM.
Targeted exposure site/sector/stakeholder communications and responses	As determined by OMT - Outbreak Squad - Joint intelligence Unit - Case and Contact Management - Communications and Media	Formal written communication (e.g. by email). Saved on TRIM.

Points of Escalation

Escalation is the process of involving higher levels of governance for one or two reasons: firstly to share information to enable awareness (which might prompt a different course of action but may not necessarily), or secondly to move the management of a particular risk to a higher level of governance, due to the complexity / risk / consequences and accountability for the decision.

In the following situations there should be information escalated to the DPHC CCOM and then the Public Health Commander:

- A confirmed case in a sensitive setting.
- A significant increase in the number of cases in any one day.

- A death associated with an outbreak.
- An outbreak that is likely to attract significant media attention.
- A case linked to an outbreak that exposes a secondary site (potentially generating a second outbreak location).
- An outbreak involving individuals or organisations where there is evidence of significant non-compliance or inadequate capacity or capability to comply with DHHS requirements. This may be evidenced through delays in the provision of critical information.
- An outbreak involving individuals or organisations where there is evidence of non-compliance with DHHS legal directions.
- An outbreak where there are two or more generations of cases (outside of household transmission) after the first case was identified and notified to DHHS, i.e. initial evidence of potentially non-effective control measures.
- Where there are concerns regarding preparedness activities as requested by DHHS or other regulators.
- Where there are potential or actual impacts with broader consequences for communities.
- Further escalation will be to the Chief Health Officer who will inform the State Controller-Health, Deputy Secretary Public Health Operations and Coordination, the Secretary and the Minister's Office as required.

Closure of an outbreak

An outbreak is declared over (no longer active) after two full incubation periods (28 days) since the day the last case is effectively isolated.

Step	Responsible	Documentation
Determining that the outbreak meets above criteria for being declared over	DPHC CCOM	Recorded in the Outbreak Management Plan
Closure of outbreak on PHESS	Epidemiology Lead	Recorded on PHESS
Finalise Outbreak Report	Epidemiology Lead	Final Outbreak Report saved on TRIM
Evaluation/discussion	Determined by DPHC CCOM. Every outbreak should have a final debrief meeting documented, including a rapid evaluation of the work of the OMT and any on-site work by the Outbreak Squad.	Evaluation documented and saved on TRIM.

Outbreaks in Sensitive Settings

Sensitive Settings

Sensitive settings are defined as settings where there is a high risk of rapid transmission of COVID-19 and/or where there are vulnerable people who are at high risk of serious illness or death. Put another way, a sensitive setting is a setting where factors come together that cause high attack rates amongst people at the setting, and potentially increased morbidity and mortality from COVID-19 if there is transmission.

Early detection and rapid management of suspected or confirmed cases in these settings is critical to limit the spread of the virus and reduce the potential for severe illness or death.

The following are considered sensitive settings:

- Residential and Aged Care Facilities (RACF)
- Healthcare and mental health settings
- Prison/Justice settings (correctional facilities, detention centres)
- Aboriginal rural and remote communities
- Accommodation with shared facilities
- Defence force operational settings
- Boarding schools and other group residential settings
- Schools
- Childcare centres
- Remote industrial sites with accommodation (e.g. mine sites)
- Certain high-risk work sites where workers are unable to undertake physical distancing or where outbreaks have been identified in the past:
    - Meat processing or other manufacturing plants
    - Restaurants/industrial kitchens
    - Workplaces with highly casualised workforces (who may be less likely to report symptoms)
- Settings with high-risk potential or actual impacts and broader consequences for communities, where physical distancing cannot be undertaken, and in critical infrastructure and essential services workplaces, including:
    - Banking and finance (banks, insurance, payroll, accounting)
    - Communications (telecommunications and data centres)
    - Energy (power generation, fuel supply and transmission)
    - Food and grocery logistics (processing, manufacturing and supply)
    - Government (frontline and critical services)
    - Transport (airports, transport maintenance and operations)
    - Water (supply and disposal facilities)
    - Emergency services (police, fire, ambulance)

See Reference materials for further guidance on sensitive settings

Outbreak Briefings and Reports

Summary of outbreak briefings, plans and reports

- Daily COVID-19 Intelligence Morning Briefing
    - Sent by PH Intelligence to Public Health Command and CCOM/Intelligence Leads, DHHS Agency Commander and State Controller-Health, Outbreak Squad Operations and Coordination Director, Public Health Emergency Operations and Coordination Deputy Secretary and Assistant Deputy Secretary in the mornings (by email, typically between 8-9am)
    - Includes summary statistics and background on currently active outbreaks.
- Individual Outbreak Management Plan
    - This plan will be created after the first OMT meeting and will be updated daily prior to each OMT meeting with actions added immediately after the meeting.
- Daily Outbreak email summary – bullet points for each active outbreak
    - Sent by DPHC CCOM to Public Health Commander, DHHS Agency Commander and State Controller-Health, Outbreak Squad Operations and Coordination Director, Public Health Emergency Operations and Coordination Deputy Secretary and Assistant Deputy Secretary (typically between 6-7pm)
- Outbreak Report – finalised upon closure of the outbreak
    - The outbreak report will be a finalised version of the Individual Outbreak Management Plan.
    - Sent by DPHC CCOM to Public Health Commander, Chief Health Officer, DHHS Agency Commander and State Controller-Health, Outbreak Squad Operations and Coordination Director, Public Health Emergency Operations and Coordination Deputy Secretary and Assistant Deputy Secretary within 2 weeks of outbreak closing

Business rules for distribution of outbreak reports and data requests

Additional requests for outbreak reporting products (or more detailed outputs, e.g. underlying line lists) may occur over the course of the pandemic. For each request, the relevant data custodian will determine the appropriateness of response and will need to seek approval for provision of information from the DPHC CCOM on a case-by-case basis.

Requests for support or additional Joint Intelligence Unit products should be forwarded to the State Controller–Health for assessment sccvic.sctrl.health@scc.vic.gov.au, cc: sccvic.stratintel@scc.vic.gov.au.

Tips for Liaising with Stakeholders

- Identify a single point of liaison (role / person) in the department and for the setting – ensure name, role, email and phone number are exchanged.
- After an OMT or a teleconference with stakeholders, send a short confirmation of agreed assessment and agreed actions by email.

Evaluation

Key Performance Indicators (KPIs)

Following identification of a single case of COVID-19 in a sensitive setting, or identification of an outbreak in another setting, the following KPIs should be met:

Within 1 hour

- A verbal discussion with the Deputy Public Health Commander Case Contact and Outbreak Management [responsibility of CCOM Team Lead or other officers who may identify a potential outbreak].

Within 2 hours

- A written heads-up to Deputy Public Health Commander Case Contact and Outbreak Management, DHHS Agency Commander, Public Health Commander and Outbreak Squad Operations and Coordination Director [responsibility of CCOM Team Lead or other officers who may identify a potential outbreak].
- Problem Assessment Group has been convened and met to determine the need for an OMT [responsibility of DPHC CCOM].

Same day – 50 Lonsdale St

- Outbreak Management Team convened, and first meeting occurred [responsibility of designated Outbreak Lead].
- Confirm the presence of an outbreak.
- Make contact with the setting and commence a risk assessment.
- Initial notified case interviews and exposure sites entered into PHESS.
- Construct a working case definition.
- Determine requirement for site visit.
- Determine external stakeholders who require to be notified.
- Determine support or relief requirements.
- Provide a written summary to for PHC to forward to CHO, and subsequently the Deputy Secretary Public Health Operations and Coordination, State Controller- Health and the Minister's Office [responsibility of DPHC CCOM]

Within 12 hours (extended business hours) – 50 Lonsdale St

- Commence contact tracing of identified contacts.
- First draft of Outbreak Management Plan completed.

Within 24 hours – site visit requirements

- Form an Outbreak Squad when required.
- Determine if any other agency personnel are required to attend the site.
- Attend the site.
- Complete a risk assessment to determine whether a closure of the facility / workplace / setting is required or not (if relevant) and provide this information to the OMT lead, Public Health

Commander, DHHS Agency Commander, Deputy Public Health Commander Case Contact and Outbreak Management, Outbreak Squad Operations and Coordination Director.

- Request a list of close contacts and all attendees within risk period in writing from manager / relevant contact person.
- Advise of need and associated requirements for closure in writing (if Deputy Public Health Commander, Case Contact and Outbreak Management determines this is required).
- Advise on immediate environmental controls including in writing if closure is not warranted
- Ensure cleaning and disinfection requirements have been completed.
- Send formal letter to setting manager indicating presence of an outbreak and stating plan/recommendations of the department.
- Escalate request for details of all attendees or close contacts in period of risk if not yet received.
- Send internal Situational-Background-Assessment-Recommendation (SBAR) email to Secretary, Public Health Commander (PHC), Chief Health Officer (CHO), State Controller-Health, Outbreak Squad Operations and Coordination Director, Public Health Emergency Operations and Coordination Deputy Secretary and Assistant Deputy Secretary and Minister's Office (MO).

Within 48 hours – on site actions

- Within the OMT:
    - Review closure decision (if not closed: reconsideration of closure made).
    - Aim to have contacted all close contacts / attendees identified within 48 hours of receipt of initial list, including provision of quarantine/test advice in writing.
    - Initial literature review on specific controls for that setting tasked to Intelligence if new setting.
    - Formal report established by Intelligence and specific KPIs established for the outbreak (1-2 based on specific things that work in that setting from literature).
- In relation to onsite:
    - Ensure definitive environmental cleaning and disinfection review commenced (IPC lead) or controls expectation provided in writing.

Closure of the outbreak

- Final outbreak report completed.
- Debrief documented.
- Lessons learnt incorporated into outbreak management plan.

Reference Documents

Guidelines

Document	Internal / External	Link to Document
Outbreak specific documentation		
COVID-19 Outbreak management plan (this document)	External	
COVID-19 Outbreak management protocol	Internal	
COVID-19 Outbreak management guidelines for residential care facilities	External	
COVID-19 Outbreak management guidelines for sensitive settings	External	
COVID-19 Outbreak management standard operating procedure	Internal	
COVID-19 PHESS – Cluster Quick Entry Guide	Internal	Link
COVID-19 Outbreak action plan template	Internal	
COVID-19 Intelligence Team Outbreak Plan	Internal	
Supporting documentation		
Case Questionnaire COVID-19 (Novel Coronavirus)	Internal	Link
Case and Contact Management Guidelines	Internal	
COVID-19 Guidelines for Health Services and General Practitioners	External	
Healthcare worker PPE guidance	External	Link
Managing upset, angry, confused or challenging callers	Internal	Link
New Cases Standard Operating Procedures		
New Contact Cases Standard Operating Procedures		
PHESS Summary Notes	Internal	
Screening of visitors for COVID-19 - Advice for sensitive settings	External	Link
State Emergency Relief Plan for COVID-19	External	

Factsheets

Factsheet	Audience	SharePoint Link
Confirmed Case	External	Link
Suspected Case	External	Link
Close Contact	External	Link
Telephone Interpreter Service	External	Link

System Requirements

1. PHESS
2. TRIM/EDRM
3. DHHS Intranet
4. Microsoft Teams/SharePoint
5. PureCloud Telephony

Appendix 1

Public Health Outbreak Control Squads

Role and focus

A new Public Health Outbreak Control Squad function (squads) will be established in DHHS to ensure the rapid deployment of public health outbreak control squads to sites of COVID-19 outbreaks. Working closely with the new outbreak joint intelligence unit, the public health team will place new outbreak squads on the ground at outbreak sites.

The squads will be supported by public health services across Victoria. Squads will deliver rapid testing, infection prevention and control, isolation of close contacts and support and relief to ensure effective containment of public health risks. The squads will deliver a dedicated focus to ensuring testing, contact tracing and deep cleaning is carried out as soon as a potential outbreak is identified. That includes delivering rapid mobile testing at outbreak sites.

The new Public Health Outbreak Control Squads will deliver rapidly responding mobile expertise of infection prevention and control specialists, nurses, epidemiologists, environmental hygienists and others as required to respond to the circumstances of the outbreak.

In addition to the outbreak control squads, the public health team will increase infection prevention and control activities in relation to COVID-19, including a workforce of infection control outreach nurses employed to focus on both infection prevention and control preparedness in high risk settings, as well as contribution to on the ground outbreak control squads.

The new function will work within each Outbreak Management Team, including closely with the COVID-19 Joint Intelligence Unit to enable a whole-of-government response to the outbreak. The public health team within DHHS as a whole will work closely with the COVID-19 Joint Intelligence Unit to provide public health input and support to assist the Unit in its work in identifying and managing potential threats, developing response plans and communications to government, industry and the community.

Squad composition

A new squad co-ordination and operations director will work with Public Health Command to rapidly stand up a control outbreak squad to provide field support to ensure Outbreak Management Teams can respond to any new COVID-19 outbreak and work closely with the COVID-19 Joint Intelligence Unit to enable a whole-of-government response to the outbreak.

The outbreak control squads will build on the existing public health management process, to enable additional and rapid support at outbreak settings – with the immediate aim of ensuring the public health risks arising from the outbreak are controlled.

The public health response in an outbreak will be led by the Outbreak Management Team, which determines the composition of the team required to manage the public health risks.

Functions of the squads may entail:

- Case and contact management
- Epidemiological data collection and analysis
- Infection control advice
- Testing, including ensuring mobile testing at site

The outbreak control squads will be multidisciplinary public health teams. Composition of the outbreak control squad could include a combination of:

- Lead logistics and coordinator
- Case and contact management – public health officer from the Case and Contact Management (CCM) cell
- Epidemiologist or Information officer– from the public health intelligence Cell
- Infection control outreach nurse – from the Infection Prevention and Control cell
- +/- Mobile testing unit
- +/- translator if required
- Emergency Management support and relief staff.

On the ground staff will usually require at least one Authorised Officer.

The team will be led in the field by the senior member based on the focus of the Squad's activities. The Squad will receive direction from and report back to the OMT via the Squad Lead.

Activation of outbreak control squad

The Outbreak Management Team will identify cases or outbreaks requiring rapid, multidisciplinary, on the ground support at the outbreak site, based on a risk assessment approach.

Squad deployment will be based on a range of factors including:

- Level of sensitivity of outbreak setting
- Capacity of outbreak setting to respond
- Concerns or evidence over lack of compliance to required measures
- High case numbers at initial presentation of outbreak, indicating that ongoing transmission has been taking place for an extended period of time.

Engagement with the Outbreak Squad commences at the initial OMT meeting via the Squad Lead. The decision to deploy a squad is made at this initial meeting and, in situations where a Squad is not deployed revisited at subsequent meetings. It is ultimately the decision of the Outbreak Lead.

Pre-deployment briefing

A pre-deployment briefing must take place that provides a situation update on cases and contacts, and information on the setting to date. Roles and responsibilities are expected to be as follows but must be confirmed before deployment:

Roles and responsibilities

A squad may be deployed involving as few as two persons, and potentially a wider number of the roles below.

Squad member	Roles and responsibilities
Outbreak Squad coordinator	Management of the squad Logistics Health and Safety
Case and contact management	Interview cases and identified close contacts Contact management
Intelligence	Data collection and analysis to inform to inform outbreak characterisation and ascertain transmission dynamics

Infection control outreach nurse	Review infection control plans and procedures in place On the ground inspection of facility adherence to infection control guidance Review of PPE use and staff donning/doffing procedures if relevant Make recommendations for improved infection control, e.g. physical barriers and cohorting
Environmental Health Officer	Advise on site set up, systems, environmental cleaning
Emergency Management Officer	Assess support and relief needs Links to Local services, support and trusted networks
Mobile testing unit	Testing of facility staff/residents if appropriate

Informing the outbreak setting of squad deployment

The Outbreak Squad Coordinator will contact the identified outbreak setting manager/liaison and inform them of the planned deployment of the outbreak control squad to their location. An explanation should be given outlining the reason for the activation and deployment, the legislative environment that supports these activities, an explanation of what the squad intends to do on site, and what the objective is of the visit. Their full cooperation, support and assistance should be sought.

Documentation

The following should be documented by the Outbreak Squad Coordinator and provided to the Outbreak Management Team to form a section of the outbreak report:

- Rationale and decision to stand up outbreak control squad;
- Composition of squad including presence of authorised officer (AO);
- Date(s) squad deployed to outbreak site;
- Form for site assessment – site report
    - Case and contact management
    - Physical distancing
    - Infection control processes
    - Environmental measures including cleaning
    - Data collection
- Recommendations from site visit
- OHS requirements for site visits, including travel arrangements
- Records management processes

Appendix 2 – Use of Genomics

Use of Genomics

Microbiological Diagnostic Unit (MDU) Public Health Laboratory

MDU is currently engaged with the department in a COVID-19 Genomics Collaboration that seeks to improve COVID-19 surveillance through integration of COVID-19 genomic data (obtained by MDU) with epidemiological data (obtained during case investigation by the department). Combined epidemiological and genomic sequence data will be added to an integrated data visualisation tool (named SeeSARS-2) to visualise relationships between SARS-CoV-2 sequences.

The degree to which genomic relatedness between sequences can be used to infer transmission networks for SARS-CoV-2 is not yet known. Interpretation of clusters of infection will be dependent on both epidemiologic and genomic data.

MDU epidemiologists and bioinformaticians will:

- Perform genome sequencing on all SARS-CoV-2 positive samples received at VIDRL or MDU.
- Within 24 hours of availability, add sequence data to the SeeSARS-2 integrated data visualisation tool to visualise relationships between SARS-CoV-2 sequences.
- Examine the combined data to identify additional genomic clusters and, where possible, answer questions posed by the department.
- Allocate a 'genomic cluster ID' to sequences where the degree of genomic relatedness is consistent (supports the existence of a cluster) and provide this information back to the department.
- Upload sequences without metadata to public viral sequence databases (GISAID and NCBI).

Clusters of interest and other related topics at a weekly meeting involving representatives of department, MDU and VIDRL.

The Outbreak Intelligence member of the Outbreak Squad is the designated departmental liaison with MDU. Any requests for genomic information from people working on COVID-19 outbreaks should be sent via email to REDACTED by 12pm on Mondays to allow representatives from MDU sufficient time to comment, including the following information:

- Question being asked of the data (e.g. is Case X genomically linked to Cluster Y).
- Relevant PHESS numbers.
- Brief statement on priority/rationale (e.g. name of cluster, level of risk/sensitivity, whether it is in a healthcare setting).

Outbreaks in sensitive settings (with a clear question that can reasonably be answered by the genomic data, given the limitations) will be given the highest priority. Outbreaks involving health care workers and/or healthcare settings will also be given priority.

Documents pertaining to Genomics will be stored in the PUBLIC HEALTH – HEALTH PROTECTION – MDU genomic sequencing folder on TRIM (IIEF/20/1215). This includes:

- Protocol documents
- Meeting minutes

- Genomic data requests
- Genomic reports

Information delineated from genomic investigation will be shared with the department for integration with epidemiological data and use in public health control of COVID-19 under the *Public Health and Wellbeing Act 2008*. Further dissemination, reporting or publication of genomic or epidemiological data will only be performed in collaboration with the department. No data to come from genomic investigation under this project will be shared with external parties without the written permission of the department. The department retains the right to veto publication of genomic information obtained through this project.

Appendix 3 – Outbreak Management Plan template

Purpose

[Insert general purpose and statement relating to use of the report in OMT meetings]

Governance

Outbreak Management team

Functional role	Name:	Mobile No:	Email:
Outbreak Lead			
Case and Contact Lead			
Epidemiology Lead			
Joint Intelligence Lead			
Communications and Media Lead			
Outbreak Squad Coordinator			
DHHS Agency Commander			
Administrative Support Officer			

Outbreak Management Team meeting dates

Situation

[Insert overview of the situation]

Epidemiological and clinical investigation

COVID-19 in Victoria

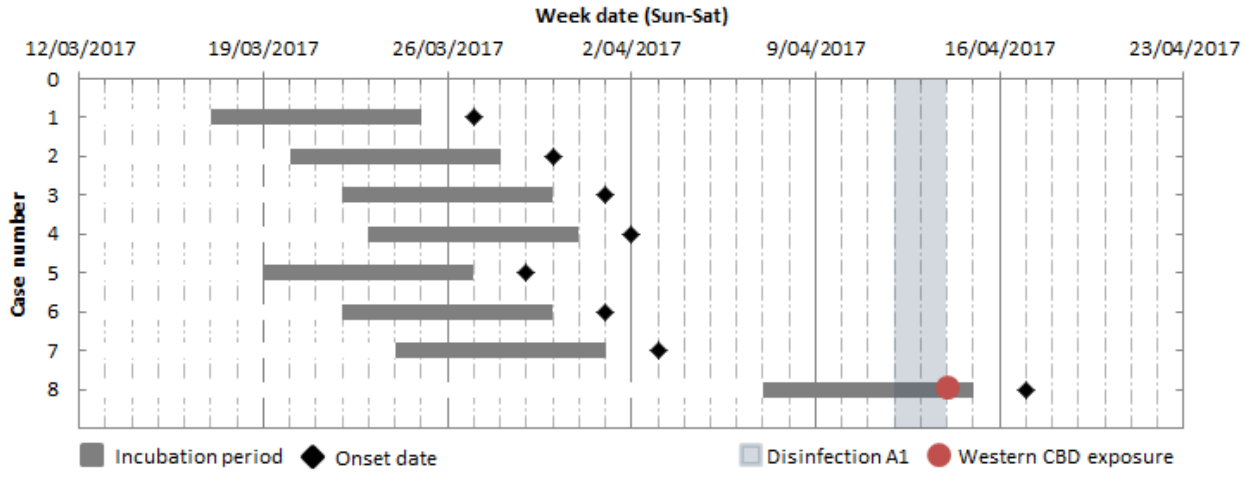
[Insert background epidemiology]

Epicurve

[Insert epidemiology curve. Include at least one incubation period before first confirmed/suspected outbreak case]

[Consider inserting timeline for each case – example for a legionella outbreak is included here]

Figure X [EXAMPLE]: Onset date and incubation period for confirmed and probable cases. Melbourne CBD legionellosis outbreak, as at 5pm 15 May 2017.



Case definitions

Current department case definition

[Include current departmental general case definitions for confirmed cases and testing criteria]

Outbreak case definitions

Confirmed case – outbreak

[Agree a confirmed case definition for the outbreak that incorporates person, place and time]

Suspected case – outbreak

[Agree a suspected case definition for the outbreak that incorporates person, place and time]

Person under investigation – outbreak

[Agree a description of a person under investigation for the outbreak that incorporates person, place and time]

Rejected case

[Insert relevant criteria based on epidemiological, clinical and/or laboratory evidence]

Case follow-up

[Describe case follow-up procedures for both business hours and after hours follow-up

Case finding

[Describe active case finding activities]

Case summary

Total confirmed cases	
Sex distribution	
Age (median, range)	
Date of first notification	
Date of first symptom onset	
Total hospitalisations	
Current hospitalisations	
Total ICU admissions	
Current ICU admissions	
Deaths	

Line list

[Include a line list of each case – can be an attachment if necessary]

Environmental investigation

[Include details of any relevant environmental investigations – eg activities at a given setting, abattoir]

Hypothesis

[Develop a hypothesis for the outbreak that can be tested using epidemiological analysis if necessary]

Control measures

[Describe any control measures taken]

Stakeholder mapping

[List identified stakeholders]

Risk communication

Key events

[Include information on internal communication, including briefings and communication with the Minister's Officer. Detail when media releases and press conference are released/take place]

Escalation point	Date of escalation
Deputy Public Health Commander CCOM	
Public Health Commander	
State Controller-Health	
Chief Health Officer	
Minister's Office	

Communication with exposed settings

[Add dates and details of any communication with workplace/health facility/aged care facility/school etc.]

Chief Health Officer Alert

[Link to CHO alert if developed and issued]

Key messages – health professionals

[Develop and record key messages]

Key messages – general public

Develop and record key messages]

Outbreak Management Team meeting actions list

Action	Due date	Responsible person

Timeline of outbreak

Date	Action

Appendix 4 – Initial Outbreak Management Team Agenda

Step	Responsible
Welcome and introductions	Outbreak Lead
Overall situation report, - confirmation of cases and current epidemiological information - proposed case definition for the outbreak in time, person, place	Epidemiology Lead
Case and contact management actions to date	Case & Contact Management Lead
Risk assessment to determine: - Further information required regarding cases? o Expedite genomics if required - Further information required regarding contacts? o Broaden or change definition? - Further information required regarding exposure site/s? o Site maps o Rosters o Sampling o Plans and procedures o Infection control/hygiene/social distancing plans o Critical/essential service o Workplace demographics - Whether site visit is necessary at one or more sites by an outbreak squad?	All – a decision will be made as to the need for an Outbreak Squad.
Hypothesis for transmission	All – guided by Epidemiology Lead
Control measures - Isolation of cases - Quarantining of close contacts - Environmental measures in place - Setting closure considered - Active case finding strategy discussed (including screening)	

- Sector specific responses	
Support and Relief requirements	DHHS Agency Commander
Identification of relevant stakeholders and agencies to contact/seek details for - Government – internal and external - Industry - Regulators - Unions - Media - Exposure sites	Outbreak Lead supported by Joint Intelligence Lead and other members
Risk communication - Agree reporting requirements, including outbreak reports, TRIM file etc - Media and communications plan and immediate requirements.	Epidemiology Lead Communications and Media Lead
Actions and agreed timelines	Outbreak Lead

Fwd: Rydges on Swanston qu

From: REDACTE (DHHS)"REDACTED
To: REDACT (DHHS)" REDACTED "Simon Crouch (DHHS)" <REDACTED
Cc: REDACT (DHHS)" REDACTED REDACT (DHHS)" REDACTED
Date: Sat, 30 May 2020 10:51:23 +1000

Hi RE and Simon,
See below for first Rydges case sequencing - clusters with cases from REDAC 2nd case hopefully available soon - will be v interesting to see if it clusters with the same cases or not.
I don't know who's running the Rydges OMT today so could you or RE or RE forward this to the right people please?
Get Outlook for iOS

From: REDACTED
Sent: Saturday, May 30, 2020 10:36:47 AM
To: REDACT (DHHS) <REDACTED
Cc: REDACT (DHHS) <REDACTED REDAC (DHHS) <REDACTED
Subject: Fw: Rydges on Swanston qu

Hi RED (and company),

We now have results for one of the Rydges cases - 320203450603.
The sample from the other Rydges case, 320203487846, is undergoing sequencing over the weekend - and provided there are no hiccups, should be available early next week.

However, we do have some interim results.

In particular, the sequence from case 320203450603 is in the same genomic cluster as sequences from four cases reporting travel to REDAC and who are listed as contacts of each other, with initial positive specimen collection between 13 and 16 May. These cases are listed in Table 1.

Table 1: Cases that cluster genomically with case 320203450603

PHESS_ID	Surname	First name	Date of Birth	MDU_ID	VIDRL_ID	Originating lab	Originating lab ID	Collection date	Genomic cluste
320203280317	REDACTED	REDACTED	REDACTED	2020-14329	20203884	DHHS-V	NA	16/05/2020	Yes
				2020-14684	20205307	DHHS-V	NA	19/05/2020	Yes
320203280574				2020-14683	20205305	DHHS-V	NA	19/05/2020	Yes
320203300010				2020-14270	20201243	DHHS-V	NA	13/05/2020	Yes
				2020-14676	20205191	DHHS-V	NA	19/05/2020	Yes
320203360831				2020-14328	20203875	DHHS-V	NA	16/05/2020	Yes
				2020-14677	20205193	DHHS-V	NA	19/05/2020	Yes
320203450603				**2020-25051**	**20210985**	**MMCC-V**	**204567201**	**25/05/2020**	**Yes**

RE provided a list of 14 cases for comparison with 320203450603 and 320203487846, which are in Table 2. We currently have sequences available for nine of these cases, none of which are in the same genomic cluster as those listed above.

