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

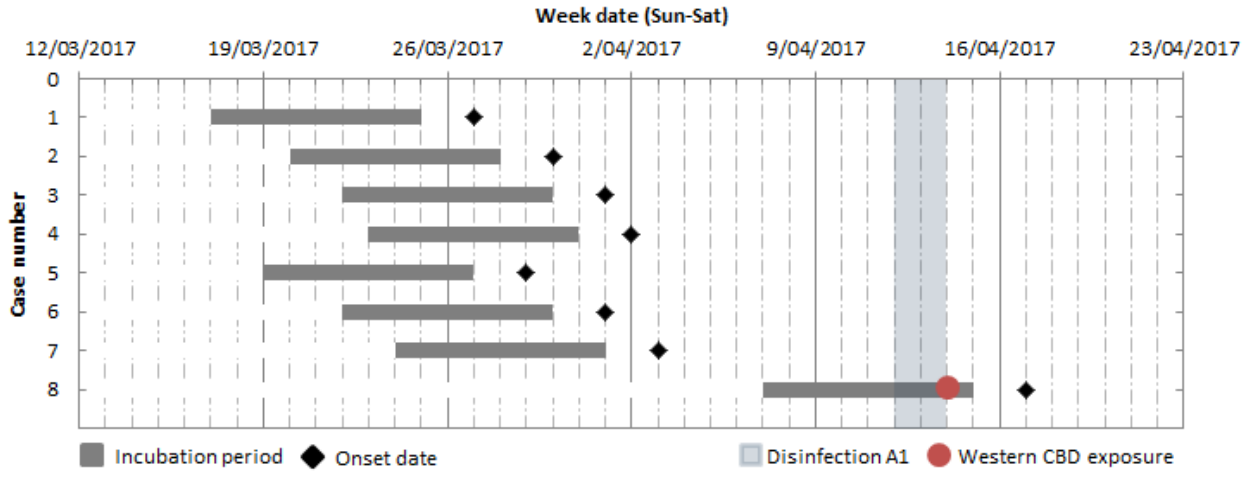
[Insert background epidemiology]

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.

Coronavirus disease 2019 (COVID-19)

Case and contact management guidelines for health services and general practitioners

10 July 2020

Version 23

VICTORIA State Government | Health and Human Services

Contents

Background

Coronavirus disease 2019 (COVID-19) was first identified in Wuhan City, Hubei Province, China in December 2019. Updated epidemiological information is available from the World Health Organization (WHO) and other sources. Current information on COVID-19 is summarised in a section at the end of this guideline entitled 'The disease'.

These guidelines and a range of other resources for health services and general practitioners can be found at the department's Coronavirus disease (COVID-19) website <https://www.dhhs.vic.gov.au/novelcoronavirus>.

A hotline is available for the general public who have questions or concerns – 1800 675 398.

Public health response objectives

This situation has evolved rapidly since the start of this year with new clinical and epidemiological information. Following the declaration of a State of Emergency in Victoria on Monday 16 March and subsequent Directions, the Department of Health and Human Services' (the department) public health response 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 physical 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.
5. Respond rapidly to contain outbreaks through enhanced outbreak response activities.

Checklist for general practitioners

The following actions should be undertaken when a patient presents to a general practice or community health service who may be a case of COVID-19:

1. Provide a single-use surgical mask for the patient to put on.
2. Isolate the patient in a single room with the door closed.
3. Any person entering the room should don droplet and contact precautions personal protective equipment (single-use surgical mask, eye protection, gown and gloves).
4. Conduct a medical assessment, and focus on:
   a) the date of onset of illness and especially whether there are symptoms or signs of pneumonia
   b) contact with confirmed cases of COVID-19
   c) precise travel history and occupation
   d) history of contact with sick travellers or other people or overseas health care facilities
   e) work or residence in an at-risk setting for transmission
   f) residence in a geographically localised area with elevated risk of community transmission, as defined by the department.
5. Determine:
   (a) Does the patient need testing for COVID-19? Refer to *Who should be tested for COVID-19*
   (b) Does the patient require further assessment in an emergency department? Where there is suspicion of pneumonia or the patient is quite unwell, a suspected case of COVID-19 should be tested and managed in hospital.
   (c) If further assessment is required, how will the patient be transferred?