Table 2: Cases provided for genomic comparison with cases 320203450603 and 320203487846

PHESS_ID	Surname	First name	Date of Birth	MDU_ID	VIDRL_ID	Originating lab	Originating lab ID	Collection date	Sequence avail
320203127673	REDACTED	REDACTED	REDACTED	2020-14737	20181598	DHHS-V	NA	2/05/2020	Yes
				2020-14313	20202420	MELP-V	358991656	10/05/2020	Yes
320203272623				2020-14675	20205190	DHHS-V	NA	19/05/2020	Yes
				2020-14311	20202418	MELP-V	358998568	10/05/2020	Yes
320203321187				2020-14298	20201850	DHHS-V	NA	14/05/2020	Yes
320203321188				2020-14299	20201871	DHHS-V	NA	14/05/2020	Yes
320203321405				2020-14296	20201746	DHHS-V	NA	14/05/2020	Yes
320203383387				2020-14674	20205057	DHHS-V	NA	19/05/2020	Pending
320203444169				2020-14965	20209783	DHHS-V	NA	23/05/2020	Yes
320203444179				2020-14964	20209782	DHHS-V	NA	23/05/2020	Yes
320203406041									Pending
320203406042									Pending
320203446573									Pending
320203446575									Pending
320203446577									Pending
320203474768									Pending

We'll keep you updated as more results become available,

Thanks,

REDA

From: REDACT (DHHS) REDACTED
Sent: Friday, 29 May 2020 1:20 PM
To: REDACTE REDACTED
Cc: REDACT (DHHS) REDACTED REDAC (DHHS) REDACTED
Subject: Rydges on Swanston qu

Hi REDA
RE is away today and I have a quick question re genomics that has been ongoing this week. We sent through a couple of PHESS IDs re the Rydges on Swanston outbreak.
Do you have any news on them?
Specifically, the main question is 'do they cluster together?"
If so, there is 1 episode of resident-to-staff transmission. If not, there could be more – important question

The other question is "do they cluster with someone else we know of from overseas?" which will be interesting and help us identify where IPC breaches have occurred, but much less important than 1

If no info available, that's fine but just wanted to make sure all info we have is being used!

Cheers

Outbreak Management Plan – Rydges Swanston

Updated 14 June 2020 at 20:10h (S. McGuinness)

Epi update 13 July 15:00

Purpose

The purpose of this document is to provide an update on the current status of the Rydges on Swanston Street Outbreak.

Governance

Outbreak Management team

Functional role	Name:	Mobile No:	Email:
Outbreak Lead	Simon Crouch Sarah McGuinness Ramona Muttucumaru Naveen Tenneti	REDACTED	REDACTED
Case and Contact Lead	REDACTED		
Epidemiology Lead	REDACTED		publichealth.intelligence@dhhs.vic.gov.au
DHHS Command	Jason Helps		
Joint Intelligence Lead	REDACTED		
Communications and Media Lead	REDACTED		
Outbreak Squad Coordinator	REDACTED		
Administrative Support Officer			

Outbreak Management Team meeting dates

First meeting – 1830 on Tuesday 26 May 2020.

Second meeting – 1130 on Wednesday 27 May 2020

Third meeting – 1000 on Thursday 28 May 2020

Fourth meeting – 1000 on Friday 29 May 2020

Fifth meeting – 1000 on Saturday 30 May 2020

Sixth meeting – 1000 on Sunday 31 May 2020

Seventh meeting – 1230 on Monday 1 June 2020

Eighth meeting – 1300 on Tuesday 2 June

Ninth meeting – 1300 on Wednesday 3 June

Tenth meeting – 1300 on Thursday 4 June

Eleventh meeting – 1300 on Friday 5 June

Twelfth meeting – 1300 on Saturday 6 June

Thirteenth meeting – 1300 on Monday 8 June

Fourteenth meeting – 1200 on Thursday 11 June

Fifteenth meeting – 1300 on Friday 12 June

Outbreak summary (Epi)

A total of **17** cases of COVID-19 epidemiologically associated with the Rydges Hotel on Swanston Street. have been notified to the department in Victoria (an additional case notified in QLD brings the total to 18). One is REDACTED the Rydges Hotel; six are security guards working at the hotel, one is a REDACTED (HCW) working at the hotel, nine are household close contacts of a staff member (secondary contacts – this includes one QLD notification) and one is a close contact of a household contact of a staff member. The first case was notified on 26 May 2020. Rydges Swanston Street was being used for hotel quarantine of returned travellers, specifically positive COVID-19 cases. All staff cases were in those that worked night shift. The first seven staff cases worked overlapping shifts on R E May, and it is hypothesised that there may have been a common exposure on this date. However, the 8th staff case only worked at the hotel from 24-27 May inclusive.

A case (REDACTED) was notified in Queensland on 5 June, symptom onset 1 June 2020. **This case is included in the epi curve but is NOT counted in Victoria case numbers as was diagnosed in Queensland**. This case had six close contacts in Victoria that were investigated by the department. (COVID-net ID - Rydges outbreak REDACTED). The most recent staff case (notified on 9 June 2020) was detected on return-to-work testing, but reported an onset date of 4 June 2020, which is eight days after the end of RE last shift. The case was in isolation during their infectious period (last date of work was 27 May 2020). A new case was notified on 10 June 2020 in a household contact of the most recently notified staff member, who until 27 May 2020 was sharing a room with the staff member.

As of 10 June 2020, five cases show genomic link to a single detainee family. As of the 12 of June 2020,120 close contacts have been identified and all close contacts have been tested. All results so far have been negative; 3 close contacts have pending results for day 11 testing and one is yet to be tested. Rydges is now planned to re-open as a quarantine hotel, but not for positive cases.

On 12 June a new case was notified to the department in a previously known household close contact REDACTED of three confirmed cases (one of whom is a security guard staff member) following a positive day 11 swab while in home isolation.

On 18 June a case was notified to the department in a contact of the case notified in QLD. This case, residing in Victoria, had been identified as a close contact and commenced home isolation on 6 June. The case developed symptoms 11 June and went for testing on 17 June.

Total Confirmed cases	17 (18 including the case diagnosed in QLD)
Total active cases	0
Relationship to exposure site	Household: 8
	Staff: 8
	Social: 1
Sex distribution	Female: Male:
Age (median (range))	25
Indigenous	Indigenous: Non-Indigenous: Unknown:
Date of first diagnosis	26 May 2020
Date of first symptom onset	25 May 2020
Date of most recent symptom onset	11 June 2020
Total hospitalisations	1
Current hospitalisations	0
Total ICU admissions	1
Current ICU admissions	0
Deaths	0
Presumptive first case	– first case notified) preliminary genomics have suggested links with sequences from a family of overseas returnees from in hotel detention at
Close contacts (active)	144 (4)
Casual contacts (active)	46 (38)
Actions (high level)	-

*QLD case not included in the above summary table

Situation

The Rydges on Swanston Hotel currently operates as a mandatory quarantine hotel accommodating people who test positive to COVID-19 during mandatory quarantine and a number of close contacts.

The proposed index case with symptom onset 25 May, tested same day. The case worked the night of May, having travelled by bus from and then by train. He lives in a

Case 2 works as a security guard. Symptom onset 25 May, tested 26 May. The case worked the night of May (drove in by private car). Household contacts include housemates (all of whom work in security) in a house (all are close contacts), none have been confirmed as cases.

Case 3 works as a security guard. reported being asymptomatic and was tested at the request of employer following notification of the first case. Four close contacts were identified within a household. and housemate have since tested positive.

Case 4 works as a security guard. reported being asymptomatic and was tested at the request of employer following notification of the first case. Two close contacts were identified. Case 4 also worked as and lives in a housemates is currently isolating at home. shift schedule is unclear.

Case 5 (RED ACT) works as a security guard. RE reported symptom onset on 27 May. RE was tested at the request of RE employer following notification of the first case. Two household close contacts were identified, both were tested.

Case 6 REDA is a REDACTED nurse whose symptom onset was 29 May (swabbed same day). RE last worked at Rydges on Swanston on RE May. RE also worked at the Marriott Hotel on REDACT May (not during infectious period). RE presented to the Marriott Hotel for a shift on R May, but was turned away by the manager on the basis of RE recent work at the Rydges (as by then, the first 2 cases had been publicly reported). This interaction is currently being investigated to determine if it meets criteria for close contact. R did not work at another health care facility during RED infectious period. RE lives in a REDACTED (deemed a close contact) and was isolating at home until 4 June, at which time RE was transferred to RED by ambulance due to worsening symptoms. RE was admitted to ICU on R June, transferred to ward on R June and granted clinical clearance from the department on 17 June.

Case 7 REDA is a security guard whose symptom onset was 25 May. RE lives in a REDACTED house with REDACTED (all of whom were deemed close contacts) and is currently isolating in emergency accommodation at the REDA hotel. RED housemates have subsequently tested positive.

Four more cases (Cases 8, 9. 11 and 12) are housemates of REDA and had symptom onset 31 May and 1 June. One is a REDACTE with REDAC who worked between RED May.

Two more cases (Cases 10 and 13) are REDA and housemate of RED. One is asymptomatic and was in isolation prior to testing positive.

All staff who attended the site between 11-28 May were asked to seek testing for COVID-19. The majority of staff were tested on-site (swabs taken by on-site nurses, couriered to VIDRL). To date, results received from VIDRL include 127 negative and 2 positive results (cases 5 & 6). Some staff sought testing elsewhere – this includes 19 Alfred health nurses who all tested negative. The highest attack rate is seen amongst security guards, with 5/42 testing positive (remaining security guards have tested negative).

One staff member (REDACTED) was transferred from their home and presented to REDACTED emergency with ongoing fevers, shortness of breath and productive cough. They were admitted to REDACTED ICU late on R June on oxygen, not ventilated.

A housemate of the HCW, who was not mentioned to the department as a close contact, had moved to RE the day after the case was interviewed, has since tested positive in Qld. This case will not be counted in Victoria numbers (as diagnosed in Qld). RE had six close contacts in Victoria who are being followed up. During infectious period, this case took the Skybus (22min journey) to Tullamarine airport and flew to REDACTED A review of the CCTV footage by Skybus management has not revealed any close contacts that have resulted from this exposure. The Melbourne to REDACTED flight has been traced by the REDACTE Public Health Unit.

Case 14 is a staff member previously identified as a close contact of the Rydges exposure site (i.e. who worked there during the period 18-28 May but had no identified contact with a confirmed case). This case was notified to the department and interviewed on 9 June and has a symptom onset date of 4 June. The case was in isolation during their infectious period and does not report having close contact with anyone during this time.

Case 15 is a household contact of case 14 (not previously disclosed / identified) with symptom onset 7-June, diagnosed 10-June. This case is REDACTED however, did not work during their infectious period. This case was not in isolation during their infectious period, and visited a butchers, a chemist, and a friend.

Case 16, symptom onset 7 June, diagnosed 12 June, is a household contact of Cases 12 and 13. Case 16 had been isolating at home for four days with Case 12 before they moved to hotel

accommodation. Case 13 (asymptomatic) had been isolating at the same home in a bedroom with ensuite.

Case 17, symptom onset 11 June, diagnosed 18 June, is a close contact of the RED notified case. They were identified as a close contact and commenced isolation on 6 June.

Epidemiological and clinical investigation

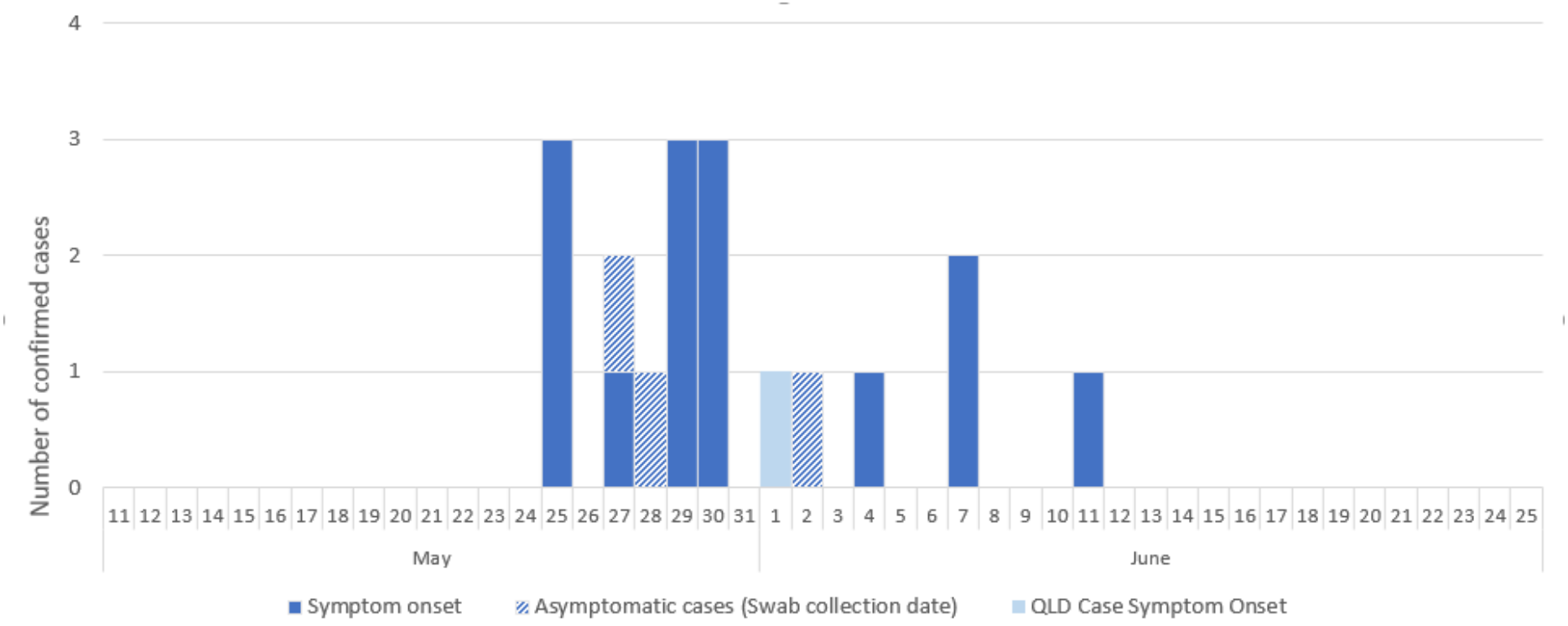


Figure 1: Epidemic curve for Rydges on Swanston Outbreak, by date of calculated symptom onset, including QLD case

*for asymptomatic cases symptom onset is estimated as first positive specimen collection date

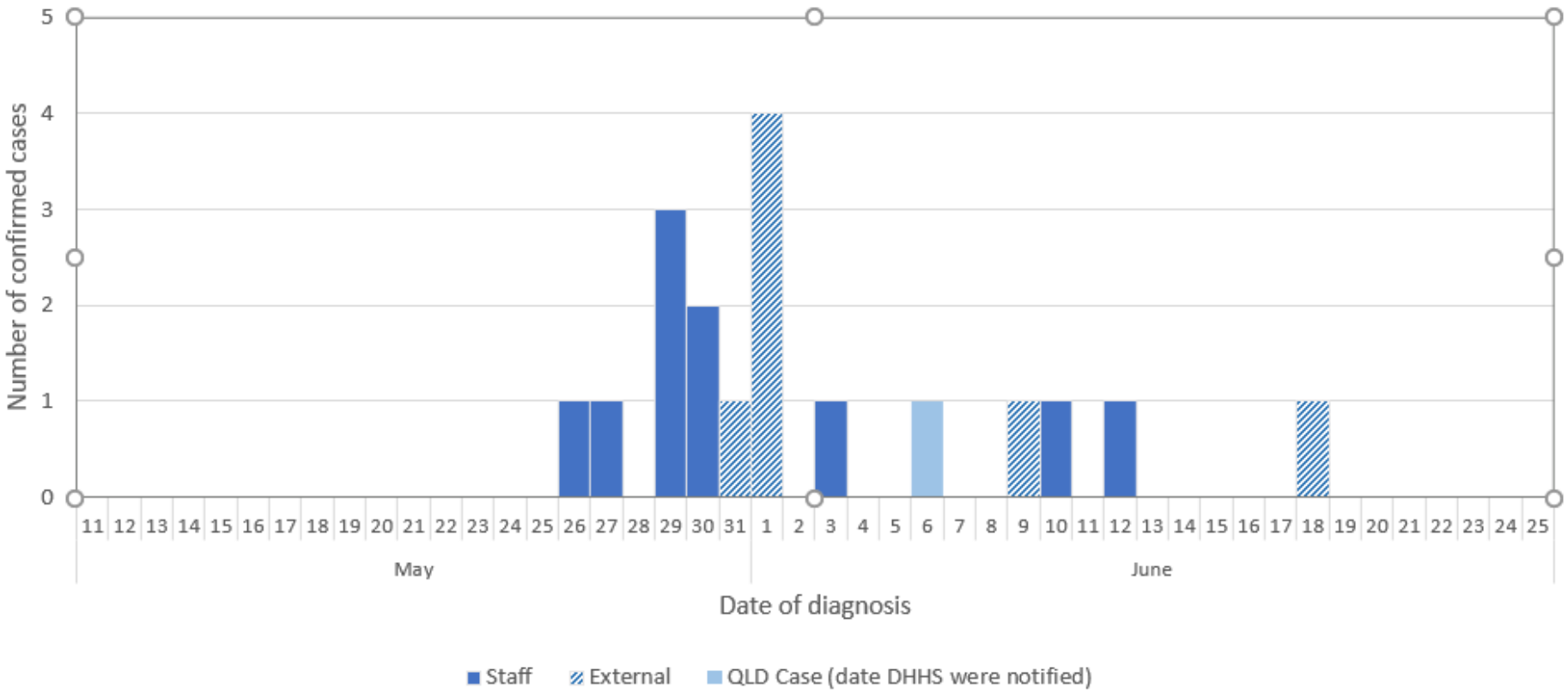


Figure 2: Epidemic curve for Rydges on Swanston Outbreak, by date of diagnosis, including QLD case

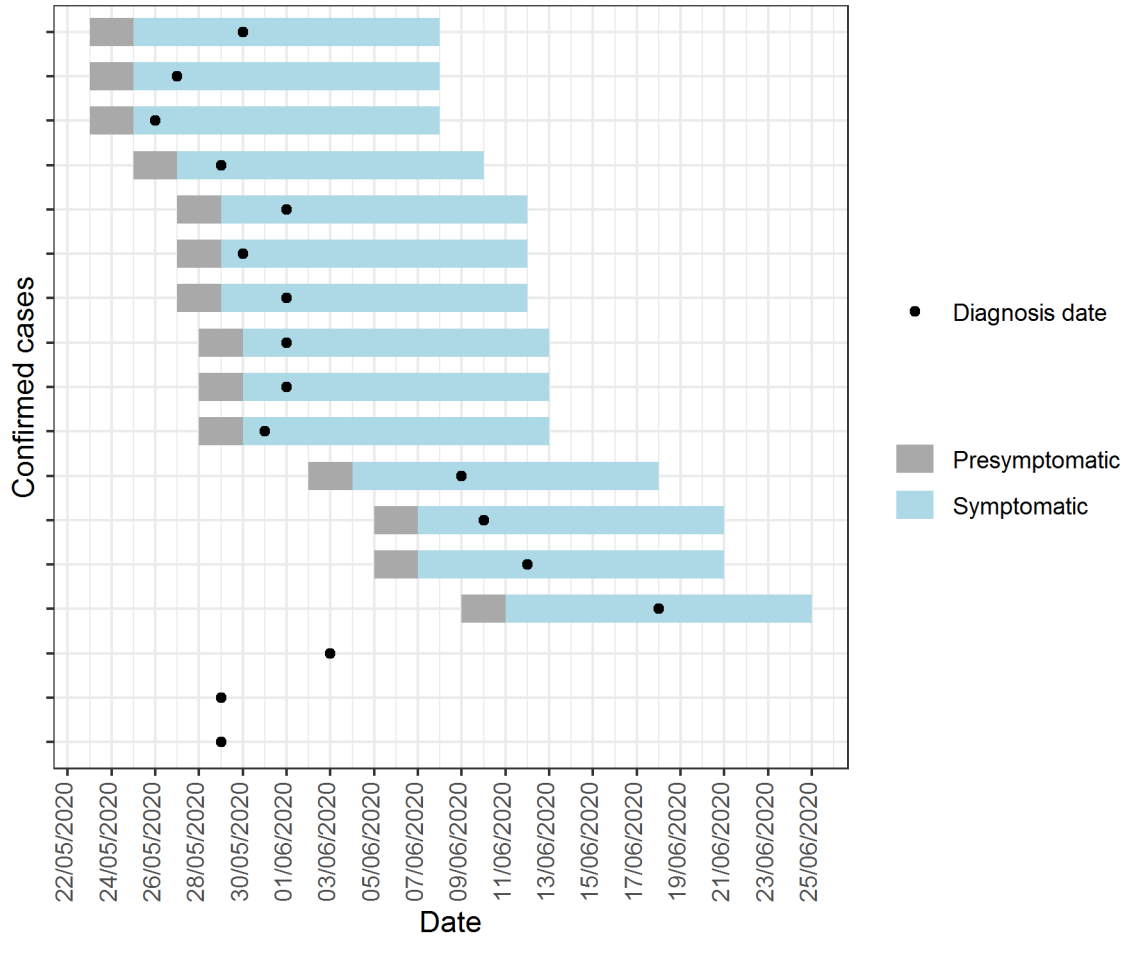


Figure 3: Onset date and incubation period for confirmed cases, Rydges on Swanston

Note: The timeline cascade will not include the case diagnosed in Queensland

Case definitions

Current COVID-19 case definition (as of 2 June 2020)

A person who tests positive to a validated SARS-CoV-2 nucleic acid test or has the virus identified by electron microscopy or viral culture.

Outbreak case definitions

Confirmed case:

A person tested positive for COVID-19 with an epidemiological link to the Rydges on Swanston Outbreak whose symptoms began on or after 11 May 2020.

Note: travellers who are in detention at Rydges on Swanston will be consider as a potential outbreak case if they have had direct contact with another confirmed outbreak case or if they are linked by genomic analysis.

Close Contact:

Any person who has had exposure of 15 minutes face to face or two hours in the same enclosed space to a confirmed outbreak case.

Casual Contact:

A person who has had any contact with, or worked a parallel shift with, a confirmed outbreak case.

Acquisition period:

11 May – 25 May 2020 (14 days prior to symptom onset in a case). All staff who spent 30 minutes or more at Rydges during this period have been asked to be tested.

Case follow-up

All cases are well having completed isolation.

Close Contact Follow up

Case 1 has 5 household contacts who have been designated as close contacts.

Case 2 has 3 household contacts who have been designated as close contacts. A work contact from another security job was initially designated as a close contact, but on review of the situation this person had <=5 minutes contact with the case while maintaining physical distancing and therefore does not meet the close contact criteria.

Case 3 has three household contacts who have been designated as close contacts – two have subsequently been confirmed as cases.

Case 4 has 2 household contacts who have been designated as close contacts.

Case 5 has 5 household contacts who have been designated as close contacts – four have subsequently been confirmed as cases.

Case 6 has 1 household contact who has been designated as a close contacts.

Case 7 has 3 household contacts who have been designated as close contacts.

Cases 8-14 are all household contacts of the above staff cases.

On 5 May, Queensland health notified us of a previously unrecognised household close contact of case 6 who reported moved out of the house (to Queensland) on 31 May 2020. This person has subsequently tested positive.

As of 30 May, any staff member who attended the Rydges on Swanston Hotel for 30 minutes or more during the period 18 May to midday on 28 May inclusive is now considered a close contact and is being asked to self-quarantine for 14 days since their last visit to the hotel. This includes:

- Medi7 GPs
- Alfred health nurses
- Unified Security staff
- YNA nurses
- Hotel staff
- SwingShift nurses
- Outbreak Squad nurses
- DHHS staff (AOs and team leaders)
- DJPR staff member

Environmental investigation

The hotel is located at 701 Swanston Street, Carlton.

A visit was made to the site by an IPC outbreak squad nurse on 27 May. Photographs and a report have been uploaded to PHESS. Key findings included:

- The hotel has no dedicated cleaning staff. Cleaning of common areas (including the lift used to transport positive cases) is currently performed by hotel staff (including the night manager), using a range of products that are unlikely to be effective against SARS-CoV-2 (e.g. PineOCleen, Glen20, home variety wipes and chux). Terminal cleaning of hotel rooms (following exit of a case) is contracted out to a cleaning company called Ikon.
- A 'deep clean' involving cleaning and disinfection using agents with antiviral activity is yet to be performed in the areas where the two infectious staff members worked
- Security staff are wearing vinyl gloves and non-approved masks for their shifts
- Education around PPE usage and separation of "clean" and "dirty" tasks is needed

Discussion with hotel management over processes for garbage disposal and linen changes:

- The hotel provides linen and ask guests to change their own linen
- Soiled linen is to be placed in double bags and placed outside rooms
- Soiled linen is then collected by people wearing full PPE including gown.

Discussion with nurses who cleaned room REDACTED and changed linen:

-

Information provided by hotel management and AO notes re: contact of guests from room REDACTED (the REDACTED genomically linked with staff cases) with environment & staff:

- The guests arrived on RED May and departed RE May
- The room was very messy and the kids drew on the walls
- Two nurses provided assistance in cleaning and changing bedlinen on RE May as the REDACTED REDAC was very flustered managing REDACTE
- The REDA is reported to have been taken for a walk on 18th May, accompanied by 4 security guards (wearing masks and gloves) and two nurses (wearing full PPE) – we are awaiting CCTV footage to confirm this and glean more information about environmental contact
- The area where guests are taken for a break is an empty room. Guests are advised not to touch anything. The nurses call the lift and open doors for guests when needed. This info is to the best of my knowledge and what I am informed

Genomic Investigation

Request:

Request for expedited genomic testing. Preliminary genomic analysis has identified that the first case and second case cluster genomically with sequences from a family REDACTED that are overseas returnees from REDACTE Based on PHESS notes, they appear to have been moved into the Rydges on R May from the Crowne Promenade hotel. Symptom onset dates range from 9-15 May.

Details of these genomic findings are at REDACTED

Results

As of 13 July, MDU has provided information on the genomic analysis of sequences associated with The Rydges on Swanston Outbreak. The onwards transmission from cases associated with the original Rydges outbreak has seeded five clusters that are distinct and well-supported clusters

associated with the main Rydges Parent Cluster. These clusters are examples of local transmission and diversification, the groups are all very closely related, and the availability of more sequences could allow for the merging or splitting of these clusters.

The main parent cluster contains sequences from RED The earliest identification of this cluster was in sequences from security staff at the Rydges Hotel which cluster with a family of RE overseas returnees from REDACTE that were in hotel isolation at the Rydges. This parent cluster also includes sequences from cases associated with REDA (previously REDACTE), REDACTED Family Outbreak, REDACTED REDACTED REDACTED REDACTED REDACTED REDACTED sequences from five different public housing towers, a single case from REDACTED REDACTED and several other complex cases. There were 34 additional cases genomically linked that are not known to be epidemiologically linked to an outbreak.

The first of the seeded clusters from the main parent cluster includes sequences from three cases, all of these were associated with the REDACTED

The second of the seeded clusters contains sequences from 15 cases. This includes 11 cases epidemiologically linked to the REDACTED Outbreak, one associated with Ilim REDACTED REDAC Outbreak and three not linked to clusters that all live in REDACTED One of these is a REDACTE two others are spouses.

The third seeded cluster contains sequences from 38 cases. This includes those from the REDACTE REDACTED REDACTED and two cases associated with complex cases in REDACTE and a single case from REDACTED This also includes three cases that are still under investigation, four cases not linked to a cluster with an unknown source of acquisition and another case that reported recent overseas travel and commenced hotel detention R June at Crown Metropol and subsequently tested positive and was moved to the Brady Hotel.

The fourth seeded cluster contains sequences from 45 cases. This includes 14 from the REDA REDACTED , six from cases that attended the REDACTED , two cases associated with separate public housing towers and a case from REDACTED It also includes cases associated with several ELC (REDACTED) and workplaces (RED). Ten of the cases genomically linked were not known to be associated with an outbreak.

The fifth seeded cluster contains sequences from 32 cases. This contains 19 sequences from cases associated with REDACTED Outbreak and five from REDACTED Eight additional cases were not known to be associated with an outbreak and three of these have been identified as an unknown source of acquisition.

As at 10 July 2020, there are 274 cases that are genomically linked to the REDAC Parent Cluster. Due to travel restrictions, there are less travel associated importations of COVID-19 and more local transmission occurring. This means sequences from cases are very similar to one another and therefore, it is harder to distinguish and determine relatedness between them. A sequence from an outbreak may be genomically linked to a different cluster than another sequence from that same outbreak, however please note this does not definitively mean the outbreak has multiple sources of infection as these cluster groups are very closely related and constantly changing with availability of more sequence data.

Hypothesis

Transmission of SARS-CoV-2 has occurred at the workplace from a COVID case in quarantine (either directly, via fomites or through contact with an unidentified intermediary staff case).

Control measures

Case 1, 3 and 5 were originally isolated at the Rydges, but were moved to the Novotel with other cases (due to staffing concerns at Rydges).

Identified close contacts have been quarantined.

Cleaning of work areas to be undertaken (commercial deep clean completed on 28 May).

Testing of all contacts from the acquisition period (from 11 May 2020) to be conducted at the workplace on 27 and 28 May (nurses from YNA to collect swabs; sent to VIDRL for testing).

All staff members who attended the Rydges on Swanston Hotel for 30 minutes or more during the period 18 May to midday on 28 May inclusive are considered close contacts. Rationale for this period is that it extends from 7 days prior to symptom onset in first case (and a date which is almost 14d ago), until the date on which a full clean and disinfection of the site was undertaken (28th May).

Staff who only attended the site between 11 and 17 May inclusive AND who have had a negative test have been advised that they can continue their usual activities.

Staff who have only attended the site since 28 May have been asked to only work at Rydges while an investigation is underway.

Stakeholder mapping

Rydges Hotel Management:

- Key contact: Rosswyn Menezes – General Manager, REDACTED @evt.com, hotel: REDACTED mobile: REDACTED

Your Nursing Agency (YNA)

SwingShift (mental health nurses):

- Eric Smith – Managing Director; RED @swingshift.com.au, phone: REDACTED

Alfred Hospital (nursing staff)

- REDACTED

Unified Security

- Key contact: Nigel Coppick – National Operations Manager (Victoria Office), REDA @unifiedsecurity.com.au, mobile: REDACTED phone: REDACTED

Medi7 GPs:

- Key contact: Stuart Garrow – Clinical Lead, Melbourne Quarantine Hotel Doctor Team, REDACTED @gmail.com, REDACTED

DJPR:

- Key contact: Rachaele May – DJPR Hotel Quarantine Agency Commander, REDACTED @agriculture.vic.gov.au, djprcovidaccom-lead@ecodev.vic.gov.au, mobile: REDACTED

Operation Soteria (Pam Williams, Merrin Bamert)

Issues/risks:

There is a high risk of transmission from COVID positive cases being detained in the hotel to the staff members working at the hotel. This is due to the inadequate education and cleaning procedures that are currently in place. The cleaning duties of communal areas were the responsibility of the security staff; specifically, for the elevators used to transport COVID positive cases. Because of this, there is a

high likelihood of fomite spread from poor cleaning products being utilised, poor PPE used by security staff, and a lack of education surrounding cleaning practices. At risk populations include staff members from the hotel, DHHS staff, nurses, and various other HCWs that were onsite to attend to the people in hotel detention. Outside of the hotel, there has been onward household transmission to partners and housemates.

Risk communication

Key events

[Include information on internal communication, including briefings and communication with the Minister's Officer. Detail when media releases and press conference are released/take place]

Escalation point	Date of escalation
Deputy Public Health Commander CCOM	17:00, 26 May 2020
Public Health Commander	17:48, 26 May 2020
Chief Health Officer	20:10, 26 May 2020
Minister's Office	20:10, 26 May 2020

Communication with exposed settings

Initial request for information from the Rydges on the evening of 26 May 2020.

Key messages – general public

Approved media holding lines as of 26 May 2020

Statement

The department has been notified of a COVID-19 case in a staff member at Rydges on Swanston, Melbourne.

The source of acquisition for this case is under investigation and all potential sources of transmission will be explored.

All identified close contacts of the staff member have been contacted and placed into quarantine.

Any staff who are classified as close contacts of the case will be tested.

Thorough cleaning of relevant parts of the hotel is being undertaken, alongside other appropriate public health actions including contact tracing, isolation and quarantine where required.

Background

The hotel is not currently open to the public.

There are some returned overseas travellers observing their quarantine at the hotel.

The cause of the infection is under investigation.

Timeline of outbreak

Date	Action
26/05/2020	Case 1 notified to DHHS – REDACTED interview completed Emergency accommodation arrangements made for Case 1
26/05/2020	Worksafe informed
26/05/2020	Email sent to Operation Soteria team & Rydges Swanston with the following directions: - Request to provide background as to duties/jobs/functions undertaken by the REDACTED and RE[illegible] interactions with other staff and guests - Request for rosters for shifts worked by manager since 11th May REDACTED - Request for floor plan of hotel - Request for list of staff that had been swabbed and whether any staff are symptomatic - Instruction that 'A clean of all common areas, and the cases' direct work areas will need to occur'
27/05/2020	On-site visit by IPC nurse from outbreak squad (report in TRIM) - Noted that a 'deep clean' involving application of a disinfectant with antiviral properties had not yet been carried out - Noted inconsistencies in staff use of PPE and issues with inappropriate use of PPE (masks not applied correctly, incorrect use of gloves) - Noted that the REDACTED 's duties include cleaning of common areas and the lift used to transport COVID-19 cases
27/05/2020	Case 2 notified to DHHS – security guard REDACTED
27/05/2020	Request made to DJPR to arrange a commercial 'deep clean' of all common areas / areas visited by two
27/05/2020	Decision made to ask all staff who have been on-site for 30 minutes or more from 11 May 2020 (14 days prior to symptom onset date for Cases 1 and 2) to undergo testing for COVID-19
27/05/2020	Contact made with Stuart Garrow (RED ACTED GP providing on-site services) - Confirmed that 3 x medical staff who have been on-site since 11th May attended Rydges on 27/5/2020 for sample collection - Confirmed that RE[illegible] is happy to contact any staff members with positive results through any positive results in staff
28/05/2020	Contact made with Alfred Hospital re: Alfred staff who attended site between 11-27 May (19 staff). Spreadsheet received from infection prevention and control team.

28/05/2020	Full commercial bioclean of common/affected areas conducted by Ikon cleaning – documentation received and filed in TRIM folder
28/05/2020	On-site visit by outbreak squad nurses to provide IPC education
29/05/2020	Notification of Case 3 by ACL at ~1000h; case interview completed Emergency accommodation arrangements made for Case 3 Notification of Case 4 by Doctor at ~1200h; case interview completed Notification of Case 5 by VIDRL at ~1800h; case interview completed Notification of Case 6 by VIDRL at ~2000h; unable to contact case
29/05/2020	Following notification of cases 3 and 4, decisions made that: • Any staff who have worked at Rydges on Swanston since the 11th May (14 days before symptom onset in Case 1 & 2) should not work elsewhere, unless they have not been on site in the past 14 days AND have had a negative swab. Information relayed to relevant agencies (including Swing Shift, YNA, Unified Security, Alfred Health, Rydges, DHHS) • Directive to implement at least daily commercial cleaning (using disinfectant with antiviral activity) with a particular focus on common areas and high touch surfaces Following notification of cases 5 and 6 decision made to limit movement of staff and patients in and out of premises effective immediately: • No new admissions to hotel • Minimising all movement of residents outside their rooms (except for emergency care) • No movement of staff between hotel sites, including all health staff, AOs, team leaders, support staff, DJPR team leaders, security and hotel staff (time frame currently unclear)
30/05/2020	Actions from OMT #5: • At least once daily cleaning & disinfection of all common areas and frequently touched surfaces to commence • Ongoing education and PPE training for staff • Explore option of embed IPC lead from a health service • Quarantine staff who attended for 30 min or more between 18 May and midday on 28 May for 14 days since last exposure • Emergency accommodation for cases 3 & 5 • Communications to staff
3/06/2020	Late on 3 June, PHU staff became aware that a close contact of the exposure site worked two shifts at a correctional facility when they were supposed to be in quarantine. The close contact is asymptomatic and has received one negative test; a second test is pending. Although the public health risk is considered low, the correctional facility, Justice Health and Corrections Victoria have been advised of this situation.

4/06/2020	PHU staff arranged for an ambulance to transport one of the staff cases REDACTED from home to hospital after their symptoms deteriorated. The case is currently under close observation in ICU.
4/06/2020	Due to difficulties in staffing the Rydges, alternative accommodation was sought. Residents have been moved today to a different hotel in the CBD. Department outbreak control squad nurses have visited this hotel and are providing training and support to enable the lifting of restrictions. It is expected that following training of security staff today (3 June) that restrictions can be lifted tomorrow (4 June)
5/06/2020	Notified by Queensland health of an additional close contact – housemate of case REDACTED who moved out on REDACTED May 2020 (during cases' infectious period). Now symptomatic and has sought testing in QLD
5/06/2020	Request made to Operation Soteria for CCTV footage and documentation of movements of staff and family in hotel. AO handover notes provided (scanned PDF placed in TRIM)
08/06/2020	Household contacts associated with outbreak called and provided verbal and written advise to seek testing prior to end of quarantine (day 11 advised).
9/06/2020	All close contacts associated with outbreak being called and provided provided verbal and written advise to seek testing prior to end of quarantine (day 11 advised).
9/06/2020	Notification of Case 14 (in Victoria) Case 14 interviewed – security guard identified as close contact of exposure site; has been in quarantine since 27/5
10/06/2020	Notification of Case 15 (in Victoria) Case 15 interviewed – household close contact of case 14; had not been in quarantine as case 14 had advised R had been quarantining separately from rest of household (in studio)
12/06/2020	Notification of Case 16 (in Victoria)
14/06/2020	Awaiting results on 2 close contacts for day 11 testing. Outbreak control squad visited site on 13 June and advised that Rydges site was not ready for opening and that an effective terminal clean needed to be undertaken and correct signage put up.
17 June 2020	Preliminary information from MDU linking the case associated with Embracia Aged Care genomically to cases from Rydges on Swanston St Outbreak.
18 June 2020	Department notified of Case 17.

OMT meeting actions list

Outbreak Meeting 1 – 26th May

Action	Due date	Responsible person
Request further information from Rydges on: - Interactions with guests - Rosters - Floor plan - Duties of case	27 May 2020	REDACTED
Test all staff who have worked the same shift (including staff handed over to and from) as the case	27 May 2020	Simon Crouch
Confirm staff not working across different hotels	27 May 2020	Jason Helps
Clean areas case has worked	27 May 2020	REDACTED
Outbreak squad visit	27 May 2020	REDACTED
Media holding lines	26 May 2020	

Outbreak Meeting 2 – 27th May

Action	Due date	Responsible person
Document and map staff interactions and contacts with case 1 and case 2 across hotel to provide comprehensive mapping of potential contact points	28 May 2020	Pam
Coordinate testing for those who had overlapping shifts with cases as a priority	27 May 2020	REDACTED
Work with team to procure hotel floor plans and staff rosters	28 May 2020	REDACTED
Draft lines for staff testing +/- letter	27 May 2020	Sarah
Complete on-site visit and provide report	27 May 2020	REDACTED
Interview case 2	27 May 2020	
Escalate outbreak brief to Brett via Finn	27 May 2020	Simon
Facilitate expedited genomics analysis	28 May 2020	REDACTED
Ensure pathology slips are labelled as URGENT: priority 1 – outbreak (Rydges) to ensure quick turnaround of results by VIDRL	27 May 2020	

Outbreak Meeting 3 – 28th May

Action	Due date	Responsible person
Prepare materials (video and written) on proper hygiene and use of PPE, to be distributed to staffing agency leadership (both health services and security guards) via Pam Williams	30/05/2020	Outbreak Squad REDACTED
Liaise with Katherine Ong and intelligence leads to determine current knowledge about eye protection vs face shields for PPE when collecting deep nasal and oropharyngeal swabs	29/05/2020	REDACTED
Discuss potential support for procuring contact details and complete rosters of all staff in the hotel from the Public Health OMT (via RED)	28/05/2020	REDACTED
Liaise with VIDRL and REDACTED re: coordination of collection & testing of samples from Rydges hotel staff	28/05/2020	Sarah M
Coordinate distribution of negative test results to staff	28/05/2020	Sarah M REDACT
Confirm with DJPR that commercial cleaning is underway	28/05/2020	Sarah M
Follow up status on genomics	28/05/2020	Sarah M

Outbreak Meeting 4 – 29th May

Action	Due date	Responsible person
Procure staff contact details for Rydges staff	29/05/2020	REDACTED
Conduct interview & contact tracing for case 3	29/05/2020	
Investigate standard cleaning arrangement at the hotel and report back to team	29/05/2020	
Ensure that negative results received from VIDRL are sent via SMS to staff	29/05/2020	

Outbreak Meeting 5 – 30th May

Action	Due date	Responsible person
Complete interview of Case 6 and assess potential close contacts at Marriott hotel	30/05/2020	CCOM
Chase genomics over the coming week		Intelligence
Arrange at least daily cleaning and disinfection of all common areas & frequently touched surfaces	30/05/2020	Operation Soteria (Merrin)
Continue education regarding PPE, hand hygiene and discuss these with security company management	30/05/2020	Outbreak squad
Embed IPC lead from a health service		Operation Soteria (Merrin)

Limit movement of guests today only, until full environmental clean		Operation Soteria
Maintain block on new admissions of well people until full clean today		Operation Soteria
Quarantine staff who attended for 30 min or more between 18 May and midday on 28 May inclusive for 14 days from last exposure		REDACTED
Arrange emergency accommodation for Case 5		DHHS commander
Liaise with WorkSafe		CCOM
Communicate to various work groups / agencies who have been on-site		Merrin (Operation Soteria) REDACTED CCOM (DJPR, YNA, Swingshift, Medi7, Alfred, Unified Security, outbreak squads)

Outbreak Meeting 11 – 8 June

Action	Due date	Responsible person
Follow up cleaning practices at the hotel prior to 4/06/2020	5/06/2020	REDACTED
Share any updates regarding the nurse who worked at REDACT with the OMT team	5/06/2020	
Sarah to collate questions for finding details about the genomically linked family, REDAC to summarise info known so far; both to escalate concerns about the family's movement within the hotel to Pam Williams	5/06/2020	SarahREDACT
Schedule OMT meetings for Saturday and Monday	5/06/2020	Sarah
Clarify plan to move COVID-19 cases back Rydges Swanston St with Merrim Bamert from Operation Soteria	09/06/20	REDACTED
Advise all close contacts of the requirement for day 11 clearance testing	09/06/20	REDAC and CCOM team
Provide IPC advice given to hotel security staff and AOs	09/06/20	REDACTEand Outbreak Squad team

Outbreak Meeting 14 – 11 June

Action	Due date	Responsible person
ContacREDACTED Outbreak squads to arrange site visit to Rydges	12/06/2020	Sarah

Chase CCTV footage from Rydges	12/06/2020	Sarah
Ensure that emergency accommodation arrangements are underway for two most recently reported cases	12/06/2020	REDACTED
Provide an update to DJPR and Operation Soteria	12/06/2020	Sarah
Follow up results of close contact day 11 testing	12/06/2020	CCOMREDACTED
Escalate discussion of whether staff working at the COVID-19 positive hotel can work elsewhere to Deputy PHC	12/06/2020	Sarah

Line list

List does not include the QLD notified case.

Case	PHESS ID	Age Group	Sex	Onset Date	Diagnosis Date	Clinical Status	Cluster Link
17	320203567743	REDACTED	RED)AC ACT) ED	2020-06-11	2020-06-18	Well, isolation complete	Social
16	320203518386			2020-06-07	2020-06-12	Well, isolation complete	Household
15	320203585777			2020-06-07	2020-06-10	Well, isolation complete	Household
14	320203506661			2020-06-04	2020-06-09	Well, isolation complete	Staff
13	320203514855			NA	2020-06-03	Well, isolation complete	Household
12	320203514833			2020-05-29	2020-06-01	Well, isolation complete	Household
11	320203515292			2020-05-29	2020-06-01	Well, isolation complete	Household
10	320203515305			2020-05-30	2020-06-01	Well, isolation complete	Household
9	320203515315			2020-05-30	2020-06-01	Well, isolation complete	Household
8	320203515304			2020-05-30	2020-05-31	Well, isolation complete	Household
7	320203514863			2020-05-25	2020-05-30	Well, isolation complete	Staff
6	320203514969			2020-05-29	2020-05-30	Well, isolation complete	Staff
5	320203509872			NA	2020-05-29	Well, isolation complete	Staff
4	320203511748			NA	2020-05-29	Well, isolation complete	Staff
3	320203513656			2020-05-27	2020-05-29	Well, isolation complete	Staff
2	320203487846			2020-05-25	2020-05-27	Well, isolation complete	Staff
1	320203450603			2020-05-25	2020-05-26	Well, isolation complete	Staff

Outbreak demographic summary

Includes Victorian notified cases only.

		N	Perc %
Total		**17**	**100**
Sex	Female	4	23.5
	Male	13	76.5
	Unknown	0	0
Age group	0-9	0	0
	10-19	2	11.8
	20-29	11	64.7
	30-39	2	11.8
	40-49	1	5.9
	50-59	1	5.9
	60-69	0	0
	70-79	0	0
	80-89	0	0
	90+	0	0
Indigenous status	Indigenous	0	0
	Non-Indigenous	16	94.1
	Unknown	1	5.9
Clinical status	Admitted, not known to be in ICU	0	0
	Admitted to ICU	0	0
	Home isolation	0	0
	Hospital in the home	0	0
	Deceased	0	0
	Well, isolation complete	17	100
	Not recorded	0	0

Shifts worked by staff cases at Rydges

Date	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6	Case 7	Case 8
Details	REDACTED 320203450603 REDACTED	320203487846	320203509872	320203513656	320203514863	320203514969	320203511748	320203506661
Role	REDACTED	REDACTED	REDACT	REDAC	REDACTE D	REDACT EDA REDA	REDACTED	REDACTE D
Sx onset	25/05/2020	25/05/2020	Asymptomatic	27/05/2020	25/05/2020	29/05/2020	Asymptomatic	04/06/2020
11 May	REDACTED							
12 May								
13 May								
14 May								
15 May								
16 May								
17 May								
19 May								
20 May								
21 May								
22 May								
23 May								

			REDACTED			REDACTE		
24 May								
25 May								
26 May								
27 May								
28 May								

*text in red denotes shifts worked during infectious period

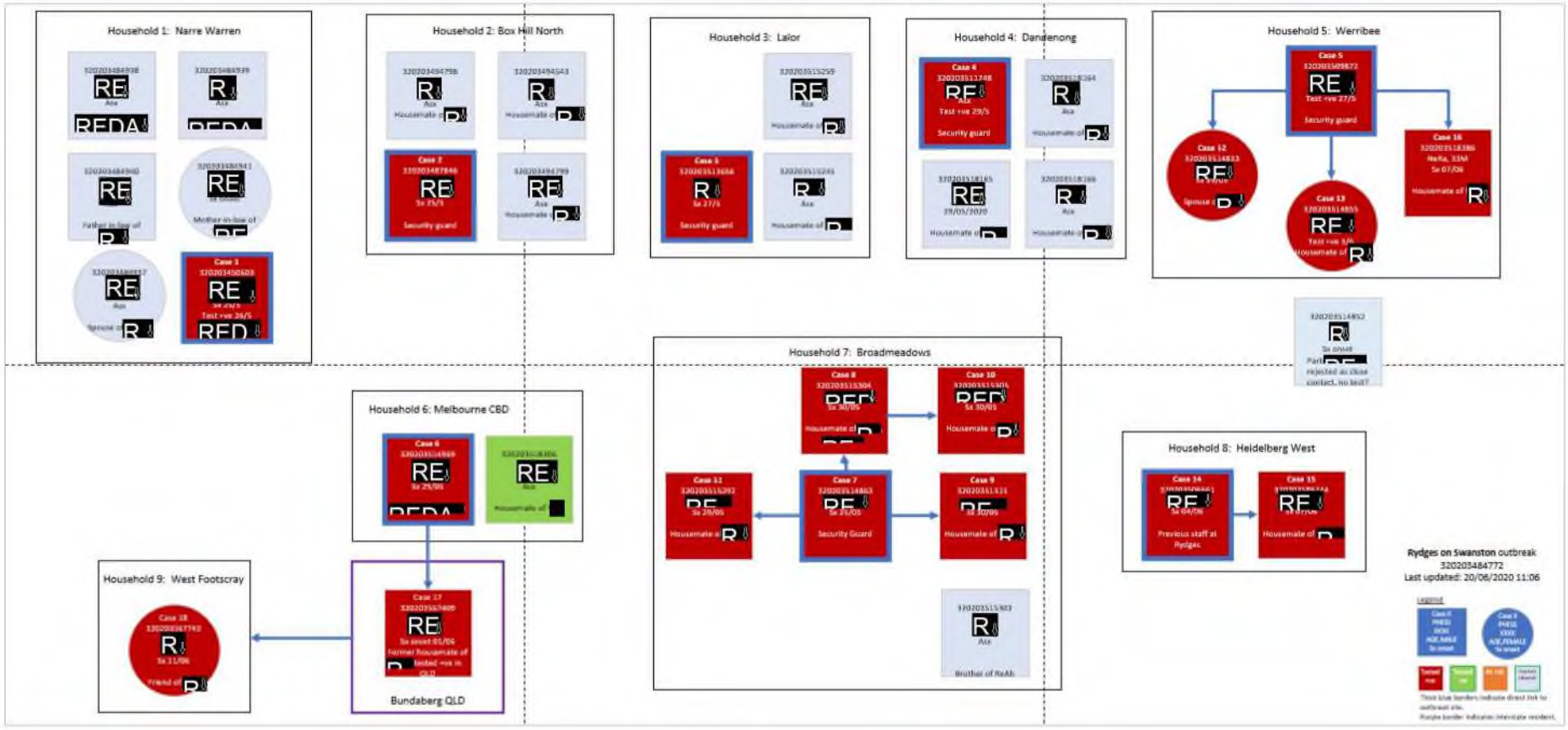


Figure 4: Visio transmission diagram, Rydges Swanston, Updated 21 June 2020, 15:00

Rydges Swanston Visit 27/5 IPC

From: REDACTED

To: "Sarah McGuinness (DHHS)" <REDACTED>

Cc: REDACTED Pam Williams (DHHS)" <REDACTED>, "Simon Crouch (DHHS)" <REDACTED>, REDACTED (DHHS)" <REDACTED>, REDACTED

Date: Wed, 27 May 2020 08:26:26 +0000

Attachments: 1.1.jpg (1.22 MB); 1.2.jpg (1.26 MB); 1.3.jpg (1.42 MB); 1.4.jpg (1.35 MB); 1.5.jpg (1.62 MB); 1.6.jpg (1.45 MB); 1.7.jpg (1.35 MB); 1.8.jpg (1.29 MB); 1.9.jpg (2.1 MB); 1.11.jpg (0 bytes); 1.12.jpg (1.49 MB); 1.13.jpg (1.52 MB); 1_.jpg (1.31 MB); 2_.jpg (1.33 MB); 3_.jpg (1.49 MB); 4_.jpg (1.81 MB); 5_.jpg (1.64 MB); 6_.jpg (1.47 MB); 7_.jpg (1.88 MB); 8_.jpg (0 bytes); 9_.jpg (2.35 MB); 10_.jpg (1.38 MB); 11_.jpg (1.54 MB); 12_.jpg (2.21 MB); 13_.jpg (1.21 MB); 14_.jpg (1.1 MB); 15_.jpg (1.21 MB); 16_.jpg (1.93 MB); 17_.jpg (1.31 MB); 18_.jpg (1.51 MB); Copy of COVID Roster WE 120520 HSK 1 (002).xls (802.82 kB); Copy of Rydges list.xlsx (12.03 kB); Rydges IPC Notes RED.pdf (705.51 kB)

Hi All,

Attached are a variety of items. Photos from the site, rosters of the Rydges staff, rosters of the Unified Security staff, and our scrawled notes pages as a pdf (as we worked our way through our first hotel visit). We are currently missing the layout plan of the facility as it was unable to be provided by Rydges currently. It might be worth trying the onsite Rydges DHHS RE again, they tried to chase up one for us REDACTED

Key points:

- 4 silos of staff: Rydges, YHA, Unified Security and DHHS. All onsite through out the day.
- Needs bioclean.
- Rydges staff were doing all kinds of cleaning. No dedicated cleaning staff. For example the REDA REDACT (+ve case) did not only work reception and the office behind, but also would attend cleaning of other sites: reception, function rooms (now 'clean rooms') for nursing and DHHS staff overnight, toilets, tea towels coffee machine, and 'hot' elevator when used. It has been stated that RE wore gloves and a mask as a way of protecting RE self constantly. The masks seen are not approved, and appropriate glove usage doubted. The REDACTED REDA also did varied cleaning delivery of meals but also removal of black double bagged rubbish from the CoVid +ve client rooms. Plus varied cleaning from coffee machine to toilets also.
- No 'deep clean', they cleaned it themselves, of special note is the usage of PineOCleen, Glen20, home variety wipes and chux used to clean particularly of the reception, office, and 'hot' b/w escort of +ve patients elevator.
- 'Hot' elevator used for +ve cases (masked), nurses and infectious waste transfer
- Service elevator used for food, double bagged black rubbish bags and dirty bagged linen.
- Unified staff: were constantly wearing vinyl gloves, non approved masks, and using unidentifiable hand alcohol/gel. They also need urgent education re PPE usage. No great understanding they also cleaned the stairwell handle to reception.

Kind regards,

REDACTED
Infection Prevention & Control Outreach Team Nurse, COVID-19
IPC Outbreak Management I Legal and Executive Services Division
Department of Health and Human Services | 50 Lonsdale Street, Melbourne, Victoria, 3000
REDACTED

delete the e-mail and destroy any copies of it.

Coronavirus disease 2019 (COVID-19)

Case and Contact Management Guide

Version 11

29 April 2020

VICTORIA State Government | Health and Human Services

Version control

Version number	Comment	Date of approval
v 2	Updated countries with risk	11 February 2020
v 3	Updated with new case definition and biosecurity screening	20 February 2020
v 4	Updated case definition; updates to countries with risk, travel restrictions and quarantine requirements	6 March 2020
v 5	Updated case definition	10 March 2020
v 6	Updated case definition	14 March 2020
v 7	Changes to checklists and overall structure of document	23 March 2020
v 8	Changes to structure and inclusion of procedures for notifications, case interviews and onboarding	26 March 2020
v 9	Updated case definition	01 April 2020
v 10	Updated case definition	05 April 2020
v 11	Complete overhaul	28 April 2020

Last updated: 10 May 2020

This document is available at:

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Table of Contents

1 Background

Coronavirus disease 2019 (COVID-19) was first identified in December 2019. It has since spread globally and has been declared a pandemic by the WHO.

1.1 Public health response objectives

This situation is evolving rapidly with new clinical and epidemiological information. Following the declaration of a State of Emergency in Victoria on Monday 16th March 2020 and subsequent Directions, the public health response of the Department of Health and Human Services (the department) has now transitioned from the Initial Containment stage (which encompassed an inclusive approach to identifying cases and a precautionary approach to the management of cases and contacts), to the Targeted Action stage, with implementation of social distancing measures and shutdowns of non-essential services to slow disease transmission, prioritisation of diagnostic testing to critical risk groups, and adoption of sustainable strategies and models of care.

The overall objectives of the public health response are to:

1. Reduce the morbidity and mortality associated with COVID-19 infection through an organised response that focuses on containment of infection.
2. Rapidly identify, isolate and treat cases, to reduce transmission to contacts, including health care, household and community contacts.
3. Characterise the clinical and epidemiological features of cases in order to adjust required control measures in a proportionate manner.
4. Minimise risk of transmission in healthcare and residential aged care environments, including minimising transmission to healthcare and residential aged care workers.

1.2 Staying up to date with advice

Definitions, criteria and guidance around optimal public health management for COVID-19 is constantly changing, as understanding of the virus progresses. Guidelines developed by the Department of Health and Human Services will be regularly updated, however constant vigilance is required for all people involved in COVID-19 operations.

To ensure you are aware of the most recent advice, it is recommended you access and review online definitions and guidelines daily on the department's website (https://www.dhhs.vic.gov.au/coronavirus).

1.2.1 Daily update

The Chief Health Officers daily update, including developments in the outbreak and updated advice for clinicians can be accessed at https://www.dhhs.vic.gov.au/coronavirus-covid-19-daily-update

1.2.2 Testing criteria

The current case testing criteria for Victoria can be accessed at https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

1.2.3 Who is required to self-quarantine?

Requirements for self-quarantine in Victoria can be accessed at https://www.dhhs.vic.gov.au/victorian-public-coronavirus-disease-covid-19

1.3 Information technology and documentation

Before team members commence working they need to have access to and competence with the following IT processes:

- DHHS computer access (to access completable electronic forms). This includes access to the following databases and systems
  - PHESS
  - TRIM
  - Microsoft Office/Sharepoint
  - Teams
- Genesys PureCloud (to make and receive phone calls)

Formal requests, escalations and decisions should be clearly documented by email to the relevant lead position. Most other communications can be performed through the 'chat' and 'posts' functions on Teams.