   The department no longer needs to be notified about suspected cases (only confirmed cases).

   If the patient is **not** tested – advise them to stay at home until their acute symptoms (including fever) have resolved and they feel well.
6. If a suspected case of COVID-19 is unwell enough to require ambulance transfer to hospital, call Triple Zero (000) in the normal manner but advise that the patient may have suspected COVID-19 infection. Ambulance transfers do not need to be approved by the department. Where there is no clinical need for ambulance transfer, alternative means of transport should be used including private car driven by the case or an existing close contact (not bus, taxi or Uber).
7. Remember to provide a surgical face mask for the patient and driver if being transferred to an emergency department by any means.
8. If a patient is tested in the community by a general practitioner, the general practitioner should **undertake testing** as indicated in this guide. Ensure arrangements are in place for contacting the patient with the test result – this is the responsibility of the general practitioner.
9. **Advise a suspected case they must self-isolate at home**, and provide a factsheet for suspected cases from the department's COVID-19 website.
10. Undertake **cleaning and disinfection** of the room as detailed in the COVID-19 infection prevention and control guidelines available on the department's website <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>.
11. When the test result is available:
    a) **If the test is negative** for COVID-19 provide the negative result from the laboratory to the patient and manage any other cause of illness you have assessed as requiring treatment. Symptomatic patients should stay home until their acute symptoms have resolved and they feel

well. Consider advising the patient in the normal manner that admission to hospital and further testing may be required if they deteriorate.

b) **If the test is positive** for COVID-19, call the department on 1300 651 160 to confirm that the department is aware of the result and agree on next steps for management of the patient.

Checklist for health services

The following actions should be undertaken when a patient presents to an emergency department or urgent care centre who may be a suspected case of COVID-19:

1. Staff at triage points should wear personal protective equipment for droplet and contact precautions (single-use surgical mask, eye protection, gown and gloves).
2. Triage high risk patients to a separate isolated waiting area away from low risk patients, staff and general public.
3. Provide a single-use surgical mask for the patient to put on.
4. Isolate the patient in a single room with the door closed.
5. Any person entering the room should don droplet and contact precautions personal protective equipment (single-use surgical mask, eye protection, gown and gloves).
6. Conduct a medical assessment, and focus on:
   (a) the date of onset of illness and especially whether there are symptoms or signs of pneumonia
   (b) contact with confirmed cases of COVID-19
   (c) precise travel history and occupation
   (d) history of contact with sick travellers or other people or overseas health care facilities
   (e) work or residence in an at-risk setting for transmission
   (f) residence in a geographically localised area with elevated risk of community transmission, as defined by the department.
7. Determine whether the patient fits the current criteria for testing. Refer to *Who should be tested for COVID-19*
8. If admission is not required and the patient can return to the community:
   a) for patients that do **not** fit the current criteria for testing for COVID-19 – advise the patient to stay at home until their acute symptoms (including fever) have resolved and they feel well.
   b) for patients that fit the current criteria for testing - the notifying clinician should **advise the patient to self-isolate at home** (if not already) and minimise contact with other people. Provide a factsheet for suspected cases from the department's coronavirus disease (COVID-19) website <https://www.dhhs.vic.gov.au/novel-coronavirus-suspected-case-what-you-need-know>
   c) consider advising the patient in the normal manner that admission to hospital and further testing may be required if they deteriorate
   d) ensure **arrangements are in place for the patient to be contacted with the test result** – this is the responsibility of the testing clinician and health service.
9. If admission is required:
   a) maintain infection control precautions and actively consider taking multiple samples for testing including from lower respiratory tract specimens.
10. When the test result is available:
    a) **if the test is positive** for COVID-19, provide the result to the patient. The health service infectious diseases lead, or senior clinician should call the department on 1300 651 160 to

confirm that the department is aware of the result and to provide any additional clinical information.

b) **if the test is negative** for COVID-19, provide the negative result to the patient and manage any other cause of illness you have assessed as requiring treatment.

c) consider advising the patient in the normal manner that admission to hospital and further testing may be required if they deteriorate and no other cause is found.