1.3.1 Guidelines

- Coronavirus disease 2019 (COVID-19) Case and Contact Management Guidelines (this document)
- Coronavirus disease 2019 (COVID-19) Guidelines for Health Services and General Practitioners – Available from:
- PHESS Quick Entry Guide

1.3.2 Factsheets

- Confirmed case – Available from: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19
- Close Contact – Available from: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19
- Telephone Interpreter Service – see the SOP for accessing the Translating and Interpreting Service (TIS)
- Location of coronavirus testing centres (Acute Respiratory Assessment Clinics and GP respiratory clinics) – list available on the department's webpage under "Where can I get tested for coronavirus?": https://www.dhhs.vic.gov.au/victorian-public-coronavirus-disease-covid-19

1.3.3 Completable Forms

- Notification of COVID-19 (novel coronavirus) by Medical Practitioners (paper form)
- Notification of COVID-19 electronic form: https://forms.business.gov.au/smartforms/servlet/SmartForm.html?formCode=internalnovelcoronav&tmFormVersion=0.1.2
- Communicable Disease Call Log Sheet (paper form)
- Communicable Disease Call Log -electronic form
- Call log sheet (used in the triage team to record calls received) accessed at https://forms.office.com/Pages/ResponsePage.aspx?id=H2DgwKwPnESciKEExOufKBgNxs0yxExHhPbFAW8y1dBUQ1JMMkRFSEVGMzdDOENQR0hTTDRGT0RWVyQlQCN0PWcu (I hope this link works)
- Case questionnaire COVID-19 (Novel Coronavirus) Part A and Part B (paper form)

2 Testing criteria, case and contact definitions

2.1 Testing criteria

The latest testing criteria can be accessed under 'Current Victorian coronavirus disease (COVID-19) case definition and testing criteria' at: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

2.2 Case definition

The confirmed case definition is also available in the Coronavirus disease 2019 (COVID-19) General Practice quick reference guide: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

2.2.1 Confirmed case

A person who tests positive to a validated SARS-CoV-2 nucleic acid test or has the virus identified by electron microscopy or viral culture.

2.2.2 Probable case

Victoria does not currently employ a probable case definition

2.3 Close contact definition

The close contact definition is also available on the Coronavirus disease 2019 (COVID-19) – Guidelines for health services and general practitioners: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

Close contact means greater than 15 minutes face-to-face, cumulative, or the sharing of a closed space for more than two hours with a confirmed case without recommended personal protective equipment (PPE) which is droplet and contact precautions.

Contact needs to have occurred during the period of 48 hours prior to onset of symptoms in the confirmed case until the confirmed case is no longer considered infectious.

2.3.1 Examples of close contact include:

- living in the same household or household-like setting (for example, a boarding school or hostel)
- direct contact with the body fluids or laboratory specimens of a confirmed case without recommended PPE (droplet and contact precautions)
- a person who spent two hours or longer in the same room (such as a GP clinic or ED waiting room, a school classroom; an aged care facility)
- a person in the same hospital room when an aerosol generating procedure (AGP) is undertaken on the case, without recommended PPE for an AGP (airborne and contact precautions)
- Aircraft passengers who were seated in the same row as the case, or in the two rows in front or two rows behind a confirmed COVID-19 case.
- For aircraft crew exposed to a confirmed case, a case-by-case risk assessment should be conducted by the airline to identify which crew member(s) should be managed as close contacts. This will include:
  - Proximity of crew to confirmed case
  - Duration of exposure to confirmed case
  - Size of the compartment in which the crew member and confirmed case interacted

  - Precautions taken, including PPE worn, when in close proximity to the confirmed case
  - If an aircraft crew member is the COVID-19 case, contact tracing efforts should concentrate on passengers seated in the area where the crew member was working during the flight and all of the other members of the crew.
- Close contacts on cruise ships can be difficult to identify, and a case-by-case risk assessment should be conducted to identify which passengers and crew should be managed as close contacts.
- Face-to-face contact for more than 15 minutes with the case in any other setting not listed above.

Healthcare workers (HCWs) and other contacts who have followed recommended infection control precautions, including the use of recommended PPE (droplet and contact precautions for the purposes of this contact definition), while caring for a suspected or confirmed case of COVID-19 are **not** considered to be close contacts.

3 Triage and Notification

DHHS operates a 24-hour communicable diseases hotline (1300 651 160). This number receives urgent communicable disease notifications from clinicians, including notifications for COVID-19. Some health services have instituted processes to send notifications via text message or email. As case numbers evolve, different models of notification are being explored.

In addition to receiving notifications, DHHS receives a large number of calls through the 24-hour communicable disease hotline, including:

- Queries from confirmed cases or close contacts of confirmed cases.
- Queries from members of the public on testing criteria, symptoms of concern and other risks.
- Queries from institutions regarding processes and risks relating to suspected or actual cases.
- Offers of assistance to the department in providing services or equipment.

The objectives of the Triage and Notification team are to:

- Ensure 24-hour coverage of the COVID-19 hotline through the 1300 number
- Record notifications of confirmed cases of COVID-19
- Manage enquiries from confirmed cases, close contacts and other stakeholders relating to case and contact management
- Manage other miscellaneous enquiries and where relevant, triage to the correct part of the response

3.1 Processes and workflow

3.1.1 Receiving a new notification of COVID-19

When receiving a new notification of COVID-19, the team member needs to access the form “Notification of COVID-19 (novel coronavirus) by Medical Practitioners”. This form may be completed in hardcopy (paper) form OR electronic form (do not complete both).

3.1.2 Managing other non-notification enquiries

Non-notification enquiries can be segmented into case and contact related enquiries and other.

Any enquiries relating to a new case, new close contact, existing confirmed case, or existing close contact should be recorded in the call log and where relevant, escalated to the appropriate team leader.

All phone calls to the 1300 number should be related to case and contact management. Other enquiries may need to be re-directed to the appropriate number or contact address. There are several generic inboxes that have been created for managing other parts of the response. Discuss with your team leader if you are not sure of where to direct an enquiry.

3.1.3 Escalation and workflow

Team members may escalate any concerns to the Assistant Team Leader. This includes enquiries about the correct interpretation and completion of the “Notification of COVID-19 (novel coronavirus) by Medical Practitioners).

Any notifications that require an urgent public health response or that are received from a sensitive setting must be escalated to the Team Leader. This includes the following situations:

- The case is a health care or aged care worker
- The case lives in a residential aged care facility or other care facility

- The case works in or attends a school or childcare centre
- The case is in an intensive care unit
- The case has died
- The case is part of a known outbreak or cluster

Complete notifications are sent for data entry before the “New Cases” team will contact cases to begin the case and contact management process.

3.2 Troubleshooting common issues

3.2.1 Misdirected phone call

All incoming calls to the 1300 number should be related to case and contact management. Any other enquiries should be re-directed, if required, to one of the below hotlines.

Number/email	Title	Functions
1800 675 398	Victorian Coronavirus hotline	1: Health information or symptom assessment or health professional 2: Information on social distancing measure (business or individual) 3: Self isolating and have urgent relief needs (e.g. food, personal care, wellbeing) 4: Alleged breach of Chief Health Officer directions
1800 020 080	National Coronavirus hotline	1: Health information or symptom assessment 2: For health professionals
1800 960 944	DJPR ‘concierge support’ for those in hotel quarantine	Relief, accommodation and other requests from people in mandatory hotel quarantine
1800 825 955	Homelessness support team	For Hospitals/clinicals to provide advice on accommodation for homeless people (for example a homeless COVID-19 patient in hospital who is medically fit for discharge)

3.2.2 Incomplete notification form

An incomplete form should be discussed with the Assistant Team Leader, to discuss whether sufficient information has been provided. As a guide the following information must be provided:

- The name (first and last name) of the case
- A contact phone number for the case
- The name and contact phone number of the notifying clinician
- Occupation of the case (where available)

If it is determined that sufficient information to complete the public health response is provided, then notification can be finalised in the usual manner.

If insufficient information to complete the public health response has been provided, a solution should be discussed with the Assistant Team Leader or Team Leader that does not breach confidentiality of the case. For example, if a notification has been provided by a laboratory, the requesting clinician may be contacted for further information.

If no solution can be found to complete the necessary information, escalate to the Team Leader who will finalise the notification.

3.2.3 Indeterminant/Suspected/Low positive test results

Current testing for the SARS-CoV-2 virus (the virus that causes COVID-19) is undertaken by laboratories using a method called Nucleic Acid Amplification Test (NAAT), also called Polymerase Chain Reaction (PCR). Due to the rapid rollout of laboratory testing for SARS-CoV-2, the methods of laboratory testing have not undergone the same, intense, validation that occurs with more established tests. Some test results may not be clearly positive or clearly negative. Depending on the laboratory, these may be reported as “suspected”, “indeterminant” or “low positive”.

For the purpose of the public health response, cases with laboratory tests results that are not negative (i.e. “suspected”, “indeterminant” or “low positive”) should be managed as confirmed cases, and should undergo the same isolation and contact tracing procedures as all cases with a “positive” test result.

If the treating clinician or testing laboratory calls the department to discuss an indeterminant/low positive test result, the call should be escalated to the Operations Lead (and/or the Strategy, Policy and Planning Lead). In select cases, such as where the treating clinician feels that the pre-test probability for COVID-19 is low, it may be appropriate for the patient to be re-tested for COVID-19. If the second sample tests negative, the Operations/Strategy, Policy and Planning Lead (or someone they delegate) should discuss the case with the treating clinician and testing laboratory to determine whether it is appropriate to continue to manage the case as a confirmed case. Approval should be sought from the deputy Public Health Commander: Case, Contact and Outbreak Management before a decision is made to reject a case.

This information is subject to change as the pandemic progresses and team members should ensure they are aware of the most up to date guidance.

3.2.4 Patient has not been notified of their positive test result

It is preferable that patients are contacted by the requesting clinician and informed of their positive test result before the DHHS case and contact management begins. This allows the clinician to review the medical requirements of the patient and answer any questions that the patient may have.

When receiving a notification from a clinician who has not informed the case of their positive test result, you should request the clinician contact the patient ASAP to discuss their result and follow usual processes. Document on the notification form your request to the clinician to contact the case and the clinician’s response. The DHHS response will proceed as usual (DHHS will not confirm the case has been contacted or wait for the clinician to contact the case before beginning the usual follow-up).

4 New Case and Contact Management

The New Case and Contact (NCAC) Team are the first point of contact between the DHHS and a confirmed case of COVID-19.

The objectives of the NCAC team are to:

- Identify the likely source of exposure of a case, including if they are part of an outbreak or cluster
- Identify if a case is from a sensitive setting (e.g. a healthcare worker)
- Provide a case with clear instructions about their public health requirements (e.g. their period of isolation)
- Identify close contacts of a case of COVID-19
- Inform close contacts of confirmed cases of COVID-19 of their isolation requirements
- Complete appropriate documentation in case questionnaire and PHESS

4.1 Processes and workflow

4.1.1 New Case

Following receipt of a confirmed COVID-19 notification from either a laboratory or a clinician, a PHESS event is created by the data entry team. New cases appear on the 'Confirmed cases, actions pending' workflow. After checking to ensure the case is not a duplicate entry or a case being managed in another jurisdiction, the case is allocated for interview by the New Cases team leader.

The NCAC Team Leader will distribute cases for interview to team members. The following cases should be prioritised for urgent interview:

- Case is a healthcare worker
- Case lives in or works in a sensitive setting (e.g. correctional facility, aged care facility, childcare centre)
- Case is related to a known cluster or outbreak
- Case presents significant public health risk

Team members should review the notification form and data in PHESS prior to contacting the case.

4.1.2 Taking the history

The "case questionnaire COVID-19 (Novel Coronavirus) Part A and Part B" for provides the structure to taking a targeted public health history from a confirmed case of COVID-19. All sections of the form should be completed.

The incubation period for COVID-19 is up to 14 days. This is the time between exposed to the SARS-CoV-2 virus and the development of symptoms.

The infectious period for COVID-19 is currently unknown. However, for the purposes of isolation and contact tracing, cases are considered to be infectious (able to transmit the virus to others) from 48 hours before onset of symptoms until they meet the criteria for release from isolation.

The incubation period and infectious period are used to determine specific timelines used in the case questionnaire. For example:

- Considering case exposures (including travel) in the 14 days before symptom onset (incubation period)
- Identifying close contacts of the case from **48** hours prior to the onset of symptoms (infectious period)

The incubation period and the infectious period are subject to change as understanding of the SARS-CoV-2 virus progresses. The most up-to-date guidelines should be reviewed to ensure accurate definitions of incubation period and infectious period are being applied.

4.1.3 Initial management of cases

Confirmed cases should be informed that a member of the DHHS Existing Cases team will contact the case every day. Verbal information must be followed up with written information – send the case the Factsheet – confirmed case via email. The fact sheet provides the 24-hour communicable diseases phone number should the case need to speak with DHHS.

The Isolation (Diagnosis) Direction that is currently in effect (see: https://www.dhhs.vic.gov.au/state-emergency) makes it **compulsory** for anyone with a confirmed diagnosis of COVID-19 to go into isolation for a minimum period, and to meet other compulsory conditions before being able to resume normal activities. Penalties apply to those who refuse or fail to comply with this direction.

Cases must isolate themselves at home until they are advised otherwise by a Public Health Officer:

- They must not leave their house or accommodation except to seek medical attention or limited other permitted reasons, such as an emergency or if required by law
- They should stay in a different room to other people as much as possible. Sleep in a separate bedroom and use a separate bathroom if available.
- They should wear a surgical face mask when they are in the same room as another person and when seeking medical care.
- They should not go to work, school, university, or attend public places or events. Do not use public transport or taxi services.
- Where possible, they should get others such as friends or family who are not required to be isolated to get food or other necessities for them.

If they have difficulties getting food or necessities, call 1800 675 398 for support.

The above isolation requirements are outlined on the Factsheet – confirmed cases, available from: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

It is important to reiterate to the case the implications of not maintaining appropriate self-isolation and the risks that this can pose to other people including close contacts located in their household. If they do not sufficiently isolate themselves 5n

- The period of time for which household contacts will be required to self-quarantine will be extended. This is because household contacts will be required to self-quarantine from the time that they are identified as a close contact of a case until 14 days have elapsed since the date they last had close contact with the case while they were infectious (i.e. their total quarantine period may be >14 days).

4.1.4 Close Contacts

It is desirable, but not essential, that the case contacts people they have identified as close contacts themselves and advises them that they (the case) have been diagnosed with COVID-19. Regardless of whether they have been contacted by the case, all close contacts must be contacted by the New Case and Contact Team to explain their requirement to quarantine at home and provide instructions on testing should they develop symptoms. If any close contact requires medical advice, they need to seek this from their usual sources (e.g. their GP).

Close contacts should be informed that a member of the department's close contact team will contact them. Verbal information must be followed up with written information, send the Factsheet – close contacts via email. The fact sheet provides the 24-hour communicable diseases phone number should they need to speak with DHHS.

Close contacts should quarantine themselves at home (or in other appropriate accommodation) until 14 days after they were last exposed to the infectious person.

- They should not leave their house except to seek medical attention.
- They should stay in a different room to other people as much as possible. Sleep in a separate bedroom and use a separate bathroom if available.
- They should not go to work, school, university, or attend public places or events. Do not use public transport or taxi services.
- Where possible, they should get others such as friends or family who are not required to be quarantined to get food or other necessities for them.
- If they have difficulties getting food or necessities, call 1800 675 398 for support.

The above isolation requirements for close contacts are outlined on the Factsheet – close contacts: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

4.1.4.1 Interstate/overseas cases and close contacts

An interstate resident who is isolating in Victoria should be followed up and managed by the department (i.e. the Department of Health and Human Services, Victoria).

If interstate or overseas close contacts of a confirmed Victorian case of COVID-19 are identified, collect their details and email these to the relevant jurisdiction. Provide as much information as has been obtained, for example:

- Name
- Date of birth
- Phone number
- Date of exposure
- Any other relevant information obtained.

The team leader has access to the appropriate email address for each jurisdiction. For international close contacts email publichealth.intelligence@dhhs.vic.gov.au

4.1.5 Households

When multiple cases within a single household are interviewed together, it is appropriate to assess their close contacts together and determine the close contacts' last date of exposure to the case(s) at this time.

If the interviews of the household members occur separately, the last exposure date to any of the confirmed cases must be identified for each close contact. The close contact's quarantine period must be updated to reflect a 14-day period from last exposure to any confirmed case. This must be communicated to the close contact at the time of interview.

4.1.6 Hotel Detention

International arrivals into Australia are subject to a 14-day mandatory quarantine period in designated hotels. For couples and families, there are a number of room sharing options. The team leader at the hotel must communicate these options in advance of hotel check-in and inform people of the consequences of their choice. These consequences include an increased risk of infection, and a prolonged quarantine period should their roommate become a confirmed case of COVID-19.

When a person who is a current confirmed case of COVID-19 arrives in Australia, they will be placed in mandatory quarantine and asked to provide confirmation of their diagnosis. If there is doubt surrounding the certainty of the diagnosis, they will be offered additional testing at the hotel.

If an individual arriving in Australia states that they are a recovered (confirmed) COVID-19 case, they will initially be placed in mandatory quarantine, and asked to provide evidence of their diagnosis and that the required amount of time has passed such that they are no longer considered infectious. The department will decide on a case-by-case basis whether evidence from other sources is sufficient.

Further information relating to hotel detention can be found in sections 5.1.4 and 6.1.4.

4.1.7 Escalation and workflow

Team members may escalate any concerns to the Assistant Team Leader. This includes enquiries about the correct interpretation and completion of the "Case Questionnaire COVID-19 (Novel Coronavirus)" or any issues contacting confirmed cases.

Any notifications that require an urgent public health response or are received from a sensitive setting must be escalated to the Team Leader. This includes the following situations:

- The case is a healthcare worker
- The case works in or lives in a residential aged care facility
- The case works in or attends a school or childcare centre
- The case is in an intensive care unit
- The case has died
- The case is part of (or suspected to be part of) a known outbreak or cluster
- The case may trigger a large response (i.e. a large number of close contacts have been identified or if the case has been at work while infectious)
- The case is from a cruise ship
- The case is likely to generate media interest (for example if they are a celebrity or politician)
- The case appears resistant or reluctant to isolate
- The case appears resistant or reluctant to identify close contacts

Complete notifications are sent for data entry to complete the data entry requirements.

4.2 Troubleshooting common issues

4.2.1 Aeroplane flights taken by the case

For flights that were taken by the case, while infectious, obtain:

- flight number
- ports of departure and arrival
- date of arrival
- seat number

Currently, there is no contact tracing requirements for international flights or domestic flights < 2 hours duration. Contact tracing is required on domestic flights of > 2 hours duration. For the purposes of airline crew follow up, inform the National Incident Room by emailing publichealth.intelligence@dhhs.vic.gov.au regarding any flights that had an infectious case on board.

4.2.2 Outbreaks and sensitive settings

Outbreaks (sometimes called clusters) may occur in any setting but are of particular concern when they occur in sensitive settings, such as healthcare settings or residential aged care facilities.

The definition of an outbreak varies according to context. Outbreak definitions usually have elements of person, place and time. In Residential Aged Care Facilities, a confirmed outbreak is defined as "two or more cases of fever or acute respiratory infection in residents or staff within 3 days (72 hours) AND at least one case of COVID-19 confirmed by laboratory testing".

Established outbreak definitions do not currently exist for other sensitive settings. However, an outbreak should be suspected if two or more cases of suspected or confirmed COVID-19 (linked by time and place) occur within a sensitive setting.

When an outbreak is suspected, the details of the outbreak (for example the setting) should be recorded by the Team Leader. The Team Leader should also inform the Operations Lead, who will decide if escalation to the Deputy Public Health Commanders/Public Health Commanders is required. The Operations Lead will also arrange for the outbreak to be investigated by the "outbreak" team within the NCAC team. If extra support is required, the Team Leader can request input from the Strategy, Policy and Planning Operations Liaison and/or the Strategy, Policy and Planning

Lead.

In some cases, a single confirmed case of COVID-19 in a sensitive setting may warrant investigation. Team Leaders should inform the Operations Lead of cases in sensitive settings, to determine if escalation or further investigation is warranted.

4.2.3 Contacts who are healthcare workers

The same definition of close contact applies to healthcare workers (HCW) as other members of the community and should be managed in the same way. If a HCW is determined to be a close contact of a confirmed case, they must be isolated for a period of 14 days following their last contact with the case. A HCW who is a close contact of a confirmed case should not be swabbed for SARS-CoV-2 unless they develop symptoms (unless direction to do so is provided by a Deputy Public Health Commander/Public Health Commander).

A HCW who has had contact with a confirmed case of COVID-19 but does not satisfy the criteria as a close contact does not require isolation but should isolate immediately if they become unwell and seek testing for COVID-19.

4.2.3.1 Emergency Accommodation

The Victorian Government's COVID-19 Healthcare worker Emergency Accommodation (CHEA) Program (also known as the "Hotels for Heroes" program) provides access to free accommodation for hospital workers and paramedics who need to self-quarantine or self-isolate because of COVID-19 (i.e. as confirmed cases or close contacts) and who do not have a suitable home environment to do so. Examples of unsuitable home environments include HCWs who live with a member of an at-risk population group (e.g. people aged >65, or people who are immunosuppressed or have an underlying chronic condition), those who live in share houses, and those who live with other HCWs. If a contact wishes to access emergency accommodation, they should be advised to contact their employing health service, who will complete a request form on their behalf and send it to the email address covid19.hcwaccom@dhhs.vic.gov.au

4.2.4 Healthcare workers and PPE

HCWs who wear adequate PPE when caring for confirmed cases of COVID-19 are not considered to be close contacts, as is outlined in the close contact definition.

For routine care of confirmed COVID-19 cases (during their infectious period), adequate PPE consists of:

- surgical mask
- long sleeved gown
- face shield or goggles
- gloves

For aerosol generating procedures (AGPs), adequate PPE consists of:

- N95 mask / P2 respirator
- long sleeved gown
- face shield or goggles
- gloves

Further details, including a list of what constitutes an AGP can be found in the document "Coronavirus disease 2019 (COVID-19) Healthcare worker personal protective equipment (PPE) guidance for performing clinical procedures" which is available under the "Guidelines for health services and general practitioners" tab on the following webpage: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

If a HCW works in a setting that has an infection control unit (such as a hospital), an assessment of the adequacy of PPE should be undertaken in consultation with the facility's infection control unit.

Healthcare workers who are assessed as wearing inadequate PPE (e.g. incomplete/inappropriately applied PPE or where a PPE breach occurred) and who meet the definition of a close contact should be considered close contacts and managed accordingly. For example, if a nurse spends 30 minutes directly caring for a patient, wearing a surgical mask, gloves and long sleeve gown, but no eye protection, they are not wearing adequate PPE and should therefore be considered a close contact.

Judgement may be applied in some circumstances for HCWs who are wearing most of the required PPE and have had a low risk contact. In these situations, the department has recommended that a case not attend work for 14 days, but do not need to be in isolation. This can only be recommended after discussion with a Cell Lead.

4.2.5 Close contacts unable to isolate from confirmed cases

Every effort should be made for close contacts with ongoing contact to a confirmed case to isolate from that case. For example, a husband and wife couple should make every attempt isolate. Ideally this would mean having access to alternative accommodation. If this is not possible then every attempt to live

separately within their house including, not sleeping together, not eating or preparing meals together, using separate bathrooms, cleaning appropriately between use of common areas, kitchen and bathrooms (where alternative is not available). Isolating from each other protects the contact from an ongoing risk of infection with COVID-19, and reduces the period that they will be required to remain in isolation. If DHHS is not satisfied that a contact living in the same house as a case is isolated, the contacts period of quarantine will extend for 14 days after the last infectious period of the case (i.e for 14 days after the case is cleared).

If the close contact were to become unwell and test positive for COVID-19, the couple should continue to attempt to isolate from each other. If this is not possible, the original case can still be “cleared” by the Existing Cases Team when they meet the appropriate clearance criteria. No further quarantine is required for the exposure to their spouse or housemate. The Existing Close Contact and Existing Cases team will need to work together to identify cases and contacts requiring changes to their management based on inadequate isolation.

5 Existing Cases Team

The Existing Cases Team maintain contact with cases following their initial interview (conducted by the NCAC team). The Existing Cases Team make daily contact with confirmed cases of COVID-19, to monitor the isolation, health of the case, and to escalate any concerns as necessary. The Existing Cases Team also assess and provide clearance to cases who have met the end of isolation criteria.

The objectives of the existing cases team is

- Reduce the morbidity experienced by cases by:
  - Providing daily contact with cases and ensuring they have access to necessary medical support
  - Ensuring minimal impact of isolation requirements by releasing cases from isolation when they meet the appropriate criteria.
- Reduce transmission of COVID-19 by:
  - Ensure cases are aware of their isolation requirement through reinforcement of the message provided at first contact, and as a portal to answer questions cases may have.
  - Provide support and encouragement to cases to maintain their isolation requirements through daily contact with cases.
- Minimise the risk of transmission in healthcare settings by:
  - Applying the appropriate return to work criteria to healthcare workers
  - Advising confirmed cases on how to safely access medical care during their infectious period.

5.1 Processes and workflow

Confirmed cases of COVID-19 are entered into PHESS following receipt of the notification. Case interviews must be completed before the existing confirmed team takes over management.

Existing cases team generate a workflow from PHESS that is populated into an excel spreadsheet that outlines the required actions.

The Existing Cases Team Leader distributes the actions to the Team Members.

For the purpose of the public health management, confirmed cases are categorised into one of three groups, general community, healthcare workers, hospitalised patients and hotel detention.

5.1.1 Hospitalised patients

Together with the Intelligence team, the Existing Cases team collect information on hospitalised patients to ensure up-to-date statistics are available for decision makers. This includes understanding the number of COVID-19 patients in Victoria who are hospital inpatients, patients in an Intensive Care Unit (ICU) and those ventilated in ICU.

Up to date clinical data about COVID-19 patients who are currently in hospital is obtained via VICNISS (VICCNISS Healthcare Associated Infection Surveillance Coordinating Centre) and updated in PHESS by the Intelligence team. The Existing Cases team do not regularly contact cases while they are in hospital.

In the 'Guidelines for health services and general practitioners', the department recommends that a confirmed case may be discharged if the following criteria are met:

- a senior member of the treating team (or appropriate consulting team) has determined the patient is clinically improved and well enough to be managed in the community, and
- appropriate infection control measures can be implemented in the community or household setting to ensure risk to other household members can be managed, and
- the department is notified about the pending discharge

A confirmed case in the home must remain in isolation until criteria for release from isolation are met.

5.1.2 Healthcare workers

Healthcare workers who are in home isolation are contacted daily during their isolation by the Existing Cases Team.

When the case is eligible to meet end of **isolation** criteria (see below) they are called by an Existing Case team member to confirm criteria is met. An email of a standardised letter is provided. When the case is eligible to meet **return to work** criteria (see below) they are called by an Existing Case team member to confirm criteria are met. An email of a standardised letter is provided.

5.1.3 General community members

A person in isolation at home, who is not a healthcare worker, is contacted daily during their isolation by the Existing Cases Team. This contact, particularly for those deemed to be low risk, may be made through text message (via Soprano).

The team member provides a daily check on the cases condition. When the case is eligible to be "cleared" from isolation (see clearance criteria below) this is provided by the team member and confirmed by emailing the standardised letter.

5.1.4 Hotel detention

Confirmed cases of COVID-19 that are in hotel detention are managed, as per all cases, by the Existing Cases team.

When the confirmed case in hotel detention meets the criteria for release from isolation, the clearance certificate is provide (via email) to COVID.quarantine@dhhs.vic.gov.au.

Confirmed cases that meet the criteria for release from isolation, will also be eligible to be released from hotel detention.

A confirmed case that requires ongoing isolation, will not be detained longer than the 14 day quarantine period and appropriate conditions for them to maintain their isolation need to be arranged. The following table summarises situations provided in the *Guidelines for managing COVID-19 in mandatory quarantine*.

Excerpt from *Guidelines for managing COVID-19 in mandatory quarantine*

Scenario	Exit plan
Confirmed case of COVID-19 who has met criteria for release from isolation (i.e. is declared no longer infectious as per release from isolation), even if they have not completed their 14-day detention period	**Can leave** Must not be prevented from leaving if the AO is aware they are cleared and the person demands to leave They are non-infectious and therefore not a public health risk • End of isolation letter provided by PH Operations to COVID Quarantine Inbox and EOC inbox • Release from isolation by Case Manager following Health and Welfare checks • Transport should be arranged as part of the standard exit arrangements • Release outcome provided to EOC, PH Operations and Compliance Team via Case Manager
Confirmed case of COVID-19 who is still potentially infectious and has been in detention less than 14 days	• Must stay in detention.
Confirmed case of COVID-19 who is still potentially infectious but has reached the end of their 14 day detention period	**Can leave** Detention but is now subject to the Isolation (Diagnosis) Direction If Victorian Resident • Accommodation needs to be identified and EOC informed of needs prior to end of detention period – either home isolation with transport or continued hotel voluntary isolation • Safe travel to be arranged by EOC to place of isolation in Victoria (mask, stay separate, go straight to home; but preferred travel by non-emergency patient transport with PPE'd ambulance officers) If Interstate Resident • Not permitted to travel interstate / not permitted to fly domestically but no detention order needed to prevent • Accommodation needs identified and EOC informed of needs prior to end of detention period – continued hotel voluntary isolation (noting that interstate travel is not allowed)

5.2 Troubleshooting common issues

5.2.1 Confirmed case suspected of not isolating or putting others at risk

In the event that DHHS would like police attendance, either due to non-compliance with self-isolation or concern about a person's welfare (including when an officer is unable to reach case via phone after multiple attempts) - call 000 and ask for **welfare check** (the terminology is important). Explain that you are calling from DHHS about a confirmed case of COVID-19 and the nature of your concerns.

5.2.2 A close contact of a confirmed case, living in the same residence, becomes a confirmed case

Where a confirmed case lives in the same residence as a close contact, the opportunity for the confirmed case to isolate within their own house needs to be explored. If the close contact becomes a confirmed case, attempts for the two cases to remain isolated separately within their own house should be maintained. It is not yet known how likely reinfection is for recovered cases, although it is currently believed to be low.

When one of the confirmed cases in the residence is provided with "clearance from isolation" before the other, attempts at ongoing isolation within the residence should be maintained.

While attempts to isolate should be maintained, the confirmed case who has been provided clearance from isolation does not require isolation as a "close contact" of the confirmed case who is continuing isolation even if the attempts at isolation appear unsatisfactory.

5.2.3 Subsequent exposure of a confirmed case

If a confirmed case who has been "cleared" from isolation is subject to a second exposure (i.e is identified as a close contact of a confirmed case of COVID-19 after they have completed their isolation as a confirmed case), they will not need to undergo a period of isolation as a close contact

5.2.4 End of isolation criteria

A confirmed case who is isolating at home, no longer requires to be isolated in their own home, when all of the following criteria are met:

- the person has been afebrile for the previous 72 hours, and
- at least **ten days** have elapsed after the onset of the acute illness, and
- there has been a noted improvement in symptoms, and
- a risk assessment has been conducted by the department and deemed no further criteria are needed

5.2.5 Healthcare worker, return to work

Healthcare workers and workers in aged care facilities (HCWs) must meet the following additional criteria before they can return to work in a healthcare setting or aged care facility:

- PCR negative on at least two consecutive respiratory specimens collected 24 hours apart after the acute illness has resolved.

Testing for return-to-work clearance can commence once the acute illness has resolved, provided this is at least **7 days** after the onset of illness. Testing should be arranged by the healthcare worker's employer, the healthcare or aged care worker's treating doctor, or at a coronavirus assessment centre if testing by the treating doctor is not feasible. The patient should inform the department of where they intend to be tested. The department will follow up test results and provide a letter indicating that the patient can return to work once the return-to-work criteria are met.

In the event that a healthcare worker or aged care worker returns a positive PCR result from either of their first two consecutive clearance tests, wait 3 days before performing another “round” of 2 tests, 24 hours apart. If a positive PCR result is returned in this “second round” of testing, a third round of 2 tests, taken 24 hours apart should be undertaken after a further 5-7 days. In the event that respiratory specimens remain persistently PCR positive, a decision on suitability to return to work should be deferred until 21 days post symptom onset. At this time, a decision should be made on a case-by-case basis after consultation between the person’s treating doctor, the testing laboratory and the department.

The following criteria should be considered in this discussion:

- The person has met the criteria for release from isolation; AND
- The person’s symptoms have completely resolved; AND
- At least 21 days have passed since onset of the acute illness; AND
- Consideration should be given to mitigating circumstances such as the characteristics of the patients/residents which the person would care for at work (e.g. elderly or immunocompromised patients/residents). In certain high-risk settings (such as oncology wards), it may be appropriate for the HCW not to return to this setting until they have returned two negative swabs at least 24 hours apart. The timing of repeat swabs should be discussed with the treating doctor and the department.

The following procedures should be followed when performing return-to-work clearance testing:

- All HCWs should seek medical care from a medical practitioner. They should not be their own testing or treating clinician.
- All HCWs presenting for testing must wear a single use face mask and comply with infection control standards applicable to a confirmed case of COVID-19 until the department determines that release from isolation criteria are met
- Specimens should be collected using droplet and contact precautions
- Pathology requests must be clearly labelled with the following content under ‘clinical information’: **‘URGENT: HCW CLEARANCE TESTING, please notify result to DHHS**’ and results should be copied to the department’s COVID-19 Response team and the HCW’s treating physician.
- HCWs attending for return-to-work testing should be triaged as priority patients for testing.

The department will follow up the results of return-to-work testing and will contact healthcare and aged care workers regarding next steps. Once the return-to-work criteria are met, the department will provide healthcare and aged care workers with a letter confirming that they can return to work.

6 Existing close contacts

The Existing Close Contacts Team maintain contact with close contacts following an initial contact (conducted by the NCAC team). The Existing Close Contact Team make regular contact with known close contacts of confirmed COVID-19 cases to monitor their isolation, health, and escalate any concerns as necessary.

The objectives of the Existing Close Contact Team are to:

- Reduce the morbidity experienced by close contacts by:
  - Providing support and encouragement through daily contact with close contacts. Including ensuring they have accessto necessary medical support including COVID-19 testing if they develop symptoms.
- Reduce transmission of COVID-19 by:

- Ensure close contacts are aware of their isolation requirement (including known how long they must isolate for) through reinforcement of the message provided at first contact, and as a portal to answer questions cases may have.

6.1 Processes and workflow

Close contacts of confirmed cases of COVID-19 are entered into PHESS following their identification and primary consultation by the New Cases and Contact Team.

Existing Close Contact Team generate a workflow from PHESS that is populated into an excel spreadsheet that is used as a reference form for contact and outsourced to a third party (HelloWorld).

The third party (HelloWorld) records their interaction with close contacts on the spreadsheet, which is sent to the Existing Close Contact Team leader via Sharepoint twice daily; at 11:30am and end of day. The returned spreadsheet includes details of interactions with close contacts that requires further action – principally for one of three reasons:

1. The close contact has become unwell
2. The close contact is not isolating
3. The close contact requires that their last date of isolation be clarified

6.1.1 Close contacts who become unwell

Close contacts of confirmed cases of COVID-19, are at a higher risk of becoming infected themselves. It is therefore important for close contacts of confirmed cases of COVID-19, with appropriate symptoms, to undergo laboratory testing for COVID-19, to confirm the diagnosis and ensure appropriate clinical and public health management.

Close contacts of confirmed cases of COVID-19 who become unwell should present to the medical facility that is most equipped to manage the significance of their symptoms.

After being tested for COVID-19, close contacts must remain in isolation while awaiting their test result. If the test result is negative they must continue to isolate as a close contact until their 14 day isolation period has been completed. If their test result is positive, they begin a new period of isolation as a confirmed case. They will be informed of these requirements by the New Case and Contact Team, after the notification is received by DHHS (via the Notification and Triage Team).

6.1.2 Close contacts who are not isolating

Close contacts of confirmed cases of COVID-19 are informed of their isolation requirements when they are contacted by the New Cases and Contacts Team. This includes being emailed or posted the “Factsheet – close contact” that provides the details of isolation requirements in writing.

The factsheet may be re-provided to a close contact who has not received it (they should also check the SPAM or Junk folders of their email if they have not received it).

If the close contact indicates they will not comply with the home isolation requirements, they should be advised non-compliance will be escalated to police. If the close contact continues to indicate they will not comply with the isolation requirements, the Existing Close Contact Team Member contacts the Police Hotline on 131-444 to advise that this person has indicated non-compliance with the isolation requirement.

6.1.3 Close contact who requires their last date of isolation to be clarified

A dispute about the last day of isolation may be a result of misunderstanding, a change in the date that has not been conveyed to the close contact or incorrect recording in PHESS.

The last date of isolation may change if the close contact has had further (or ongoing) contact with the confirmed case, or if they have been identified as a close contact of more then one confirmed case (for example, a second person in the same house has been identified as a confirmed case.)

If there has misunderstanding or change in the date of last contact with a confirmed case the following process should be undertaken to confirm the date:

- Review PHESS notes of the contact and confirmed case
- Review original questionnaire (available on TRIM)

Once the date is confirmed, the contact must be advised of the correct end of isolation date. This must be updated and recorded in PHESS, and resent in writing, via email, to the close contact.

6.1.4 Hotel Detention

See the “guidelines for managing COVID-19 in mandatory quarantine” for further information.

- Close contacts of confirmed cases of COVID-19 that are in hotel detention are managed, as per all close contacts, by the Close Contacts Team.
- Close contact’s end date of quarantine may be past that of 14-day detention period, if they are exposed to a confirmed case during their period of hotel detention.
- No detention order required, and no legal order preventing flying, but must be advised by case and contact management sector not to fly and that they need to quarantine.

If **Victorian** Resident

- Need for accommodation is to be identified and EOC informed of needs prior to end of detention period – either home isolation with transport or continued hotel voluntary isolation
- Safe travel to be arranged by EOC to place of isolation in Victoria (mask, stay separate, go straight to home; but preferred travel by non-emergency patient transport with PPE’d ambulance officers)
- Continued management by the Close Contacts Team.

If **Interstate** Resident

- Should be advised not to travel to interstate jurisdiction, but there are no legislative powers to prevent travel
- Accommodation needs to be identified and EOC informed of needs prior to end of detention period – either interstate transport or continued hotel voluntary isolation
- Appropriate hygiene precautions must be taken if travelling by air (i.e. face masks) and people must return straight home.
- The home jurisdiction must be informed so they can be followed up as close contacts by their home jurisdiction

6.2 Troubleshooting common issues

6.2.1 A close contact who becomes unwell and refuses testing

A close contact of a confirmed case of COVID-19 who develops any symptoms consistent with COVID-19 should be requested to undergo testing. For the purposes of this guide, symptoms consistent with COVID-19 are:

- Fever or chills
- Cough
- Sore throat

- Shortness of breath
- Headache
- Myalgia
- Runny or stuffy nose
- Anosmia
- Nausea
- Vomiting
- Diarrhoea

People meeting testing criteria who are not tested for COVID-19 or any other infectious disease should self-isolate until the acute symptoms have resolved and it has been 72 hours since the last fever.

6.2.2 A close contact who needs to seek medical attention during their isolation period

Seeking medical attention is an acceptable reason for a close contact of a confirmed case of COVID-19 to leave isolation.

If an ambulance is required (for emergency treatment), when speaking to the 000 operator, the close contact should inform them that they are a close contact of a confirmed case of COVID-19 and are currently in home quarantine.

When seeking other medical attention, the close contact should call ahead and inform the staff at the facility they are attending that they are a close contact of a confirmed case of COVID-19.

If required to be driven by another person or utilise a taxi they should be informed to sit in the back seat (if possible), wear a mask if available and minimise time spent together in vehicle.

After receiving the required medical care, a close contact of a confirmed case of COVID-19 should ensure they are provided with a medical certificate that can be provided to VicPol if required, as proof of the legitimacy to leave their isolation requirements.

6.2.3 Request for documentation of quarantine end date

A contact may request an ‘end of isolation letter’. This can be emailed providing that the contact is not symptomatic, awaiting results and/or has not breached isolation guidelines if isolating with a confirmed case.

7 Management of asymptomatic cases and their contacts

Asymptomatic testing is currently being performed in Victoria in two different contexts:

1) Testing is being offered to asymptomatic individuals belonging to specific occupational groups and individuals at higher risk of severe illness as part of a 'testing blitz'. These people have a lower pre-test probability for COVID-19.
2) Testing of asymptomatic individuals is also occurring in selected high-risk outbreak settings (e.g. aged care facilities) as part of an 'active case finding' approach. These people have a higher pre-test probability for COVID-19.

7.1 Testing blitz

The current Victorian coronavirus testing blitz includes testing of asymptomatic individuals belonging to certain occupational groups. The aim of this testing is to gain information on the degree of community transmission that is occurring. Asymptomatic testing will be made available to various groups throughout the blitz. This testing is not compulsory.

Testing of asymptomatic individuals belonging to specific occupational groups may only be conducted at designated testing sites including:

- Respiratory Assessment Centres at Victorian public health services
- Respiratory Assessment Centres at community health centres
- Designated mobile drive-through testing clinics (located in retail settings)

Asymptomatic testing is being offered to those that cannot easily move their work to the home environment. This includes workers in the following industries:

- Construction
- Supermarkets
- Healthcare
- Police force
- Emergency services

Asymptomatic testing is also focusing on those who are at a higher risk of developing severe illness from infections with SARS-CoV-2. This includes members of the following groups:

- People living with chronic illness
- Aboriginal and Torres Strait Islanders

7.2 Testing protocol

Asymptomatic person offered testing as part of 'testing blitz'

Eligible populations may present for testing (SARS-CoV-2 PCR) on a voluntary basis in the absence of symptoms. There is no requirement for asymptomatic individuals to self-isolate whilst awaiting the result of a PCR test. However, asymptomatic individuals who have been identified by the department as close contacts of a case should self-quarantine until advised otherwise by the department (including whilst awaiting test results).

Samples from asymptomatic patients should be labelled as “asymptomatic testing” when sent to the laboratory.

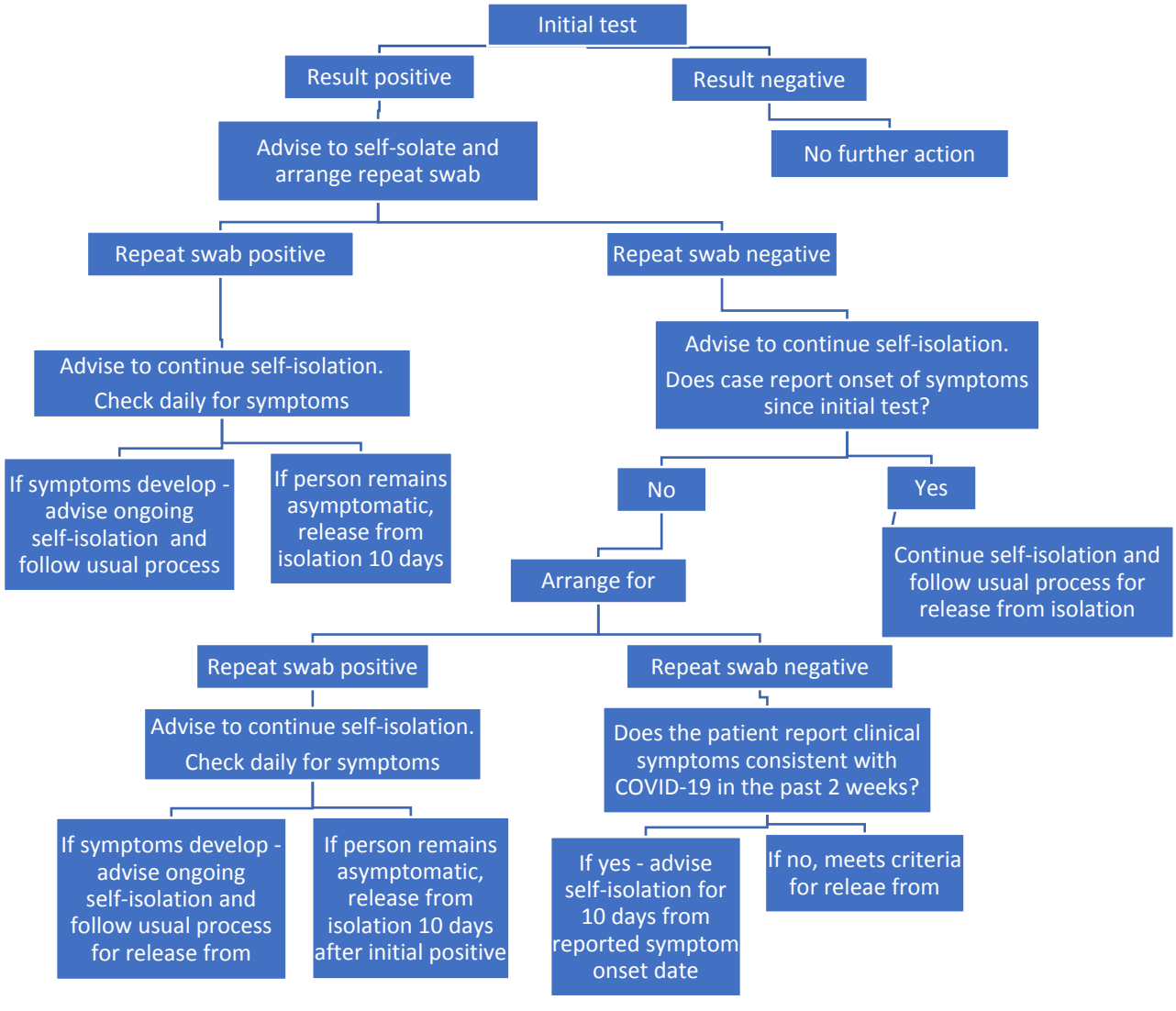
Individuals should be notified directly of the positive or negative result of the test. The current arrangement for notification of results for people who attend mobile testing centres is that those with a positive test will receive a phone call from a doctor advising them of the positive result, and those with a negative result will receive a text message from the testing laboratory.

It is the responsibility of the requesting clinician or health service to notify the department in the event of a positive result. The person will be treated as a confirmed case and a case interview and contact tracing will commence.

The requesting clinician or health service should contact the case to advise them of their positive result and request that they present for a second test. If possible, the second sample should be sent unprocessed the Victorian Infectious Diseases Reference Laboratory (VIDRL). Please ensure that the following information is provided on the pathology request form: “Repeat testing of asymptomatic positive”.

Any asymptomatic person with a positive test should be regarded as a confirmed case and should be advised to isolate. However, further testing should be undertaken as per the following algorithm:

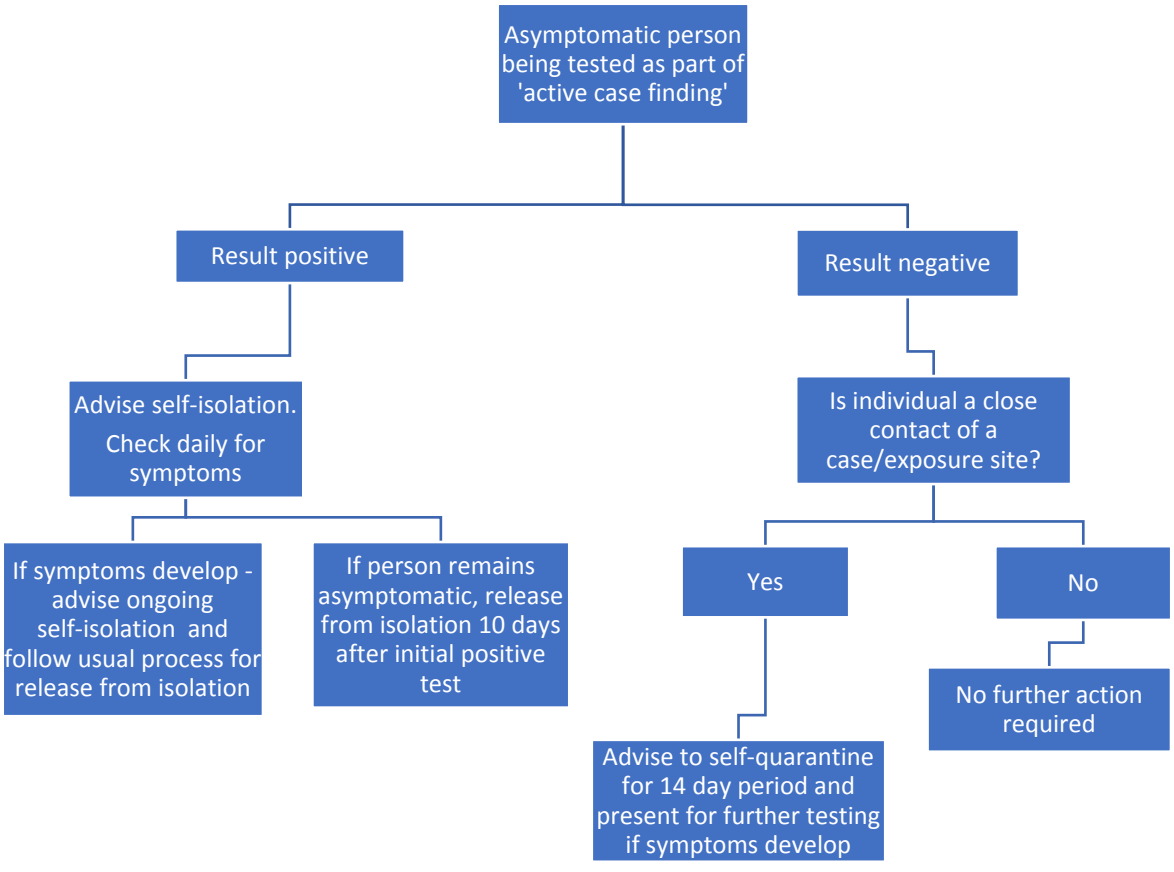
Algorithm 1: Asymptomatic person offered testing as part of testing blitz



Asymptomatic person tested as part of active case finding

In selected high-risk outbreak settings (e.g. aged care facilities), asymptomatic individuals may be offered testing as part of an 'active case finding' approach. Test results should be managed as per the following algorithm.

Algorithm 2: Asymptomatic person offered testing as part of testing blitz



7.3 Confirmed Cases

In the case of a positive result, the New Cases Team will contact the individual to conduct a case interview in the usual way. The interview will aim to establish whether the individual reports having had any recent symptoms consistent with COVID-19 preceding the positive screening test.

- If symptoms are identified, the date of onset of these symptoms should be recorded as the symptom onset date.
- If no symptoms are identified, the date of the initial positive test should be recorded as the symptom onset date

In either case, for the purposes of contact tracing the infectious period will be taken as beginning at least 48 hours prior to the recorded symptom onset date. Further investigation may extend this period.

7.4 Management of close contacts of asymptomatic cases

Close contacts of asymptomatic cases should isolate for 14 days since last contact with the case during their infectious period.

If the case is an asymptomatic person who was offered testing as part of the 'testing blitz' and has had 2 subsequent negative tests after their positive test, the close contacts may come out of isolation at the same time as the case (i.e. after the second negative test result). This is based on the following rationale:

- The pre-test probability is very low which increases the likelihood that the result is a false positive.
- It takes around seven days to return all three test results (sometimes longer).
- The case is likely at the very end of their period of infection and their infectivity is likely to be minimal in the days leading up to the initial test.

8 Glossary – Key terms

Confirmed case	A person who has the disease and meets the case definition. For COVID-

	19, the case definition is a person who tests positive to a validated SARS-CoV-2 nucleic acid test or has the virus identified by electron microscopy or viral culture.
Contact	A person who has been in contact with a confirmed case during their infectious period. Contacts are typically defined as either close contacts or casual contacts
Close contact	A person 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). See section 2.3.
Casual contact	A person who has been in contact with a confirmed case during their infectious period but who does not meet the definition of a close contact.
Contact tracing	The process of identifying people who are close contacts of a case, and ensuring they are quarantined for the maximum incubation period (14 days) after last close contact with the case.
COVID-19	Coronavirus disease 2019 (the name of the disease). COVID-19 was initially referred to as “novel coronavirus” (2019-nCoV) and is sometimes referred to as just “coronavirus”
Incubation period	The period of time between exposure to the disease and the onset of symptoms. For COVID-19 this is not yet known, but the interim view is up to 14 days (mean incubation period ~5-6 days)
Infectious agent	An infectious microorganism that causes disease – including viruses, bacteria, protozoa and fungi. The infectious agent that causes COVID-19 is the virus SARS-CoV-2.
Infectious period	Also known as the “communicable period,” this is the period during which an infected person can transmit an infectious agent to a susceptible person. The duration of the infectious period for COVID-19 is unknown. However, for the purposes of isolation and contact tracing, cases are considered to be infectious from 48 hours prior to the onset of symptoms, until they meet criteria for release from isolation.
Isolation	Isolation refers to the physical separation of ill people with a communicable disease (e.g. COVID-19) from those who are healthy
PPE	Personal protective equipment. This is clothing or equipment designed to be worn by someone to protect them from the risk of illness. For COVID-19, this usually means a mask, eye protection, gown and gloves.
Quarantine	Quarantine refers to the physical separation of people who are well but who may have been exposed with a communicable disease (e.g. contacts of a COVID-19 case) and are potentially infectious to see if they become ill.
SARS-CoV-2	Severe acute respiratory syndrome coronavirus 2 (the virus that causes COVID-19)
Sensitive settings	Settings at high risk for rapid transmission of infectious diseases and/or that have vulnerable people at high risk of serious illness or death. Sensitive settings include: • Healthcare settings • Aged care and residential care facilities • Prison / justice settings (correctional facilities, detention centres) • Aboriginal rural and remote communities

	• Boarding schools • Military operational settings • Educational settings where students are present (e.g. schools) • Childcare centres • Settings where COVID-19 outbreaks have previously occurred (e.g. cruise ships) Cases in these settings are likely to attract media attention.
Transmission	The spread of an infectious agent from one host (person or animal) to another is called transmission. COVID-19 is primarily transmitted through direct or indirect contact with respiratory droplets containing the virus, typically produced when and infectious person coughs or sneezes.

CONFIDENTIAL: New Outbreak - Rydges, Swanston St

From: "Simon Crouch (DHHS)" <REDACTED>

To: "Finn Romanes (DHHS)" <REDACTED>, "Brett Sutton (DHHS)" <REDACTED>

Cc: REDACTED <REDACTED <REDACTED, "Pam Williams (DHHS)" <REDACTED>, "Jason Helps (DHHS)" <REDACTED>, "SCC-Vic (State Intel Manager)" <sccvic.stateintelmgr@scc.vic.gov.au>, "REDACTED (DHHS)" <REDACTED REDACTED, "Kira Leeb (DHHS)" <REDACTED>, "REDACTED (DHHS)" <REDACTED REDACTED>, "REDACTED (DHHS)" <REDACTED REDACTED>, REDACTED DHHS)" <REDACTED REDACTED>, "Sarah McGuinness (DHHS)" <REDACTED>, REDACTED (DHHS)" <REDACTED>, "press (DHHS)" <press@dhhs.vic.gov.au>, "DHHS EmergencyCommunications (DHHS)" <em.comms@dhhs.vic.gov.au>, "Kym Peake (DHHS)" <REDACTED>, "Jacinda de Witts (DHHS)" <REDACTED>, "Annalise Bamford (DHHS)" <REDACTED>, "Melissa Skilbeck (DHHS)" <REDACTED>

Date: Tue, 26 May 2020 20:10:15 +1000

Dear Finn and Brett

Situations
The department is investigating an outbreak of coronavirus at the Rydges, Swanston St (note: currently there is one case in a staff member – given the likely transmission is from a resident this meets the outbreak definition due to transmission in a setting that is not a household)

Background
The Rydges, Swanston St is one of the hotels used by Operation Soteria to house returned travellers who are in quarantine. It is the designated hotel for COVID positive travellers. Currently there are 12 COVID positive cases at the hotel, 2 close contacts and four people with pending results as residents.

The case is a RED employee of the hotel who works REDACTE RE duties include cleaning and security in a REDACTED type role.
RE became unwell on 25 May with cough, fever, sore throat and lethargy. RE was tested that day and isolated in a room at the hotel (provided by RE employer).
RE worked one night while infectious on 23 May.
RE generally works alone and takes breaks alone. RE has a brief handover period at the start and end of the shift. At this time we believe RE work is restricted to the ground floor with minimal to no contact with residents (although this is being further explored).
RE travels to work on public transport (bus and train), which R did as usual on 23 May.

At this stage there are no identified close contacts at work.
There are R household close contacts REDACTED. All are currently well and in home quarantine.

Hypothesis
Transmission at the workplace form a COVID case in quarantine (either directly, via fomites or through contact with an intermediary staff case)

Actions
Case and contacts will remain in isolation/quarantine.
Further investigation of the workplace tonight and tomorrow including:

- Duties (including any cleaning duties)
- Interaction with guests
- Floor plan of work areas
- Rosters (RE and other staff)

Testing of all staff who worked shifts that coincide with the case during RED acquisition period

(including those RE handed over to).
Confirm no staff are working across other sites
Clean areas where case has worked while infectious (using in house cleaning – used to cleaning case rooms).
Outbreak Squad visit tomorrow (2 nurses to review IPC procedures and cleaning – further discussion to be had around whether those nurses can return to Lonsdale St)
Prepare media holding lines for tonight
Confirm staff have been informed of case
OMT tomorrow:

- Invite Pam Williams to next OMT – Pam to liaise with DJPR
- Review further actions re public transport at next OMT
- Review notification of WorkSafe at next OMT
- Review whether to inform residents tomorrow (probably not if there is no risk they have been exposed)

Thanks
Simon

Dr Simon Crouch BA MBBS MA MPH PhD FAFPHM
COVID-19 Deputy Public Health Commander (Case, Contact and Outbreak Management)
Health Protection Branch | Regulation, Health Protection and Emergency Management
Department of Health and Human Services | 50 Lonsdale Street, Melbourne, Victoria 3000
t. REDACTED | m. REDACTED | e. REDACTED
w. www.dhhs.vic.gov.au | he/him

RE: Urgent Fw: Emerging issue sick Rydges staff member

From: REDACTED (DHHS)" <REDACTED>
To: "Simon Crouch (DHHS)" <REDACTED>, "REDACTED" <REDACTED>
Cc: "REDACTED (DHHS)" <REDACTED>, "Pam Williams (DHHS)" <REDACTED>, DHHSOpSoteriaEOC <dhhsopsoteriaeoc@dhhs.vic.gov.au>, "REDACTED (DHHS)" <REDACTED>
Date: Tue, 26 May 2020 13:41:14 +1000

Dear Simon and REDACTED
I thought you should be made aware as part of the Case,Contact and Outbreak unit that the REDACTED at one of our Quarantine Hotels, the Rydges, has tested positive,
REDACTED worked on the following dates:
REDACTED

I will be checking with our rostering team to see who, if any of our staff were rostered on that time, however, the REDACTED is also checking this.