Who should be tested for COVID-19?

People without symptoms should *not* be tested except in special circumstances as directed by the department such as:

- as part of an outbreak investigation/response (active case finding)
- as part of department-led enhanced surveillance (to investigate how widespread COVID-19 is in certain groups in the community).
- All close contacts and returned international travelers prior to the end of quarantine as directed by the department.

Patients who meet the following clinical criteria should be tested:

Fever OR chills in the absence of an alternative diagnosis that explains the clinical presentation*

OR

Acute respiratory infection (e.g. cough, sore throat, shortness of breath, runny nose, anosmia or loss of smell or loss of taste)

Additional testing note: testing is also recommended for people with new onset of other clinical symptoms consistent with COVID-19** AND who are close contacts of a confirmed case of COVID-19; who have returned from overseas in the past 14 days; or who are healthcare or aged care workers

*Clinical discretion applies including consideration of the potential for co-infection (e.g. concurrent infection with SARS-CoV-2 and influenza)
**headache, myalgia, stuffy nose, nausea, vomiting, diarrhoea

Confirmed case:

A person who tests positive to a validated SARS-CoV-2 nucleic acid test;

OR

has the virus isolated in cell culture, with PCR confirmation using a validated method;

OR

undergoes a seroconversion to or has a significant rise in SARS-CoV-2 neutralising or IgG antibody level (i.e. four-fold or greater rise in titre).

Probable case:

A person who has detection of SARS-CoV-2 neutralising or IgG antibody **AND** has had a compatible clinical illness **AND** meets on or more of the epidemiological criteria outlined in the additional testing note above.

Only confirmed and probable cases need to be notified to the department. Notify the department of confirmed cases as soon as practicable by calling 1300 651 160, 24 hours a day.

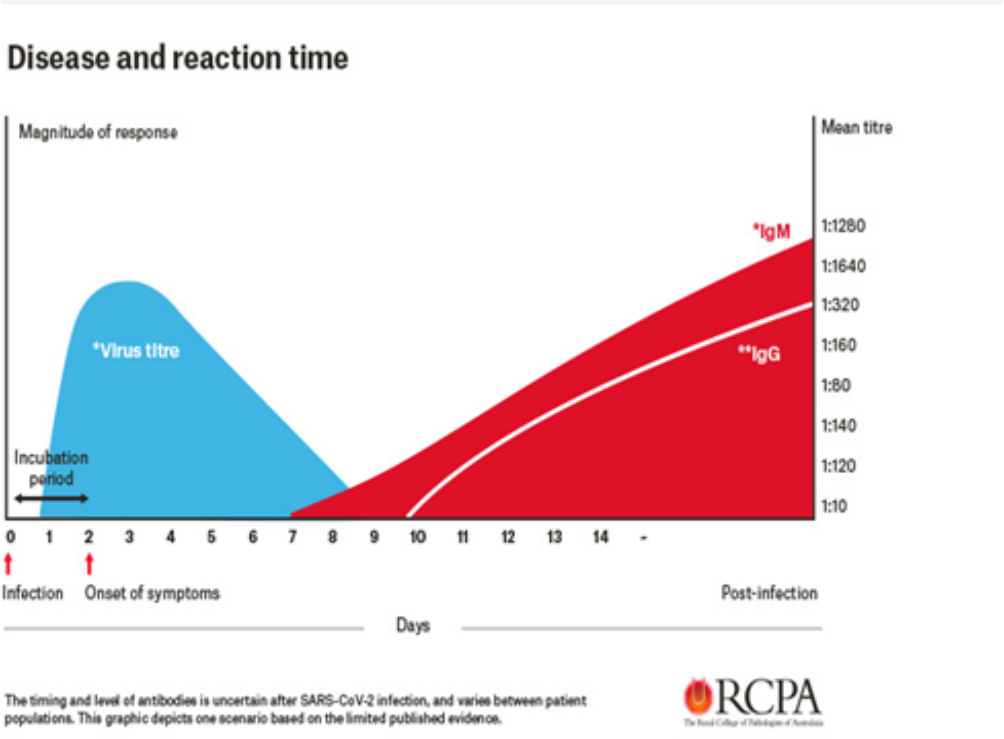
General comments:

- All patients being tested for COVID-19 should home isolate until test results are available. All patients should attend an emergency department if clinical deterioration occurs.