Regards,
REDACTED

Deputy Commander, Hotels
Operation Soteria

From: DHHSOpSoteriaEOC <DHHSOpSoteriaEOC@dhhs.vic.gov.au>
Sent: Tuesday, 26 May 2020 1:35 PM
To: REDACTED (DHHS) <REDACTED>
Cc: REDACTED (DHHS) <REDACTED>; Pam Williams (DHHS) <REDACTED>
Subject: FW: Urgent Fw: Emerging issue sick Rydges staff member

Hi REDACTED

As discussed please find below information regarding Rydges staff member positive result.

Thanks

Kind regards,

REDACTED – **Operations Officer**

OPERATION SOTERIA
Department of Health & Human Services
p: REDACTED
e: DHHSOpSoteriaEOC@dhhs.vic.gov.au

VICTORIA State Government | Health and Human Services

We respectfully acknowledge the Traditional Owners of country throughout Victoria and pay respect to the ongoing living cultures of Aboriginal people.

From: Rydges Swanston (DHHS) <RydgesSwanston@dhhs.vic.gov.au>

Sent: Tuesday, 26 May 2020 1:33 PM
To: DHHSOpSoteriaEOC <DHHSOpSoteriaEOC@dhhs.vic.gov.au>
Subject: Re: Urgent Fw: Emerging issue sick Rydges staff member

Hi Ops
In the last week or so in REDACTED (satff members name)
REDACTED

I havent located any close contracts working today. But havent asked the staff not here (leaving that to see how we want to go)
RE had a temp yesterday but is afebrile now and no other symptoms
I have asked all staff to keep this info in house at this stage
Appreciated
REDACT
ED

From: DHHSOpSoteriaEOC <DHHSOpSoteriaEOC@dhhs.vic.gov.au>
Sent: Tuesday, 26 May 2020 1:06 PM
To: Rydges Swanston (DHHS) <RydgesSwanston@dhhs.vic.gov.au>
Subject: RE: Urgent Fw: Emerging issue sick Rydges staff member

Hi REDA
CTED

Thanks for the update and will get back to you asap.

In the interim can you please try to establish days/dates/times etc when RE was on shift.

Also the level of his symptoms i.e. Is RE at home or hospital etc?

Thanks

Kind regards,

REDAC
TED – **Operations Officer**
OPERATION SOTERIA
Department of Health & Human Services
REDACTED
e: DHHSOpSoteriaEOC@dhhs.vic.gov.au

VICTORIA State Government | Health and Human Services

We respectfully acknowledge the Traditional Owners of country throughout Victoria and pay respect to the ongoing living cultures of Aboriginal people.

From: Rydges Swanston (DHHS) <RydgesSwanston@dhhs.vic.gov.au>
Sent: Tuesday, 26 May 2020 1:03 PM
To: DHHSOpSoteriaEOC <DHHSOpSoteriaEOC@dhhs.vic.gov.au>
Subject: Urgent Fw: Emerging issue sick Rydges staff member

Hi Ops
The staff member from Rydges has according to the GM tested positive today. The manager has spoken tot eh staff member and RE know of no other contacts other than here. Going back over RED movements the Manager does not believe that according to our definition of close contacts that any of RE staff members meet the criteria. I will check with

the other staff on shift now, though we will need to contact all to see if they have close contact?

I will await you advice on how to proceed I suggest testing all staff (with a very quick turn around)
Thnaks [redacted]

From: Rydges Swanston (DHHS)
Sent: Tuesday, 26 May 2020 10:33 AM
To: DHHSOpSoteriaEOC <DHHSOpSoteriaEOC@dhhs.vic.gov.au>
Cc: Rydges Swanston (DHHS) <RydgesSwanston@dhhs.vic.gov.au>; [redacted] (DHHS) [redacted]
Subject: Emerging issue sick Rydges staff member

Hi Ops
I cannot see a past email but there is an issue at Rydges.

One of the staff member of the hotel [redacted] is feeling crook with potentially covid type symptoms. [redacted] has been swabbed and tested by [redacted] GP with results pending (possibly tomorrow). The staff member is usually the [redacted] so this potentially lessens [redacted] contact with other staff, however, we will need assistance should [redacted] test positive. This will be who is a close contact/ counselling of staff cleaning ect... The nurses can do some but I'd be keen for the smooth functioning of the hotel if we had some definitive advice and contact tracing (if he has it how did he get it?). As [redacted] has older parents at home [redacted] is isolating in this hotel.

We will keep you updated as this progresses

Thank
[redacted]

Summary of Rydges cases - what we know to date

From: "Sarah McGuinness (DHHS)" <REDACTED>
To: "Simon Crouch (DHHS)" <REDACTED>, "Clare Looker (DHHS)" <REDACTED>
Date: Wed, 27 May 2020 15:09:36 +1000

Hi Simon/Clare,

Below is a summary of what we know about the 2 Rydges cases to date

Case 1: 320203450603

- REDACTED
- Symptom onset date = 25th May (fever, cough, sore throat, fatigue)
- Test date = 25th May, Monash Dandenong
- Lives in REDACTED with REDACTED
- Works at Rydges on Swanston REDACTED & also does [redacted]; last shift 11pm – 7am 23rd May (overlap with case 2)
- Takes public transport to work – bus from REDACTED to REDACTED n, train from REDACTED to the city

Case 2: 320203487846

- REDACTED
- Symptom onset date = 25th May (cough, sore throat, shortness of breath)
- Test date = 26th May, Box Hill Hospital (note: worked a shift after getting tested at Box Hill as was not specifically advised of the need to isolate).
- Lives in REDACTED with REDACTED
- Case is currently isolating at home; REDACTED close contacts quarantining at home also
- Works 3 jobs:
  - REDACTED
  - [redacted]
  - [redacted]
- Drives own car to work
- Attended Coles REDACTED at ~7:30pm on Sunday 24th May (during infectious period but before symptom onset) – no prolonged face to face contact with anyone

Just getting an update from REDACTED team now.

Cheers,
Sarah

Dr Sarah McGuinness
Infectious Diseases Physician
Case, Contact and Outbreak Management | COVID-19 Surge Workforce

Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
e REDACTED

New case - Rydges on Swanston

From: "Simon Crouch (DHHS)" [redacted]
To: "Finn Romanes (DHHS)" [redacted] "Brett Sutton (DHHS)" [redacted]
Date: Wed, 27 May 2020 14:53:08 +1000

Dear Finn and Brett

Situation
A second case has been notified linked to the Rydges on Swanston.

Background
An outbreak was declared at Rydges on Swanston on 26 May with the notification of a staff member.
Rydges on Swanston is one of the quarantine hotel and is where COVID cases are transferred.

The new case works as a [redacted] security guard [redacted] at the Rydges. [redacted] also works 2 other jobs (details below).
[redacted] symptom onset of sore throat, dry cough and runny nose was on 25 May. [redacted] sought testing at Box Hill Hospital and does not recall being given instructions to isolate while awaiting [redacted] result.
[redacted] role at the Rydges is to sit on one of the floors and monitor the rooms on that floor. [redacted] does not have contact with the residents and does not escort residents for 'fresh air' breaks – this is done by nurses in full PPE and only for asymptomatic cases.
[redacted] wears a mask and gloves while on duty but takes breaks in the foyer where [redacted] removes [redacted] mask and gloves. At this stage, we believe [redacted] has worked at least some shifts in common with case 1 (including on [redacted] May when they were both potentially infectious but asymptomatic).
[redacted] has worked at the Rydges throughout his acquisition period.

[redacted] second job is as a security guard [redacted] He works alone. The only contact in [redacted] infectious period was another guard during hand over. [redacted] is being classed as a close contact.

[redacted] third job is as a Deliveroo driver.
[redacted] has worked on 25 May while symptomatic (see comment above) and made 5 deliveries. Deliveries are no touch.

There are 3 household contacts – all being isolated.
[redacted] also attended Coles in Burwood while infectious – Coles is aware of this attendance.

The case is currently isolating at home.

Assessment
The notification of this second case supports the hypotheses that transmission has occurred from a returned traveller to one or more staff members at the hotel. Given the simultaneous onset it is possible that a third as yet unidentified staff case is the likely source.

Actions (Rydges)
Isolate the case and quarantine identified close contacts.
Identify rosters and movements of the new case to clarify any additional contacts.
Ensure cleaning of all relevant areas.
Expand testing to all staff who have worked at the Rydges since 11 May 2020 – appropriate lines being drafted to share with employees.
Reinforce that no staff working at the Rydges should work at any other quarantine hotels.
Review media lines
Map all interactions of both case 1 and case 2 with staff who have worked at the Rydges in the past week.
Review site report from outbreak squad when available.
Expedite the genomics

Note: At this stage, confirmed cases in quarantine will be allowed to be transferred to Rydges.

Close contacts of cases will not be transferred.

Actions (other)
Inform workplace where RE is a security guard to confirm contact history
Collect more information on restaurants attended while symptomatic – further action will depend on time RE spent there. It may be necessary to inform these restaurants.
Consider the need to inform the households RE delivered to (in order to monitor for symptoms).

Dr Simon Crouch BA MBBS MA MPH PhD FAFPHM
COVID-19 Deputy Public Health Commander (Case, Contact and Outbreak Management)
Health Protection Branch | Regulation, Health Protection and Emergency Management
Department of Health and Human Services | 50 Lonsdale Street, Melbourne, Victoria 3000
t. REDACTED | m. REDACTED REDACTED
w. www.dhhs.vic.gov.au | he/him

Outbreak summaries - 30 May

To: "Simon Crouch (DHHS)" <REDACTED>, "Finn Romanes (DHHS)" <REDACTED>, "Brett Sutton (DHHS)" <REDACTED>

Cc: "Jacinda de Witts (DHHS)" <REDACTED>, REDACTED REDACTED REDACTED >, "Kym Peake (DHHS)" <REDACTED REDACTED REDACTED REDACTED (DHHS)" <REDACTED REDACTED REDACTED sccvic.stateintelmgr@scc.vic.gov.au, "Jason Helps (DHHS)" REDACTED "Andrea Spiteri (DHHS)" <REDACTED REDACTED REDACTED REDACTED REDACTED (DHHS)" REDACTED (DHHS)" REDACTED REDACTED "Katherine Ong (DHHS)" <REDACTED, REDACTED REDACTED

Date: Sat, 30 May 2020 21:37:16 +1000

Dear Finn and Brett,

Please see today's update of outbreaks – apologies that it is late today.

REDACTED

- There are two confirmed cases in residents of this aged care facility. Case 1 – symptom onset 17 May; case 2 – asymptomatic.
- All staff at the site have undergone initial and follow up testing – all returning negative results.
- All but one of the residents have been tested. The resident who has not been tested has REDACTE and has consistently refused testing. Both cases live in separate areas of the facility. The resident who has not been tested lives in a separate area of the facility to both cases.
- Following an infection control assessment by Alfred Health, case 2 has been moved back into their residence. REDACTED REDACTED The department has outlined specific requirements for case 2 to be safely isolated in the REDACT
- Release from isolation testing for the first case will be conducted this week
- Staffing support is being provided by the Commonwealth
- This outbreak is active and under investigation. There is no projected closure date

REDACTED

- There is a single confirmed case in a resident of this aged care facility. Symptom onset for the case was 13 May. The case has been isolated since that time.
- All residents (bar one) have been tested and received negative results. The resident who has not been tested has REDACTED
- All staff have been tested and have returned negative results.
- A member of the department's outbreak control squad has visited the site and performed an assessment. Appropriate infection prevention and control measures are being implemented. A second visit was conducted on 22 May. Some concerns about IPC procedures have been raised that are being addressed by the facility.
- PPE training was conducted by outbreak squads on 21 May
- A second round of testing for close contacts (38 residents, 8 staff) was conducted on Monday 25 May. All tests are negative.
- Some staff who have been released from isolation by DHHS have started to return to work
- The department has commenced discussions with the facility regarding relaxing restrictions. It is anticipated that the facility will be able to lift the isolation requirements on residents on Monday.
- This outbreak is active and under investigation. There is no projected closure date.

REDACTED

- Three confirmed case have been linked to this outbreak in an aged care facility (resident), including 2 new cases today.
- Symptom onset for case 1 was 16 May. REDACTED REDACTED They have met clearance criteria. They will remain at the REDACTED REDACTED

- The facility advised that REDACTED EDACT D This was considered a suspected case as testing was not performed and REDACTED REDACTED Their family contacts were placed in quarantine but have now all tested negative.
- As of 20 May, all residents in the same wing as the case (17), and staff that worked in that wing from 14 to 17 May (21) are considered close contacts and are being quarantined. The department has also identified 7 other close contacts including 5 family members and 2 healthcare workers.
- To date, all 87 residents and 103 staff have received negative results from initial testing.
- Testing was arranged for a further 7 staff members. Of these staff members, two have returned positive results. Both are asymptomatic. The department is working closely with the facility to ensure appropriate measures are being put in place. Including quarantine of all residents.
- Testing for all staff and residents is being undertaken on 26 and 27 May. All results are negative.
- PPE training was conducted on 21 May by outbreak squads.
- This outbreak is active and under investigation. There is no projected closure date.

REDACTED

- A total of 13 cases have been associated with REDACTE family group comprising RED ACT households and their contacts (2 new).
- 9 cases live in one household. 4 cases live in another .
- The first case is a REDACTED eported on 26 May with comorbidities who was admitted to hospital (in ICU but condition improving)
- 5 family members were diagnosed on 27 May. On 28 May a case was identified in a close contact from a different household and subsequent screening has identified 3 further household cases as of 29 May.
- These cases attended or worked in their infectious periods at a number of sensitive settings and a workplace:
  - REDACTED one case attended on 26th may during infectious period
    - School/DET aware
    - ~80 students identified as close contacts (including 16 students from REDAC TED REDACTE nd 1 student REDACTED .
      - Outbreak response squad visit. Clean occurred.
    - School to open Monday
  - REDACTED ne case attended on 26th May during "infectious period" (asymptomatic)
    - School/DET/Catholic Education aware
    - Student yea RE DA class all considered close contacts (~21 students, up to 5 staff)
      - Outbreak response squad visit. Clean occurred.
      - School to open Monday
  - REDACTED REDACTE
    - Workplace of REDACTED (2 of 3 +ve; 1 -ve)
    - Both confirmed cases worked 26th May whilst infectious
    - One confirmed case had extensive contact with workers across the site
    - ~30 close contacts identified
    - Site closed. Deep clean undertaken. Outbreak response squad have visited
    - Worksafe aware
    - Discussion with CEO/Management on Friday:
      - Quarantining of such large proportion of workforce will require site closure
      - Two staff will need to attend site on Monday to active safe "shut down"
      - Industry – liquid hazardous waste treatment, waste oil processing/recycling etc
  - **Sunshine Hospital/Footscray Hospital**
    - One case treated at Sunshine Hospital and Footscray Hospital 15-18th May for tooth abscess
    - Taken to Sunshine Hospital and sat in waiting room with husband, whilst

husband was infectious (15th May)
- REDACTED
  REDACTED . No further COVID-19 symptoms post admission.
- Tested COVID-19 +ve 28th May
- Infectious period being taken from 16th May.
- Exposure sites during infectious period: Sunshine hospital ED, ambulance transfer to Footscray, Footscray hospital theatre and ward.
- Western Health IPC aware and commencing contact tracing (noting 13 days have elapsed since initial exposure).

  - Investigation and contact tracing is being undertaken
-

Rydges

- 2 cases have been linked to this outbreak – both are staff who work night shifts at Rydges on Swanston.
- The symptom onset date for both cases is 25 May. Each case worked one shift at Rydges on Swanston during their infectious period (before symptom onset).
- No close contacts have been identified at Rydges on Swanston to date, but both cases have household contacts (and one case has an additional close contact from another job) who have been contacted by the department and advised to quarantine.
- Testing has been recommended for all staff who attended Rydges on Swanston for 30 minutes or more on or after the 11 May. This testing commenced today.
- A commercial clean of relevant areas of the hotel has been arranged.
- This outbreak is active and under investigation. There is no projected closure date.

REDACTED
REDACTED

Follow the Chief Health Officer on Twitter @VictorianCHO

Please see today's update of outbreaks – apologies that it is late today.

Rydges on Swanston - OMT - 31 May

From: REDACTED

To: Public Health Operations <publichealth.operations@dhhs.vic.gov.au>, Public Health Intelligence <publichealth.intelligence@dhhs.vic.gov.au>, sccvic.stateintelmgr@scc.vic.gov.au, REDACTED "Pam Williams (DHHS)" REDACTED "Merrin Bamert (DHHS)" REDACTED "Anthony J Kolmus (DHHS)" <REDACTED >, "DHHS EmergencyCommunications (DHHS)" <em.comms@dhhs.vic.gov.au>, REDACTED REDACTED

Cc: REDACTED "Simon Crouch (DHHS)" REDACTED

Date: Sun, 31 May 2020 15:09:44 +1000

Hi all,

Thanks for your time earlier today.

Summary of actions

- Follow up on genomics – Intelligence
- Report on environmental assessment – Outbreak squad
- Chase test results for staff members – CCOM
- Advise on relaxing restrictions – Simon/REDACT
- Embed IPC lead from a health service – Merrin
- Ensure close contacts are contacted and counselled – CCOM
    - Note decision that people who attended Rydges only for the purposes of testing **and** were not working during the risk period, are **not** close contacts.
- Plan for day 11 return to work testing – CCOM

I understand that there are some other actions under way in relation to moving away from Rydges due to workforce issues. We can update on this tomorrow.

REDACTE

REDACTED
REDACTED
COVID-19 Public Health Incident Management Team
Department of Health & Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
REDACTED
Please note that I do not work on Wednesdays.

Outbreak summaries -31 May

From: "Simon Crouch (DHHS)" REDACTED

To: "Annaliese Van Diemen (DHHS)" REDACTED

Cc: "Jacinda de Witts (DHHS)" REDACTED "Annalise Bamford (DHHS)" REDACTED "Kym Peake (DHHS)" REDACTED @minstaff.vic.gov.au REDACTED "Jackie Kearney (DHHS)" REDACTED "Terry Symonds (DHHS)" REDACTED sccvic.stateintelmgr@scc.vic.gov.au, "Jason Helps (DHHS)" REDACTED "Andrea Spiteri (DHHS)" REDACTED, "Katherine Ong (DHHS)" REDACTED (DHHS)" REDACTED "Simon Crouch (DHHS)" REDACTED (DHHS)" REDACTED "Sarah McGuinness (DHHS)" REDACTED (DHHS)" REDACTED (DHHS)" REDACTED

Date: Sun, 31 May 2020 19:49:57 +1000

Dear Annaliese

Please see today's summary of outbreaks. There is one new cases associated with the Rydges Outbreak. There are no updates to the aged care outbreaks.

REDACTED **Family Cluster**

- A total of 13 cases have been associated with one large family group comprising four households and their contacts. REDACTED
- The IPC squad is visiting all four households associated with this family group on 31 May and will report on adequacy of isolation, IPC measures and any other welfare needs.
- The first was reported on 26 May with comorbidities who was admitted to hospital (in ICU but condition improving).
- REDA family members were diagnosed on 27 May. On 28 May a case was identified in a close contact from a different household and subsequent screening has identified 3 further household cases as of 29 May.
- These cases attended or worked in their infectious periods at a number of sensitive settings and a workplace:
  - REDACTED one case attended on 26 May during their infectious period
    - Around 80 students identified as close contacts (including 16 students from REDAC REDACTE and 1 student REDACTED . All are in quarantine and will undergo return to school testing.
    - School/DET aware
    - Outbreak response squad visit. Clean occurred.
    - School to open Monday
  - REDACTED one case attended on 26 May during their infectious period (asymptomatic)
    - School/DET/Catholic Education aware
    - Students in yea RE class all considered close contacts (21 students, and 6 staff). All are in quarantine and will undergo return to school testing.
    - Outbreak response squad visit. Clean occurred.
    - School to open Monday
  - REDACTED **Laverton**
    - Workplace of **three** family members (2 of 3 +ve; 1 -ve)
    - Both confirmed cases worked 26 May while infectious
    - One confirmed case had extensive contact with workers across the site
    - Around 30 close contacts identified
    - Site closed. Deep clean undertaken. Outbreak response squad have visited. Return to work testing will be undertaken.
    - Worksafe aware

- REDACTED REDACTED Hospital
  - Two cases attended REDACT Hospital and REDACTE Hospital 15-18 May. One was a patient, the other REDACTED
  - Infectious periods from 15 and 16 May.
  - Exposure sites during infectious period: REDACT hospital ED, ambulance transfer to REDACTE, REDACTE hospital theatre and ward.
  - Western Health IPC aware and commencing contact tracing (noting more than 14 days have elapsed since initial exposure).
- A pop up testing clinic has opened in Keilor Downs with targeted promotion of symptomatic testing to local communities, school communities.
- Liaison with local Pasifika community via DPC and local government. Round table with community leaders planned for next week.

Rydges

- 8 cases have been linked to this outbreak – 7 are staff who work night shifts at Rydges on Swanston. R hotel staff, 5 security staff and R mental health nurse. One is a household close contact.
- A commercial clean of relevant areas of the hotel has occurred.
- All staff cases worked night shifts at Rydges on Swanston, overlapping on 21 May.
- One staff case is asymptomatic, the other 6 have symptom onset dates ranging from 24/05/2020 – 29/05/2020 (3 have the same symptom onset date = 25/05/2020)
- Current hypothesis is that the hotel is the source of infection, either from environmental contamination in the week prior to 25th May, or possibly from an unrecognised case(s) or known hotel case; at this stage it is not possible to definitively determine.
- It is likely that environmental risk has been attenuated following a deep clean of the premises on 28 May.
- All staff who attended the site between 11 and 28 May asked to seek testing for COVID-19.
- As of 30 May, any staff member who attended the Rydges on Swanston Hotel for 30 minutes or more during the period 18 May to midday on 28 May inclusive is now being asked to **self-quarantine for 14 days** since their last visit to the hotel.
- Education and training on appropriate PPE by outbreak squad nurses (particular focus on security staff who have been wearing non-approved porous gloves)
- All staff close contacts will be required to be re-tested prior to completing their 14 day quarantine period.
- Due to difficulties in staffing the Rydges, alternative accommodation is being sought.
- This outbreak is active and under investigation. There is no projected closure date.

REDACTED

- There are two confirmed cases in residents of this aged care facility. Case 1 – symptom onset 17 May; case 2 – asymptomatic.
- All staff at the site have undergone initial and follow up testing – all returning negative results thus far. There are 10 staff test results pending.
- All but one of the residents have been tested. The resident who has not been tested has REDACTED nd has consistently refused testing. Both cases live in separate areas of the facility. The resident who has not been tested lives in a separate area of the facility to both cases.
- Following an infection control assessment by Alfred Health, case 2 has been moved back into their residence REDACTED REDACTED The department has outlined specific requirements for case 2 to be safely isolated in the REDACTE
- Case 1 has commenced clearance testing. The first swab is negative. A second swab will be taken on 1 June
- Staffing support is being provided by the Commonwealth
- This outbreak is active and under investigation. There is no projected closure date

REDACTED

- There is a single confirmed case in a resident of this aged care facility. Symptom onset for the case was 13 May. The case has been isolated since that time.
- All residents (bar one) have been tested and received negative results. The resident who has not been tested has REDACTED
- All staff have been tested and have returned negative results.
- A member of the department's outbreak control squad has visited the site and performed an assessment. Appropriate infection prevention and control measures are being implemented. A

second visit was conducted on 22 May. Some concerns about IPC procedures have been raised that are being addressed by the facility.
- PPE training was conducted by outbreak squads on 21 May
- A second round of testing for close contacts (38 residents, 8 staff) was conducted on Monday 25 May. All tests are negative.
- Some staff who have been released from isolation by DHHS have started to return to work
- The department has commenced discussions with the facility regarding relaxing restrictions. It is anticipated that the facility will be able to lift the isolation requirements on residents on Monday.
- This outbreak is active and under investigation. There is no projected closure date.

REDACTED

- Three confirmed case have been linked to this outbreak in an aged care facility (resident)
- Symptom onset for case 1 was 16 May. The case was admitted to the Epworth Richmond on 17 May following a fall. They have met clearance criteria. They will remain at the Epworth in a sub-acute ward.
- The facility advised that a resident with symptoms of a respiratory illness died on the REDACTED This was considered a suspected case as testing was not performed and the body has since REDACTED Their family contacts were placed in quarantine but have now all tested negative.
- As of 20 May, all residents in the same wing as the case (17), and staff that worked in that wing from 14 to 17 May (21) are considered close contacts and are being quarantined. The department has also identified 7 other close contacts including 5 family members and 2 healthcare workers.
- To date, all 87 residents and 103 staff have received negative results from initial testing.
- Testing was arranged for a further 7 staff members. Of these staff members, two have returned positive results. Both are asymptomatic. The department is working closely with the facility to ensure appropriate measures are being put in place. Including quarantine of all residents.
- Testing for all staff and residents was undertaken on 26 and 27 May. All results are negative so far. There are some results from agency and contract staff which are pending.
- PPE training was conducted on 21 May by outbreak squads.
- This outbreak is active and under investigation. There is no projected closure date.

Thanks
Simon

Dr Simon Crouch BA MBBS MA MPH PhD FAFPHM
COVID-19 Deputy Public Health Commander (Case, Contact and Outbreak Management)
Health Protection Branch | Regulation, Health Protection and Emergency Management
Department of Health and Human Services | 50 Lonsdale Street, Melbourne, Victoria 3000
REDACTED REDACTED
w. www.dhhs.vic.gov.au | he/him

Outbreak Management team meeting actions and notes

Date & Time: 12:30pm Monday 1 June 2020

Outbreak Name / Setting: **Rydges**

Purpose of Meeting: Daily update

Action list

Date allocated	Action	Responsible person	Due date	Date Completed
1/06/2020	Follow up / discuss provide details of taxi passengers	REDACTED	1/06/2020	
1/06/2020	Share details of at-risk taxi passengers with Tracey	REDACTED	1/06/2020	
1/06/2020	Engage Commercial Passenger Vehicles Victoria	Braedan	2/06/2020	
1/06/2020	Squads to plan visits to other quarantine hotels	REDACTED	2/06/2020	
1/06/2020	Confirm whether restrictions on residents can be lifted		1/06/2020	

Notes

Situation update:

- Notification of 8th case – household contact of existing case
  - REDACTED household contact of case 5
  - Symptom onset date was 28/05/2020
  - Has been in isolation at Rydges since 31/05/2020
  - Works as a REDACTED
    - Details of passengers during infectious period are still being established
  - Tracing being done through REDACTED – Commercial Passenger Vehicles Victoria to be engaged
- Contact tracing & testing:
  - Contact made with all so far
  - Results have been provided for everyone who was tested at Rydges
  - Contacting some of the testees is difficult as we don't have (correct) phone numbers for everyone
- There are 8 confirmed cases, none are hospitalised
- 2 cases isolating in hotel (case 5 and case 8)
- 4 close contacts are also isolating in the hotel
- All other cases / close contacts are isolating at home
- There are 2 symptomatic household contacts of one of the cases
  - Both have been tested, results pending
  - 1 is isolating at a hotel, 1 is isolating at home
  - No other symptomatic close contacts have been identified
- Contact management:
  - Attempts to communicate with all identified contacts have been made
  - Just a few people have not answered phones – attempts to contact these people are ongoing

Control measures:

- Currently moving to Novotel South Wharf

- Active case finding:
    - 132 results come through from VGRL; all are negative so far
    - There are 32 persons who have been tested but we are not presently able to identify who they are, mainly just due to administrative errors
    - Some sought testing elsewhere – we are working to get results as quickly as possible
- An outbreak control squad is going to Novotel this afternoon; the visit will include planning for and commencing training for IPC and PPE
- We need to provide confirmation of whether restrictions on residents can be lifted
- Day 11 re-testing is being offered to all staff prior to coming out of quarantine – letters to affected staff approved by Simon Crouch

Internal and external communication:

- The new hotel is not being named publicly
- Channel 7 are aware of the move
- Some lines have been prepared and are awaiting approval from Simon

Outbreak summaries -1 June

From: "Simon Crouch (DHHS)" <REDACTED>

To: "Annaliese Van Diemen (DHHS)" <REDACTED> "Brett Sutton (DHHS)" <REDACTED>

Cc: "Jacinda de Witts (DHHS)" REDACTED "Annalise Bamford (DHHS)" <REDACTED> "Kym Peake (DHHS)" REDACTED REDACTED "Jackie Kearney (DHHS)" <REDACTED> "Terry Symonds (DHHS)" REDACTED sccvic.stateintelmgr@scc.vic.gov.au, "Jason Helps (DHHS)" REDACTED "Andrea Spiteri (DHHS)" REDACTED "Katherine Ong (DHHS)" REDACTED REDACTED "Simon Crouch (DHHS)" <REDACTED> "Sarah McGuinness (DHHS)" REDACTED REDACTED REDACTED REDACTED

Date: Mon, 01 Jun 2020 20:54:33 +1000

Dear Annaliese and Brett

Please see today's outbreak summaries below. There are no new outbreaks listed here. There are 4 new cases linked to the Rydges outbreak.