Serological testing

Serology tests detect the presence of antibodies (IgA/IgM/IgG) produced against the SARS-CoV-2 virus, the cause of COVID-19 infection. Once an individual is infected with the SARS-CoV-2 virus, a detectable (IgG) antibody response usually takes between 7 and 21 days to develop (Figure 1). The timing, strength and duration of the response vary between individuals.

Figure 1: The antibody response to a SARS-CoV-2 (COVID-19) infection over time. Reproduced with the permission of the Royal College of Pathologists of Australasia.



Currently, based on the limited sensitivity of the available serology tests in early COVID-19 infection, serology does not have a role in the acute diagnosis of COVID-19 cases. Reverse Transcriptase Polymerase Chain Reaction (RT-PCR) done on respiratory samples is the best approach to diagnosis of acute cases (see below). In addition, the very low prevalence of COVID-19 disease within the community makes an accurate distinction between true positive serology tests and false positive tests very challenging with the serology tests currently available. However, in limited circumstances, serology may have a role to supplement RT-PCR testing in confirmation of recent exposure to COVID-19 infection as per the current case definition.

Further, it is recognised that serology has a potential role in supporting public health measures such as contact tracing, outbreak management and case finding (e.g. identifying the missing link in cluster analysis), and population surveillance testing (e.g. assessing the seroprevalence of COVID-19 infection, and assist in providing an estimate of the extent of undiagnosed COVID-19 infection in the community).

Decisions concerning the collection of samples for serology should be made in response to clinical and public health imperatives, and in consultation with the Department of Health and Human Services. If serological testing is deemed indicated or requested **serum can be collected from people with positive RT-PCR respiratory samples for assessment of COVID-19 serology.** If a sample is collected early in the disease course and returns a negative result, then **a repeat serum sample should be collected 14 or more days after onset of illness and marked as 'convalescent sera' for paired**

analysis. If no acute sample was collected, sera collected 14 or more days after symptom onset may also be tested. For contacts of a confirmed case, paired sera collected 4 weeks apart could be useful. **These samples should be forwarded to the Victorian Infectious Diseases Reference Laboratory (VIDRL) for storage and confirmatory testing. Note that the current Australian case definition requires an antibody rise between paired sera to define a COVID-19 case, and deems demonstration of SARS-CoV-2 antibody in a single sample to be only a probable case.**

Additional studies are needed to determine a correlate of protection (i.e. which antibodies, and what levels of these antibodies correlate with protective immunity).

Deaths

If there is a suspicion that a deceased person may have had undiagnosed COVID-19, including on request of paramedics or other first responders, an oropharyngeal and deep nasal swab for COVID-19 PCR testing should be taken, with the consent of the family.

In a community setting, swabs should be performed by the medical practitioner certifying death. The testing medical practitioner should ensure that the results are given to the family, funeral director and any relevant first responders – if negative, this will enable less restrictive funeral practices. Positive test results must also be notified to the department on **1300 651 160**, 24 hours a day, to ensure contact tracing occurs

Definition of close contact

For the purposes of testing, the department advises a precautionary understanding of close contact. In keeping with definitions of close contact developed in other jurisdictions, 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 during their infectious period without recommended personal protective equipment (PPE). Recommended PPE includes 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 to be deemed close contact.

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 taken 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.

If the case (source) is a healthcare worker and has worn a mask while infectious, a health service may consider additional factors in determining who should be considered a close contacts. For example, if two staff members interact (a case and a contact) and both are wearing a mask, this contact may not necessarily constitute close contact. Additional factors that should be considered in this assessment include the presence of symptoms in the case, the duration of contact and the distance between the case and contact.