REDACTED **Family Cluster**

- A total of 13 cases have been associated with one large family group comprising four households and their contacts. REDACTED
- The IPC squad has visited all four households associated with this family group on 31 May and reported on adequacy of isolation, IPC measures and any other welfare needs.
- One of the families have been provided with alternative accommodation as they were unable to adequately isolate in their usual dwelling.
- The first case was reported on 26 May with comorbidities who was admitted to hospital (in ICU but condition improving).
- Five family members were diagnosed on 27 May. On 28 May a case was identified in a close contact from a different household and subsequent screening has identified 3 further household cases as of 29 May.
- These cases attended or worked in their infectious periods at a number of sensitive settings and a workplace:
  - REDACTED ne case attended on 26 May during their infectious period
    - Around 69 students identified as close contacts (including 5 students from REDACTED and 1 student REDACTED . All are in quarantine and will undergo return to school testing
    - School/DET aware
    - Outbreak response squad visit. Clean occurred.
    - Advised that school has re-opened today (1 June)
  - REDACTED one case attended on 26 May during their infectious period (asymptomatic)
    - School/DET/Catholic Education aware
    - Students in year R class all considered close contacts (21 students, and 6 staff). All are in quarantine and will undergo return to school testing.
    - 2 staff members were symptomatic and have been tested – results both negative
    - Outbreak response squad visit. Clean occurred.
    - Expecting school to open on Wednesday
  - REDACTED **Laverton**

- Workplace of **three** family members (2 of 3 +ve; 1 -ve)
- Both confirmed cases worked 26 May while infectious
- One confirmed case had extensive contact with workers across the site
- Around 21 close contacts identified. Further 8 staff identified but not close contacts (were working from home). Potential for index case to have acquired COVID-19 from this site, so all staff (21 close contacts and 8 additional staff) have been tested – results pending.
- Site closed. Deep clean undertaken. Outbreak response squad have visited. Return to work testing will be undertaken.
- Worksafe aware

- REDACT **Hospital/**REDACT **Hospital**
  - Two cases attended REDACTE Hospital and REDACTE Hospital 15-18 May. One was a patient, the other REDACTED
  - Infectious periods from 15 and 16 May.
  - Exposure sites during infectious period: REDACTE hospital ED, ambulance transfer to REDACTE, REDACT hospital theatre and ward.
  - Western Health IPC aware and commencing contact tracing (noting more than 14 days have elapsed since initial exposure).
  - No close contacts identified from Sunshine Hospital (appropriate PPE used). 9 close contacts identified through Footscray Hospital – all in quarantine.

- A pop up testing clinic has opened in Keilor Downs with targeted promotion of symptomatic testing to local communities, school communities.
- Liaison with local Pasifika community via DPC and local government. Round table with community leaders planned for this week

Rydges

- 12 cases have been linked to this outbreak – 7 are staff who work RED shifts at Rydges on Swanston. 1 hotel staff, 5 security staff and 1 mental health nurse. Five are household close contacts (although interviews are still pending).
- A commercial clean of relevant areas of the hotel has occurred.
- All staff cases worked REDA shifts at Rydges on Swanston, overlapping on 21 May.
- One staff case is asymptomatic, the other 6 have symptom onset dates ranging from 24/05/2020 – 29/05/2020 (3 have the same symptom onset date = 25/05/2020)
- Current hypothesis is that the hotel is the source of infection, either from environmental contamination in the week prior to 25th May, or possibly from an unrecognised case(s) or known hotel case; at this stage it is not possible to definitively determine.
- It is likely that environmental risk has been attenuated following a deep clean of the premises on 28 May.
- All staff who attended the site between 11 and 28 May asked to seek testing for COVID-19.
- As of 30 May, any staff member who attended the Rydges on Swanston Hotel for 30 minutes or more during the period 18 May to midday on 28 May inclusive is now being asked to **self-quarantine for 14 days** since their last visit to the hotel.
- Education and training on appropriate PPE by outbreak squad nurses (particular focus on security staff who have been wearing non-approved porous gloves)
- All staff close contacts will be required to be re-tested prior to completing their 14 day quarantine period.
- Due to difficulties in staffing the Rydges, alternative accommodation was sought. Residents have been moved today to a different hotel in the CBD.
- This outbreak is active and under investigation. There is no projected closure date.

REDACTED

- There are two confirmed cases in residents of this aged care facility. Case 1 – symptom onset 17 May; case 2 – asymptomatic.
- All staff at the site have undergone initial and follow up testing – all returning negative results thus far.
- All but one of the residents have been tested. The resident who has not been tested has REDACTE and has consistently refused testing. Both cases live in separate areas of the facility. The resident who has not been tested lives in a separate area of the facility to both cases.
- Following an infection control assessment by Alfred Health, case 2 has been moved back into their residence. REDACTED

REDACTED The department has outlined specific requirements for case 2 to be safely isolated REDACTED

- Case 1 has commenced clearance testing. The first swab is negative. A second swab could not be taken as the case refused testing. Case has already had multiple negative swabs and has been cleared.
- Clearance testing for case 2 will commence on Thursday 4 June. This will include day 11 testing for close contacts (6 residents, 14 staff)
- Staffing support is being provided by the Commonwealth
- This outbreak is active and under investigation. There is no projected closure date

REDACTED

- There is a single confirmed case in a resident of this aged care facility. Symptom onset for the case was 13 May. The case has been isolated since that time.
- All residents (bar one) have been tested and received negative results. The resident who has not been tested has REDACTED case.
- All staff have been tested and have returned negative results.
- A member of the department's outbreak control squad has visited the site and performed an assessment. Appropriate infection prevention and control measures are being implemented. A second visit was conducted on 22 May. Some concerns about IPC procedures have been raised that are being addressed by the facility.
- PPE training was conducted by outbreak squads on 21 May
- A second round of testing for close contacts (38 residents, 8 staff) was conducted on Monday 25 May. All tests are negative.
- Some staff who have been released from isolation by DHHS have started to return to work
- The department has commenced discussions with the facility regarding relaxing restrictions. The facility has been advised today (1 June) that restrictions can be lifted.
- This outbreak will not be reported from now unless there are any new developments

REDACTED

- Three confirmed case have been linked to this outbreak in an aged care facility (resident)
- Symptom onset for case 1 was 16 May. The case was admitted to the Epworth Richmond on 17 May following a fall. They have met clearance criteria. They will remain at the Epworth in a sub-acute ward.
- The facility advised that a resident with symptoms of a respiratory illness died on the RE May. This was considered a suspected case as testing was not performed and REDACTED REDACTED Their family contacts were placed in quarantine but have now all tested negative.
- As of 20 May, all residents in the same wing as the index case (17), and staff that worked in that wing from 14 to 17 May (21) are considered close contacts and are being quarantined. These staff will return to work on 2 June. The department has also identified 7 other close contacts including 5 family members and 2 healthcare workers.
- To date, all 87 residents and 103 staff have received negative results from initial testing.
- Testing was arranged for a further 7 staff members. Of these staff members, two have returned positive results. Both are asymptomatic. The department is working closely with the facility to ensure appropriate measures are being put in place. Including quarantine of all residents.
- Repeat testing for all staff and residents was undertaken on 26-28 May. All permanent staff and residents (85 residents, 105 staff) have tested negative. There are some results from agency and contract staff which are pending.
- PPE training was conducted on 21 May by outbreak squads.
- This outbreak is active and under investigation. There is no projected closure date. Further repeat screening is planned for all staff and residents this coming Friday (5 June) and will guide outbreak closure planning.

Thanks
Simon

Dr Simon Crouch BA MBBS MA MPH PhD FAFPHM
COVID-19 Deputy Public Health Commander (Case, Contact and Outbreak Management)
Health Protection Branch | Regulation, Health Protection and Emergency Management

Department of Health and Human Services | 50 Lonsdale Street, Melbourne, Victoria 3000
REDACTED EDACTED
w. www.dhhs.vic.gov.au | he/him

RE: Outbreak summaries -1 June

From: "Simon Crouch (DHHS)" [REDACTED]
To: "Annaliese Van Diemen (DHHS)" [REDACTED]
Date: Mon, 01 Jun 2020 21:14:37 +1000

The team have been offering alternative accommodation where considered necessary and a number of cases and close contacts have moved first to Rydges and then to Novotel. I believe the new cases were exposed prior to the initial case being identified and moved.

Thanks
Simon

Dr Simon Crouch BA MBBS MA MPH PhD FAFPHM
COVID-19 Deputy Public Health Commander (Case, Contact and Outbreak Management)
Health Protection Branch | Regulation, Health Protection and Emergency Management
Department of Health and Human Services | 50 Lonsdale Street, Melbourne, Victoria 3000
[REDACTED] [REDACTED]
w. www.dhhs.vic.gov.au | he/him

From: Annaliese Van Diemen (DHHS) [REDACTED]
Sent: Monday, 1 June 2020 9:10 PM
To: Simon Crouch (DHHS) [REDACTED]
Subject: Re: Outbreak summaries -1 June

Thanks Simon,

Most appreciated.

Can I check if alternative accommodation has been offered to other households in the Rydges cluster where there might be difficulties with isolation?

Suspect the Minister will ask tomorrow.

Cheers

Annaliese.

Get Outlook for iOS

From: Simon Crouch (DHHS) [REDACTED]
Sent: Monday, June 1, 2020 8:54:33 PM
To: Annaliese Van Diemen (DHHS) [REDACTED]; Brett Sutton (DHHS) [REDACTED]
Cc: Jacinda de Witts (DHHS) [REDACTED]; Annalise Bamford (DHHS) [REDACTED] Kym Peake (DHHS) [REDACTED] [REDACTED]; Kira Leeb (DHHS) [REDACTED] Jackie Kearney (DHHS) [REDACTED] Terry Symonds (DHHS) [REDACTED] sccvic.stateintelmgr@scc.vic.gov.au <sccvic.stateintelmgr@scc.vic.gov.au>; Jason Helps (DHHS) [REDACTED]; Andrea Spiteri (DHHS) [REDACTED]; Katherine Ong (DHHS) [REDACTED] (DHHS) [REDACTED] Simon Crouch (DHHS) [REDACTED] [REDACTED] Sarah McGuinness (DHHS) [REDACTED]

REDACTED EDACTED

Subject: Outbreak summaries -1 June

Dear Annaliese and Brett

Please see today's outbreak summaries below. There are no new outbreaks listed here. There are 4 new cases linked to the Rydges outbreak.

REDACTED **amily Cluster**

- A total of 13 cases have been associated with RED large family group comprising RED households and their contacts. REDACTED REDACTED
- The IPC squad has visited all four households associated with this family group on 31 May and reported on adequacy of isolation, IPC measures and any other welfare needs.
- One of the families have been provided with alternative accommodation as they were unable to adequately isolate in their usual dwelling.
- The first case was reported on 26 May with comorbidities who was admitted to hospital (in ICU but condition improving).
- REDACTED s were diagnosed on 27 May. On 28 May a case was identified in a close contact from a different household and subsequent screening has identified 3 further household cases as of 29 May.
- These cases attended or worked in their infectious periods at a number of sensitive settings and a workplace:
  - REDACTED one case attended on 26 May during their infectious period
    - Around 69 students identified as close contacts (including 5 students from REDACTED nd 1 student REDACTED All are in quarantine and will undergo return to school testing
    - School/DET aware
    - Outbreak response squad visit. Clean occurred.
    - Advised that school has re-opened today (1 June)
  - REDACTED one case attended on 26 May during their infectious period (asymptomatic)
    - School/DET/Catholic Education aware
    - Students in year R class all considered close contacts (21 students, and 6 staff). All are in quarantine and will undergo return to school testing.
    - 2 staff members were symptomatic and have been tested – results both negative
    - Outbreak response squad visit. Clean occurred.
    - Expecting school to open on Wednesday
  - REDACTED REDACT
    - Workplace of REDACTED (2 of 3 +ve; 1 -ve)
    - Both confirmed cases worked 26 May while infectious
    - One confirmed case had extensive contact with workers across the site
    - Around 21 close contacts identified. Further 8 staff identified but not close contacts (were working from home). Potential for index case to have acquired COVID-19 from this site, so all staff (21 close contacts and 8 additional staff) have been tested – results pending.
    - Site closed. Deep clean undertaken. Outbreak response squad have visited. Return to work testing will be undertaken.
    - Worksafe aware
  - **Sunshine Hospital/Footscray Hospital**
    - Two cases attended Sunshine Hospital and Footscray Hospital REDACTE One was a patient, the other her husband.
    - Infectious periods from REDACTED
    - Exposure sites during infectious period: Sunshine hospital ED, ambulance transfer to Footscray, Footscray hospital theatre and ward.
    - Western Health IPC aware and commencing contact tracing (noting more than 14 days have elapsed since initial exposure).

- No close contacts identified from Sunshine Hospital (appropriate PPE used).
  9 close contacts identified through Footscray Hospital – all in quarantine.
- A pop up testing clinic has opened in REDACTED with targeted promotion of symptomatic testing to local communities, school communities.
- Liaison with loca REDACT community via DPC and local government. Round table with community leaders planned for this week

Rydges

- 12 cases have been linked to this outbreak – 7 are staff who work night shifts at Rydges on Swanston. 1 hotel staff, 5 security staff and 1 mental health nurse. Five are household close contacts (although interviews are still pending).
- A commercial clean of relevant areas of the hotel has occurred.
- All staff cases worked night shifts at Rydges on Swanston, overlapping on 21 May.
- One staff case is asymptomatic, the other 6 have symptom onset dates ranging from 24/05/2020 – 29/05/2020 (3 have the same symptom onset date = 25/05/2020)
- Current hypothesis is that the hotel is the source of infection, either from environmental contamination in the week prior to 25th May, or possibly from an unrecognised case(s) or known hotel case; at this stage it is not possible to definitively determine.
- It is likely that environmental risk has been attenuated following a deep clean of the premises on 28 May.
- All staff who attended the site between 11 and 28 May asked to seek testing for COVID-19.
- As of 30 May, any staff member who attended the Rydges on Swanston Hotel for 30 minutes or more during the period 18 May to midday on 28 May inclusive is now being asked to **self-quarantine for 14 days** since their last visit to the hotel.
- Education and training on appropriate PPE by outbreak squad nurses (particular focus on security staff who have been wearing non-approved porous gloves)
- All staff close contacts will be required to be re-tested prior to completing their 14 day quarantine period.
- Due to difficulties in staffing the Rydges, alternative accommodation was sought. Residents have been moved today to a different hotel in the CBD.
- This outbreak is active and under investigation. There is no projected closure date.

REDACTED

- There are two confirmed cases in residents of this aged care facility. Case 1 – symptom onset 17 May; case 2 – asymptomatic.
- All staff at the site have undergone initial and follow up testing – all returning negative results thus far.
- All but one of the residents have been tested. The resident who has not been tested has REDACTE and has consistently refused testing. Both cases live in separate areas of the facility. The resident who has not been tested lives in a separate area of the facility to both cases.
- Following an infection control assessment by Alfred Health, case 2 has been moved back into their residence. REDACTED REDACTED The department has outlined specific requirements for case 2 to be safely isolated REDACTED
- Case 1 has commenced clearance testing. The first swab is negative. A second swab could not be taken as the case refused testing. Case has already had multiple negative swabs and has been cleared.
- Clearance testing for case 2 will commence on Thursday 4 June. This will include day 11 testing for close contacts (6 residents, 14 staff)
- Staffing support is being provided by the Commonwealth
- This outbreak is active and under investigation. There is no projected closure date

REDACTED

- There is a single confirmed case in a resident of this aged care facility. Symptom onset for the case was 13 May. The case has been isolated since that time.
- All residents (bar one) have been tested and received negative results. The resident who has not been tested REDACTED REDACTED RED
- All staff have been tested and have returned negative results.
- A member of the department's outbreak control squad has visited the site and performed an assessment. Appropriate infection prevention and control measures are being

implemented. A second visit was conducted on 22 May. Some concerns about IPC procedures have been raised that are being addressed by the facility.
- PPE training was conducted by outbreak squads on 21 May
- A second round of testing for close contacts (38 residents, 8 staff) was conducted on Monday 25 May. All tests are negative.
- Some staff who have been released from isolation by DHHS have started to return to work
- The department has commenced discussions with the facility regarding relaxing restrictions. The facility has been advised today (1 June) that restrictions can be lifted.
- This outbreak will not be reported from now unless there are any new developments

REDACTED

- Three confirmed case have been linked to this outbreak in an aged care facility (resident)
- Symptom onset for case 1 was 16 May. The case was admitted to the REDACTED on REDACTED. They have met clearance criteria. They will remain at the REDACTED
- The facility advised that a REDACTED. This was considered a suspected case as testing was not performed and REDACTED. Their family contacts were placed in quarantine but have now all tested negative.
- As of 20 May, all residents in the same wing as the index case (17), and staff that worked in that wing from 14 to 17 May (21) are considered close contacts and are being quarantined. These staff will return to work on 2 June. The department has also identified 7 other close contacts including 5 family members and 2 healthcare workers.
- To date, all 87 residents and 103 staff have received negative results from initial testing.
- Testing was arranged for a further 7 staff members. Of these staff members, two have returned positive results. Both are asymptomatic. The department is working closely with the facility to ensure appropriate measures are being put in place. Including quarantine of all residents.
- Repeat testing for all staff and residents was undertaken on 26-28 May. All permanent staff and residents (85 residents, 105 staff) have tested negative. There are some results from agency and contract staff which are pending.
- PPE training was conducted on 21 May by outbreak squads.
- This outbreak is active and under investigation. There is no projected closure date. Further repeat screening is planned for all staff and residents this coming Friday (5 June) and will guide outbreak closure planning.

Thanks
Simon

Dr Simon Crouch BA MBBS MA MPH PhD FAFPHM
COVID-19 Deputy Public Health Commander (Case, Contact and Outbreak Management)
Health Protection Branch | Regulation, Health Protection and Emergency Management
Department of Health and Human Services | 50 Lonsdale Street, Melbourne, Victoria 3000
REDACTED REDACTED
www.dhhs.vic.gov.au | Pronouns: he/him

Outbreak summaries - 3 June

From: Simon Crouch (DHHS) REDACTED

To: Annaliese Van Diemen (DHHS) REDACTED Brett Sutton (DHHS) REDACTED

Cc: Jacinda de Witts (DHHS) REDACTED Annalise Bamford (DHHS) REDACTED Kym Peake (DHHS) REDACTED Kira Leeb (DHHS) REDACTED Terry Symonds (DHHS) REDACTED sccvic.stateintelmgr@scc.vic.gov.au, Jason Helps (DHHS) REDACTED, Andrea Spiteri (DHHS) REDACTED Katherine Ong (DHHS) REDACTED Simon Crouch (DHHS) REDACTED Sarah McGuinness (DHHS) REDACTED covid-19projectmanagementoffice (DHHS) <covid-19projectmanagementoffice@dhhs.vic.gov.au>, Melissa Skilbeck (DHHS) REDACTED

Date: Wed, 03 Jun 2020 20:31:47 +1000

Dear Annaliese and Brett

Please see today's outbreak summaries below. There are no new outbreaks and no new cases linked to these outbreaks.

THIS EMAIL MAY CONTAIN SENSITIVE PATIENT AND EXPOSURE SITE INFORMATION AND IS NOT FOR FURTHER DISTRIBUTION.

REDACTED **Family Cluster**

- * A total of 13 cases have been associated with one large family group comprising four households and their contacts. REDACTED
- * The IPC squad has visited all four households associated with this family group on RE May and reported on adequacy of isolation, IPC measures and any other welfare needs.
- * One of the families have been provided with alternative accommodation as they were unable to adequately isolate in their usual dwelling.
- * Another family group with R infected people have been provided with alternative accommodation, so that those cleared from isolation are able to separate from those who continue to be infectious.
- * The first case was reported on RE May with comorbidities who was admitted to hospital and ICU. This case is improving and the treating team are aiming for a potential discharge on Friday.
- * RED family members were diagnosed on RE May. On RE May a case was identified in a close contact from a different household and subsequent screening has identified R further household cases as of R May.
- *R family members who are currently "close contacts" in one of the houses have developed symptoms and testing has occurred today.
- * These cases attended or worked in their infectious periods at a number of sensitive settings and a workplace:

- [redacted] one case attended on 26 May during their infectious period
  - * Around 66 [redacted] identified as close contacts (including 5 [redacted] from [redacted] SC and 1 [redacted]). All are in quarantine and will undergo return to [redacted] testing. Return to [redacted] testing has been communicated to the [redacted] and is being organised to occur through Sunshine Hospital.
  - * [redacted] aware
  - * Outbreak response squad visit. Clean occurred.
  - * Advised that [redacted] has re-opened today (1 June)
- * [redacted] one case attended on 26 May during their infectious period (asymptomatic)
  - *[redacted] aware
  - * Students in year [redacted] class all considered close contacts (21 students, and 6 staff). All are in quarantine and will undergo return to school testing. Return to school testing has been communicated to the school and is being organised through Sunshine Hospital.
  - *[redacted] staff members were symptomatic and have been tested – results both negative
  - * Outbreak response squad visit. Clean occurred.
  - * Expecting school to open on Wednesday
- [redacted] **Laverton**
  - * Workplace of **three** family members (2 of 3 +ve; 1 -ve)
  - * Both confirmed cases worked [redacted] May while infectious
  - * One confirmed case had extensive contact with workers across the site
  - * Around 21 close contacts identified. Further 8 staff identified but not close contacts (were working from home). Potential for index case to have acquired COVID-19 from this site, so all staff (21 close contacts and 8 additional staff) have been tested – results pending.
  - * Site closed. Deep clean undertaken. Outbreak response squad have visited. Return to work testing will be undertaken.
  - * Worksafe aware
  - * EPA aware
    - [redacted] **Hospital** [redacted] **Hospital**
      - **Two cases attended [redacted] Hospital and [redacted] Hospital 15-18 May. One was a patient, the other [redacted] husband.**
      - **Infectious periods from 15 and 16 May.**
      - **Exposure sites during infectious period: [redacted] hospital ED, ambulance transfer to [redacted] [redacted] hospital theatre and ward.**
      - **[redacted] Health IPC aware and commencing contact tracing (noting more than 14 days have elapsed since initial exposure).**
      - **No close contacts identified from [redacted] Hospital (appropriate PPE used). 16 close contacts identified through [redacted] Hospital – all in quarantine and have been tested. 11 results are negative, 5 are pending.**
- * A pop up testing clinic has opened in Keilor Downs with targeted promotion of symptomatic testing to local communities, school communities.
- * Liaison with local Pasifika community via DPC and local government. Round table with community leaders took place this week

[redacted]

- * One case has been identified in a staff member at this residential aged care facility.
- * The case worked for one day while infectious. However they worked multiple shifts during their acquisition period.
- * Six staff members and 18 residents have been identified as close contacts. All residents on the ward where the case worked are being classified as close contacts. Further contact tracing of visitors and external close contacts is under way.
- * A member of the department outbreak control squad and a Commonwealth clinical first responder visited the site on 2 June to perform an assessment and provide training and support. The facility is being supported with supplies of PPE.
- * **Testing for all staff (131) and residents (97)** was undertaken on 2 and 3 June. 107 of the 131 staff and all 97 residents have tested negative. The remaining 20 staff will be tested on 4 June.
- * The day 11 testing date for residents and staff who are close contacts of cases 2 and 3 is

being organised for 7 June.

Rydges

- * 12 cases have been linked to this outbreak – 7 are staff who work REDACTED at Rydges on Swanston. 1 REDA staff, 5 security staff and [redacted] mental health nurse. Five are household close contacts
- * A commercial clean of relevant areas of the hotel has occurred.
- * All staff cases worked REDACTE at Rydges on Swanston, overlapping on R May.
- * One staff case is asymptomatic, the other 6 have symptom onset dates ranging from 24 to 29 May (3 have the same symptom onset date = 25 May)
- * Current hypothesis is that the hotel is the source of infection, either from environmental contamination in the week prior to 25 May, or possibly from an unrecognised case(s) or known hotel case; at this stage it is not possible to definitively determine.
- * It is likely that environmental risk has been attenuated following a deep clean of the premises on 28 May.
- * All staff who attended the site between 11 and 28 May asked to seek testing for COVID-19.
- * As of 30 May, any staff member who attended the Rydges on Swanston Hotel for 30 minutes or more during the period 18 May to midday on 28 May inclusive is now being asked to **self-quarantine for 14 days** since their last visit to the hotel.
- * Education and training on appropriate PPE by outbreak squad nurses (particular focus on security staff who have been wearing non-approved porous gloves)
- * All staff close contacts will be required to be re-tested prior to completing their 14 day quarantine period.
- * Due to difficulties in staffing the Rydges, alternative accommodation was sought. Residents have been moved today to a different hotel in the CBD. Department outbreak control squad nurses have visited this hotel and are providing training and support to enable the lifting of restrictions. It is expected that following training of security staff today (3 June) that restrictions can be lifted tomorrow (4 June)
- * Genomics has identified that case 1 clusters with a family of returned travellers who have stayed at the hotel. Genomics on case 2 has identified that it also clusters with case 1.
- * This outbreak is active and under investigation. There is no projected closure date.

REDACTED

- * Three confirmed case have been linked to this outbreak in an aged care facility (1 resident and 2 staff)
- * Symptom onset for case 1 was 16 May. The case was admitted to the Epworth Richmond on 17 May following a fall. They have met clearance criteria. They will remain at the REDACTED
- * The facility advised that a resident with symptoms of a respiratory illness died on the RE May. This was considered a suspected case as testing was not performed and the body has since been cremated. Their family contacts were placed in quarantine but have now all tested negative.
- * As of 20 May, all residents in the same wing as the index case (17), and staff that worked in that wing from 14 to 17 May (21) are considered close contacts and are being quarantined. These staff will return to work on 2 June. The department has also identified 7 other close contacts including 5 family members and 2 healthcare workers.
- * All 87 residents and 103 staff have received negative results from initial testing.
- * Testing was arranged for a further 7 staff members. Of these staff members, two have returned positive results. Both were asymptomatic at the time of testing, one case has since developed symptoms. The department is working closely with the facility to ensure appropriate measures are being put in place. Including quarantine of all residents.
- * Repeat testing for all staff and residents was undertaken on 26 - 28 May. All permanent staff and residents (85 residents, 105 staff) have tested negative. There are some results from agency and contract staff which are pending.
- * PPE training was conducted on 21 May by outbreak squads, IPC site visits occurred 26, 27 and 28 May.
- * Another round of testing for all residents, staff and contractors is planned for Friday 5 June and will guide outbreak closure planning.
- * This outbreak is active and under investigation. There is no projected closure date.

REDACTED

- * There are two confirmed cases in residents of this aged care facility. Case 1 – symptom onset 17 May; case 2 – asymptomatic (test positive 23 May)
- * All staff at the site have undergone an initial round of testing with negative results. A second round of staff testing has also been performed – one staff member is yet to be tested (returning from leave on 4 June); two have pending results, and the remainder have tested negative.
- * All but one of the residents have been tested. The resident who has not been tested has REDACTED has consistently refused testing. Both cases live in separate areas of the facility. The resident who has not been tested lives in a separate area of the facility to both cases.
- * Following an infection control assessment by Alfred Health, case 2 has been moved back into their residence. REDACTED REDACTED The department has outlined specific requirements for case 2 to be safely isolated REDACTED
- * Case 1 has received 2 x negative swabs and is now cleared.
- * Clearance testing for case 2 will commence on Thursday 4 June. Day 11 testing for close contacts of case 2 (6 residents, 14 staff) will also be conducted on 4 June
- * Staffing support is being provided by the Commonwealth
- * This outbreak is active and under investigation. Projected release date for REDACTED REDACTED case 2 REDAC is early next week, if clearance testing for residents and staff is negative and everyone remains asymptomatic.

Outbreak Management team meeting actions and notes

Date & Time: 1:00pm Thursday 4 June 2020

Outbreak Name / Setting: **Rydges**

Purpose of Meeting: Daily update

Action list

Date allocated	Action	Responsible person	Due date	Date Completed
1/06/2020	Engage Commercial Passenger Vehicles Victoria	Braedan	2/06/2020	
~~**1/06/2020**~~	~~Squads to plan visits to other quarantine hotels~~	REDACTED	~~2/06/2020~~	4/06/2020
1/06/2020	Confirm whether restrictions on residents can be lifted		1/06/2020	
~~**3/06/2020**~~	~~Provide info to REDACTED regarding how many of the 20 taxi close contacts are being obstructive or denying use of taxis~~		~~3/06/2020~~	4/06/2020
~~**3/06/2020**~~	~~Contact outbreak nurses for an update~~		~~3/06/2020~~	4/06/2020
4/06/2020	Discuss whether the RED who breached isolation requirements will be referred to AHPRA		5/06/2020	
4/06/2020	Follow up with the Operation Soteria team – will positive cases moved to Novotel be moved back to Rydges?	Sarah	4/06/2020	
4/06/2020	Follow up with the Operation Soteria team – do cleaning teams or hotel staff normally clean common areas?	Sarah	4/06/2020	
4/06/2020	Follow up IPC team – were they happy with findings from the visit to Novotel late yesterday?	REDACTED	4/06/2020	
4/06/2020	Send details of close contact requesting alternative accommodation to Carly		4/06/2020	
4/06/2020	Follow up MDU lab for genomics info of other staff members	Sarah	5/06/2020	

Notes

Situation Update:

- 1 new case notified
- 7 staff are now confirmed and notified cases
- 6 household contacts are now confirmed cases (including the 1 new case, notified yesterday)
- All positive cases have moved from Rydges to Novotel
    - It is not clear whether there are plans for these persons to return to Rydges
    - An IPC team visited Novotel yesterday
- There are currently 5 close contacts and 3 positive cases in alternative accommodation (related to this outbreak)
- 1 close contact has requested alternative accommodation

Hypothesis:

- Genomics update: case 1 and case 2 ([redacted]) are genomically linked
    - Data from NDU shows that isolates from both cases have clustered very closely with a family of 4 who were in the hotel during the period of interest
    - Symptom onset was on same day for the [redacted] and the [redacted], therefore it is likely that they had the same acquisition source
    - This suggests that infections were gained from the family of [redacted] who were recognised cases
    - Work is ongoing to trace the family's movements while they were at the hotel
    - The family was in the hotel from [redacted] onwards, so transmission could have occurred from [redacted] onwards

Risks:

- A [redacted] close contact worked during their quarantine period
    - The [redacted] was advised of quarantine requirements by both the [redacted] agency and the Department of Health and Human Services
    - The nurse worked at [redacted] for 1 day after their isolation period started
    - Their employer has been notified of the breach
    - This contact is currently on day 11, and is getting tested today
    - Currently asymptomatic
    - This person alleges they tested negative, but there is no test result on file
    - Notification to AHPRA is currently being discussed
    - It may be beneficial to push messaging out regarding the importance of not attending work for cases / close contacts to nursing bodies / industry bodies
- At Rydges, hotel staff have been cleaning the shared areas; it is unclear if this is the normal process or if professional cleaners should be brought in

Controls:

- IPC staff were on site at Rydges to train security staff in PPE use
    - Masks were also made available where 1.5m distancing was not achievable
    - Sanitiser was provided for staff to carry on their person
    - All staff were using the same toilets (DHHS, security, etc)
    - Improved signage has been implemented
    - Training around hand hygiene was provided on Saturday; additional sessions may be required to capture staff who were not on site at that time
    - Separate hand wash areas are being considered / investigated (i.e. use of a vacant room for nurses to wash hands)
    - IPC video content is being prepared for education of night staff and other key populations, using plain language and non-clinical examples
- Return to work testing will be required for staff - letters will go out to staff to provide details

OFFICIAL: RE: Rydges on Swanston OMT

From: "REDACTED (DHHS)" <REDACTED>

To: Public Health Operations <publichealth.operations@dhhs.vic.gov.au>, "Clare Looker (DHHS)" REDACTED <REDACTED (DHHS)" <REDACTED (DHHS)" <REDACTED>, Public Health Intelligence <publichealth.intelligence@dhhs.vic.gov.au>, "DHHS EmergencyCommunications (DHHS)" <em.comms@dhhs.vic.gov.au>, "Jason Helps (DHHS)" <REDACTED>, "Pam Williams (DHHS)" <REDACTED>, "REDACTED (DHHS)" <REDACTED>, sccvic.stateintelmgr@scc.vic.gov.au

Cc: "REDACTED (DHHS)" <REDACTED>, "REDACTED <REDACTED>, "Sarah McGuinness (DHHS)" <REDACTED>, "REDACTED (DHHS)" <REDACTED>, "Braedan Hogan (DHHS)" <REDACTED>

Date: Thu, 28 May 2020 13:19:34 +1000

Hi all,

Please find below actions/key outcomes from today's Rydges OMT.

Actions

1. REDACT **/Outbreak Squad team** to prepare materials (video and written) on proper hygiene and use of PPE, to be distributed to staffing agency leadership (both health services and security guards) via Pam Williams
2. REDACT to liaise with Katherine Ong and intelligence leads to determine best practice use of PPE face shields when taking swabs, and discuss next steps with OMT group
3. REDACT to discuss potential support for procuring contact details and complete rosters of all staff in the hotel with REDA
4. **Sarah M** to coordinate distribution of negative test results to staff
5. REDACT to provide stakeholder contact details to REDA and Sarah; REDA to ensure second letter (and subsequent advice) is sent to appropriate stakeholders (CC'ing in REDA and REDACT)
6. **Sarah M** to confirm with REDAC that commercial cleaning is underway
7. **Sarah M** to chase status of genomics

Key outcomes/agreements

1. Opportunity to think of innovative ways to more broadly engage with OH&S, Worksafe, and other key industrial bodies to instruct on proper and appropriate use of PPE and related prevention education
2. No change to definition of close contacts until initial test results have been received, and further information/assessment from the site occurs

Cheers,

REDA

REDACTED
REDACTED
Department of Health and Human Services
Level 5, 2 Lonsdale St, Melbourne VIC 3000
m REDACTED

OFFICIAL: RE: OMT Rydges on Swanston

From: REDACTED REDACTED

To: REDACTED REDACTED>, "Sarah McGuinness (DHHS)" <REDACTED>, Public Health Intelligence <publichealth.intelligence@dhhs.vic.gov.au>, REDACTED, REDACTED>, "Jason Helps (DHHS)" <REDACTED>, REDACTED REDACTED (DHHS)" <REDACTED REDACTED>, "DHHS EmergencyCommunications (DHHS)" <em.comms@dhhs.vic.gov.au>, "press (DHHS)" <press@dhhs.vic.gov.au>, REDACTED, REDACTED, REDACTED, REDACTED, REDACTED DHHS)" <REDACTED>, REDACTED (DHHS)" <REDACTED>

Cc: REDACTED DHHS)" <REDACTED>, "Merrin Bamert (DHHS)" <REDACTED>, "Pam Williams (DHHS)" <REDACTED>

Date: Fri, 29 May 2020 12:10:33 +1000

Hi all,

Below are key actions/outcomes from the Rydges OMT on 29 May.

Actions:

1. REDAC to contact REDA offline to assist with procuring Rydges staff contact details
2. REDA to organise case and contact interview with potential case 3, and report back details to the team ASAP
3. R ED to investigate standard cleaning arrangements at the hotel and report back to team
4. REDACTE to ensure that people tested through Rydges receive negative results

Key updates:

1. Bio clean was completed yesterday, and report from ICON saved in the OMT folder
2. Discussion re: review of PPE equipment for nursing administering tests to be resumed at IPC/CCOM/Outbreak Squad joint meeting later today at 4pm. Agreements/recommendations to be fed back into existing guidelines as appropriate
3. Hygiene & PPE education provided by to hotel staff and security guards. Further educational opportunities to be organised and provided to security firm management by IPC
4. Discussion re: policy for staff coming back into DHHS post field-visits to occur offline
5. Working hypothesis to be re-considered following case and contact investigation with case 3, and confirmed with team pending updates
6. Case 1 and 2 only worked at the Rydges Swanston hotel (no other Rydges).

Cheers,

REDACTED
Program Manager, Public Health Command COVID-19
Department of Health and Human Services
Level 5, 2 Lonsdale St, Melbourne VIC 3000
REDACTED

Rydges on Swanston - meeting summary, actions and communication

From: "Sarah McGuinness (DHHS)" <REDACTED

To: "Merrin Bamert (DHHS)" <REDACTED
REDACTED
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"Anthony J Kolmus (DHHS)" <REDACTED
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<em.comms@dhhs.vic.gov.au>, "Euan Wallace (DHHS)"
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REDACTED
"Meena Naidu (DHHS)" <REDACTED
sccvic.stateintelmgr@scc.vic.gov.au, REDACTED
"press (DHHS)" <press@dhhs.vic.gov.au>

Date: Sat, 30 May 2020 12:57:59 +1000

Dear All,

Thank you for attending the OMT meeting for Rydges on Swanston this morning.

The following information is a summary of discussion points and actions from the meeting and is not for further distribution:

Key discussion points:

- All cases have worked night shifts at Rydges on Swanston on or before 21st May; three have same symptom onset date (25/05/2020), two are asymptomatic, and one is yet to be interviewed
- Cases include hotel staff REDACTED, REDACTED (x4) and REDACTED (x1)
- Current hypothesis is that the hotel is the source of infection, either from environmental contamination in the week prior to 25th May, or possibly from an unrecognised case(s) or known hotel case; at this stage it is not possible to definitively determine. Support for this hypothesis includes preliminary genomic results, which show that the isolate for Case 1 REDACTED clusters with a family REDAC COVID-19 cases who are returned travellers from REDACTED and are currently in hotel quarantine at Rydges hotel. The REDACTED role includes cleaning duties, including of the lift used to transport cases.
- It is likely that environmental risk has been attenuated following a deep clean of the premises on 28th May.
- There is a gradient of risk for staff. Staff who spent more time on site are likely to be at higher risk of exposure. The highest risk period for exposure most likely extends from 7 days prior to symptom onset in cases, until the date that a deep environmental clean & disinfection was performed (date range: 18th – 28th May). There is a lower risk for exposure in the period from 11th-17th May (8-14 days before symptom onset in cases) and in the period from 28th May – today (when a second environmental clean is planned).

Summary of actions (and people responsible)

- Assessment
  - Complete interview of Case 6 and assess potential close contacts at Marriott hotel **[CCOM]**
  - Chase genomics over the coming week – **[Intell]**
- Management
  - Cleaning – deep environmental cleaning on an at least daily basis (preferably twice daily for frequently touched surfaces) **[Operation Soteria / DJPR]**
  - PPE training and discussion with security company management **[Outbreak Squad, CCOM]**
  - Embed IPC lead from a health service **[Merrin Bamert]**

    - Limit movement of guests today only, until full environmental clean **[CCOM]**
    - Maintain block on new admissions of well people until full clean today **[Operation Soteria]**
    - Quarantine staff who attended for 30 min or more between 18 May and midday on 28 May inclusive for 14 days from last exposure **[CCOM]**
        - Will involve a letter for quarantined persons
- Consequences
    - Emergency accommodation arrangements for cases – case 5 **[DHHS Commander]**
- Communication
    - Liaise with WorkSafe **[CCOM]**
    - Communicate with hotel guests **[CCOM / Operation Soteria]**
    - Communicate to various work groups/agencies:
        - Operation Soteria **[Merrin Bamert]**
        - AOs **[Anthony]**
        - YNA, Swingshift, Alfred, Unified Security **[CCOM, CC Merrin Bamert]**

The following is information that can be communicated with staff and agencies:

- Four new cases of COVID-19 have been detected in staff who worked at Rydges on Swanston, Melbourne, bringing the total for this outbreak to six.
- The new cases were identified as part of testing initiated after the first case was identified among staff working at hotel.
- The source of acquisition for new cases remains under investigation and all potential sources of transmission will be explored
- Thorough cleaning of relevant parts of the hotel has been undertaken, alongside contact tracing, isolation and quarantine of close contacts. A full investigation is underway to review all possible causes of transmission within the hotel, including looking into links between affected staff.
- Infection control experts from the DHHS outbreak squad are attending the hotel to review all infection prevention and control procedures.
- All staff who attended the site in the period from 11 to 28 May should seek testing for COVID-19 if they have not already done so.
- As of today (30 May), any staff member who attended the Rydges on Swanston Hotel for 30 minutes or more during the period 18 to 28 May inclusive is now being asked to **self-quarantine for 14 days** since their last visit to the hotel. Staff should monitor themselves for symptoms of COVID-19 and seek testing if symptoms develop. The department's Case and Contact team will make contact with each of these staff members directly to provide further advice and support.
- Staff who attended the site between 11 and 17 May only and who have tested negative for COVID-19 can continue with their daily activities (including work).
- Staff who have only attended the site from midday on 28 May should not work elsewhere for now while the investigation is underway.

Kind regards,
Sarah

Dr Sarah McGuinness
Infectious Diseases Physician
Case, Contact and Outbreak Management | COVID-19 Surge Workforce
Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
REDACTED

Outbreak Management team meeting actions and notes

Date & Time: 1:00pm Wednesday 3 June 2020

Outbreak Name / Setting: **Rydges**

Purpose of Meeting: Daily update

Action list

Date allocated	Action	Responsible person	Due date	Date Completed
1/06/2020	Engage Commercial Passenger Vehicles Victoria	Braedan	2/06/2020	
1/06/2020	Squads to plan visits to other quarantine hotels	REDA	2/06/2020	
1/06/2020	Confirm whether restrictions on residents can be lifted	REDAC	1/06/2020	
3/06/2020	Provide info to REDA regarding how many of the REDAC close contacts are being obstructive or denying use of REDA	REDAC	3/06/2020	
3/06/2020	Contact outbreak nurses for an update	REDAC	3/06/2020	

Notes

- No new cases
- The 4 most recent cases are household contacts of case 5
- Work is continuing to communicate with the close contacts
    - 1 person from security company has not yet answered the phone
- Results from testing conducted on 28/05/2020: all testees have been advised of their results
- Feedback from outbreak control squads (Novotel –
- 2 cases were REDACTE – lists of passengers have been contacted
    - Many have been quite obstructive / denied they were in the car
- No update available from outbreak nurses regarding assessment / training / lifting of restrictions
- The REDACTED due for clearance today does not require a clearance swab; clinical clearance only is OK

Outbreak Management team meeting actions and notes

Date & Time: 1:00pm Friday 5 June 2020

Outbreak Name / Setting: **Rydges**

Purpose of Meeting: Daily update

Action list

Date allocated	Action	Responsible person	Due date	Date Completed
1/06/2020	Engage Commercial Passenger Vehicles Victoria	Braedan	2/06/2020	
1/06/2020	Confirm whether restrictions on residents can be lifted	REDAC	1/06/2020	
4/06/2020	Discuss whether the nurse who breached isolation requirements will be referred to AHPRA	REDA Clare	5/06/2020	
4/06/2020	Follow up with the Operation Soteria team – will positive cases moved to Novotel be moved back to Rydges?	REDACTED	4/06/2020	
~~**4/06/2020**~~	~~Follow up with the Operation Soteria team – do cleaning teams or hotel staff normally clean common areas?~~		~~4/06/2020~~	5/06/2020
4/06/2020	Follow up IPC team – were they happy with findings from the visit to Novotel late yesterday?	REDACT	4/06/2020	
~~**4/06/2020**~~	~~Send details of close contact requesting alternative accommodation to RED~~	REDAC	~~4/06/2020~~	5/06/2020
4/06/2020	Follow up MDU lab for genomics info of other staff members	REDA CTED	5/06/2020	
5/06/2020	Follow up cleaning practices at the hotel prior to 4/06/2020	REDA CTED	5/06/2020	
5/06/2020	Share any updates regarding the nurse who worked at REDACTE with the OMT team		5/06/2020	
5/06/2020	Sarah to collate questions for finding details about the genomically linked family, REDACT to summarise info known so far; both to escalate concerns about the family's movement within the hotel to Pam Williams	REDAC	5/06/2020	
5/06/2020	Schedule OMT meetings for Saturday and Monday	REDAC	5/06/2020	

Notes

Situation update:

- No new cases
- 1 case was admitted to hospital [redacted]
  - They were contacted yesterday and sounded unwell
  - An ambulance was organised to transfer them to the Royal Melbourne Hospital
  - They are currently in ICU – not intubated but on oxygen [redacted]
- The above hospitalised case's [redacted] has also become symptomatic
  - Nurses are going to the house to test this contact
- Work is ongoing to understand details of the [redacted] close contact who worked 1 day at [redacted] while they should have been in isolation
  - The contact has been evasive but said a swab was done in Epping
  - There is no evidence from VDRL or Melbourne Pathology of a swab from this individual
  - [redacted] will contact the individual to follow up, and any info will be shared with the group when available
- Letters can go out to close contacts who have completed quarantine requirements
- Additional meetings will be scheduled for Saturday and Monday; a decision will be made on Saturday regarding whether a Sunday meeting is required

Risks:

- Concerns about the genomically linked family [redacted] will need to be escalated to Pam Williams from Operation Soteria
  - What type of materials are used to record movements in and out of the hotel? Who was present at those times? Did they spend any time outside? What are the interactions between staff and people staying in the hotels? Did the family move rooms? If yes, who was present at those times? Could there have been environmental contamination on surfaces or objects?
  - CCTV footage and swipe card records have already been requested
- Rumours of staff using one of the hotel rooms for naps needs to be investigated

Controls:

- Commercial cleaning at the hotel is happening twice daily as of yesterday
  - We have no info about what was going on prior to that

Outbreak Management team meeting actions and notes

Date & Time: 1:00pm Saturday June 2020

Outbreak Name / Setting: **Rydges**

Purpose of Meeting: Daily update

Action list

Date allocated	Action	Responsible person	Due date	Date Completed
~~1/06/2020~~	~~Confirm whether restrictions on residents can be lifted~~	REDACTED	~~1/06/2020~~	4/06/2020
~~4/06/2020~~	~~Discuss whether the nurse who breached isolation requirements will be referred to AHPRA~~	~~Sarah/~~REDACTED	~~5/06/2020~~	5/06/2020
~~4/06/2020~~	~~Follow up with the Operation Soteria team – will positive cases moved to Novotel be moved back to Rydges?~~	~~Sarah~~	~~4/06/2020~~	5/06/2020
~~4/06/2020~~	~~Follow up with the Operation Soteria team – do cleaning teams or hotel staff normally clean common areas?~~	~~Sarah~~	~~4/06/2020~~	5/06/2020
4/06/2020	Follow up IPC team – were they happy with findings from the visit to Novotel late yesterday?	REDACTED	4/06/2020	
~~4/06/2020~~	~~Send details of close contact requesting alternative accommodation to~~ REDACTED		~~4/06/2020~~	5/06/2020
4/06/2020	Follow up MDU lab for genomics info of other staff members	Sarah	5/06/2020	
5/06/2020	Follow up cleaning practices at the hotel prior to 4/06/2020	Sarah	5/06/2020	
5/06/2020	~~Share any updates regarding~~ REDACTED REDACTED ~~with the OMT team~~	~~Sarah~~	~~5/06/2020~~	6/06/2020
~~5/06/2020~~	~~Request information about movements of genomically linked family, including AO notes via~~ REDACTED ~~(Operation Soteria)~~	~~Sarah &~~ REDACTED	~~5/06/2020~~	~~5/06/2020~~
5/06/2020	~~Schedule OMT meetings for Saturday and Monday~~	~~Sarah~~	~~5/06/2020~~	
6/06/2020	Request CCTV footage from period of interest at Rydges – escalate to Pam Williams	REDACTED	6/06/2020	
6/06/2020	Provide educational materials to disseminate to staff (especially security)		6/06/2020	
6/06/2020	Advise timing of additional visit to Rydges by Outbreak Squad to manage potential risks (storing staff belongings, access to bathrooms) prior to relocaton of cases		6/06/2020	

Notes

Meeting attendees:

Sarah McGuinness (OMT Lead), REDACTED
REDACTED

Situation update:

- New case (1)
  - Former REDACTED of the Rydges RED staff case, who moved to REDACTE early on REDA 2020 and subsequently developed symptoms.
  - Diagnosed and reported in REDACTED
  - The case had not previously been identified as a close contact because their REDACTE (confirmed Rydges RED staff case) declined to mention that they previously had two REDACTED during their case interview.
  - Six close contacts have been identified in Victoria and are being contacted by the department.
  - During their infectious period (but before onset of symptoms), the case travelled to RE
    - Caught Skybus to airport (reported wearing a mask)
    - Flight from REDACTE to REDACT (REDACTE Health have requested flight manifest and will follow up contacts)
  - Media lines have been approved and will be released imminently – includes information that this case is linked to Rydges and travelled on the Skybus & a flight
- Close contacts:
  - Nurse who worked at REDACTED during quarantine period tested negative for COVID-19 on swab taken on REDA therefore no public health risks to REDACTED
    - REDACTED and REDACTED are aware of results
  - Another REDACT of the Rydges RED staff case who is symptomatic and was tested yesterday has tested negative for COVID-19
- Rydges re-opening plan
  - Operation Soterior have indicated that they would like to relocate back to the Rydges at some point
  - REDACT from outbreak squad raised concerns about needing to address IPC issues including shared toilet/handwashing facilities and baggage area for storing belongings before this occurs
  - REDAC to talk to Pam Williams & advise re: timing of relocation so that outbreak squad visit can occur prior to this (to address IPC concerns)
- Investigation into movements of family genomically linked to staff cases 1 and 2
  - Handwritten AO notes received yesterday and transcribed – paints a picture of potential environmental contamination of the room(s) family stayed in, and documents at least one walk for mental health reasons, where family were accompanied by 2 nurses (in full PPE) and four security guards
  - Request for CCTV footage will be made by REDA through Pam Williams/Merrin Bamert
- IPC / hand hygiene education
  - Video resources have been made available by outbreak squads – aim to disseminate from top-down (via security company)

Risks:

- Further documentation of the movements of the genomically linked family REDACTED REDACT including CCTV footage will be escalated to Pam Williams from Operation Soteria
- IPC concerns storage of staff belongings and sharing of bathrooms to be addressed prior to relocation of cases to Rydges

Controls:

- An additional visit by Outbreak Squad will be arranged to manage potential risks (storing staff belongings, access to bathrooms)
- Educational materials will be provided to management (especially security) to disseminate to staff

Next Meeting: Monday 8 June

Outbreak Management team meeting actions and notes

Date & Time: 12pm Thursday 11 June 2020

Outbreak Name / Setting: **Rydges**

Purpose of Meeting: Daily update

Action list

Date allocated	Action	Responsible person	Due date	Date Completed
11/06/2020	Contact REDACTED / Outbreak squads to arrange site visit to Rydges	Sarah	12/06/2020	
11/06/2020	Chase CCTV footage from Rydges	Sarah	12/06/2020	
11/06/2020	Ensure that emergency accommodation arrangements are underway for two most recently reported cases	REDA	12/06/2020	
11/06/2020	Provide an update to DJPR and Operation Soteria	Sarah	12/06/2020	
11/06/2020	Follow up results of close contact day 11 testing	CCOM REDACTED	12/06/2020	
11/06/2020	Escalate discussion of whether staff working at the COVID-19 positive hotel can work elsewhere to Deputy PHC	Sarah	12/06/2020	

Notes

Meeting attendees:

Sarah McGuinness (OMT Lead), REDACTED (Epi), REDACTED (JIU), REDACTED (JIU), REDACTED (CCOM), REDACTED (CCOM)

Situation update:

- New cases from last 2 days
  - Case 14 (in Victorian numbers) - notified 9 June 2020
    - Staff member of Rydges REDACTED in quarantine since REDACTED
    - Initial negative test result on 27/05/2020
    - Subsequent positive result on 8/06/2020 (day 11 quarantine period testing)
    - Symptom onset 4/05/2020
  - Case 15 (in Victorian numbers) – notified 10 June 2020
    - Household contact of above case
    - Tested positive on 9/06/2020
    - Symptom onset 7/06/2020
  - The above two cases are household contacts (REDACTED, when the staff member quarantined themselves REDACTED; they deny close contact since then (possibility of environmental transmission?)
- Identification of nurses who entered and cleaned room REDACTED during the period that the family genomically linked to the staff cases was staying
  - The two REDACTED who spent ~1.5 hours in this room, primarily for cleaning purposes, have been identified – both are asymptomatic and have tested negative REDACTED REDACTED – negative results on 28/05/2020 and 8/6/2020)
  - Both were wearing appropriate PPE and they double bagged the rubbish.
- Follow up of close contacts:
  - The majority of staff members identified as close contacts of the exposure site have now completed their quarantine period and had a negative return-to-work test
  - 6 staff close contacts are yet to be cleared – four have been tested and are awaiting results R REDACTED a further two security guards are yet to be tested but have been advised to seek testing
- Follow up of cases:
  - 7 cases have completed isolation and have been cleared to return to work
  - 8 cases remain active (not yet cleared to return to work) – 5 are staff members, and three are close contacts.
- Genomics:
  - There are now 5 staff cases (REDACTED) who have been genomically linked to a family of four staying at the Rydges hotel (all COVID-19 cases)

Risks:

- Ongoing management of COVID-19 cases as part of the mandatory hotel quarantine program – need for ongoing infection prevention controls & vigilance

Controls:

- An additional visit by Outbreak Squad will be arranged to manage potential IPC risks at the Rydges and at the current COVID-19 hotel

Next Meeting: Friday 12 June

Outbreak Management team meeting actions and notes

Date & Time: 1:00pm Friday 12 June 2020

Outbreak Name / Setting: **Rydges**

Purpose of Meeting: Daily update

REDACTED, Sarah McGuiness, REDACTED

Action list

Date allocated	Action	Responsible person	Due date	Date Completed
~~11/06/2020~~	~~Contact REDACTED / Outbreak squads to arrange site visit to Rydges~~	~~Sarah~~	~~12/06/2020~~	12/06/2020
11/06/2020	Chase CCTV footage from Rydges	Sarah	12/06/2020	
~~11/06/2020~~	~~Ensure that emergency accommodation arrangements are underway for two most recently reported cases~~	REDAC	~~12/06/2020~~	12/06/2020
~~11/06/2020~~	~~Provide an update to DJPR and Operation Soteria~~	~~Sarah~~	~~12/06/2020~~	12/06/2020
~~11/06/2020~~	~~Follow up results of close contact day 11 testing~~	~~CCOM REDACTED~~	~~12/06/2020~~	12/06/2020
~~11/06/2020~~	~~Escalate discussion of whether staff working at the COVID-19 positive hotel can work elsewhere to Deputy PHC~~	~~Sarah~~	~~12/06/2020~~	12/06/2020
12/06/2020	Speak to the lab about when test results will be available	RED	12/06/2020	
12/06/2020	Book next OMT meeting once it's clear when the test results will be available	Sarah	12/06/2020	
12/06/2020	Organise an IPC visit to review outstanding concerns	REDA	12/06/2020	

Notes

Situation update:

- 120 close contacts of exposure site have been identified
  - All close contacts have gone for testing
  - 3 close contacts are pending results for day 11 testing
  - All results so far have been negative
- Cases were originally not going to move back to Rydges, but it is now planned to re-open as a quarantine hotel (but not for positive cases)
- A few IPC concerns were flagged previously around shared bathrooms and storage areas
  - A visit can take place tomorrow – RED to organise
  - Confirm IPC and distancing around clusters

    - Goal: to provide reassurance to everyone that staff working at the COVID positive hotel will be able to work at other hotels
- The other COVID positive hotel is the Novotel
    - There was a visit bu IPC last weekend; IPC measures were under control
    - Another visit took place this week to do additional PPE training
    - IPC nurses are happy that the practices in place are appropriate
- We will be able to start standing down the outbreak response once all test results are back
    - At that time we can advise staff that they can move between hotels as needed (including between hotels with COVID positive and non-positive persons)
- We need to ensure that all hotels are vigilant about IPC, and that any symptomatic persons don't come to work