Triaging and managing high risk patients on arrival to hospital

A patient is considered high-risk for COVID-19 if:

- presenting with acute respiratory tract infection
- presenting with fever without another immediately apparent cause (e.g. UTI or cellulitis)
- they have travelled overseas and have onset of symptoms within 14 days of return
- they have been in close contact with a confirmed coronavirus (COVID-19) case with onset of symptoms within 14 days
- they are a confirmed coronavirus (COVID-19) case (this includes healthcare workers who are known confirmed cases and are attending for clearance testing to determine when they can return to work).

Patient transfer and destination health service

The following is advice on where patients should be managed:

- patients should be assessed and managed by the health service they present to
- transport of patients to other facilities should be avoided unless medically necessary
- ambulance transfer should be reserved for cases where there is clinical need; alternative means of transport should be used for other cases including a private car driven by the case or an existing close contact (not bus, taxi or Uber).
- suspected or confirmed cases in the community who require assessment or admission at a hospital should be seen and assessed at the nearest emergency department

Arrival to hospital and triage

Upon arrival to the emergency department, patients assessed as high-risk should be triaged to a separate isolated section of the waiting area, away from the general public and provided with a surgical mask. Assessment centres can support the management of high-risk patients if they are in place at the health service. All staff at triage points and assessment centres should be wearing PPE required for suspected or confirmed cases of coronavirus (COVID-19).

Ambulance triage

Patients assessed as high-risk and arriving by ambulance should be triaged to an isolated section of the waiting area away from the general public and be provided with a surgical mask as appropriate. For patients who cannot go to the waiting area (for example, stretcher, ongoing clinical care), they should remain in the ambulance vehicle until their triage and cubicle allocation is completed. Once allocated, the patient should move directly from the ambulance to the cubicle, and not stop in the corridors.

Emergency department admissions

A dedicated floor plan should be established that clearly designates areas assigned for high-risk patients within the emergency department. If able, rostering of staff to these areas to support the separation and resourceful use of PPEs should be considered. For staff working directly in the area of suspected or confirmed cases of coronavirus (COVID-19), PPE should be worn accordingly. Designated areas for donning and removing PPE should be in place.

Patient transfers

Should high-risk patients need to be moved outside of the initial isolation section, they should be transferred using a route that minimises contact with the general hospital population including clinicians (for example, dedicated lift service, external path). Staff involved in patient transfer should wear PPE required for suspected or confirmed cases of coronavirus (COVID-19). Physical distancing rules apply during all stages of the transfer.

Case management

Assessment and management of patients for COVID-19 testing

A checklist above indicates key actions for the assessment of patients for testing.

Victorian health services and general practitioners are only required to notify the department of **confirmed** cases.

The medical assessment of the patient should focus on the following:

- the date of onset of illness and especially whether there are symptoms or signs of pneumonia.
- contact with confirmed cases of COVID-19
- precise travel history and occupation
- history of contact with sick travellers or other people or overseas healthcare facilities
- work or residence in an at-risk setting for transmission.

People who were symptomatic at the time of testing for COVID-19 and are awaiting results of testing should be isolated until COVID-19 is excluded. If their test is negative, they should continue to self-isolate until the acute symptoms have resolved and they feel well.

People who were **asymptomatic** at the time of testing for COVID-19 and are awaiting results of tests are not required to self-isolate **unless** they develop symptoms OR are advised otherwise by the department.

People who are tested for COVID-19 during a period of quarantine and who receive a negative result must continue to quarantine until they have completed the required period of quarantine as directed by the department.

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 they feel well.

Further information is available for healthcare services managing healthcare workers with suspected or confirmed COVID-19 in the section Healthcare services – management of healthcare workers with suspected or confirmed COVID-19.

Exclusion of COVID-19

For patients with fever or respiratory tract infection who are not hospitalised, a single negative oropharyngeal and deep nasal swab (plus sputum if possible) is sufficient to exclude COVID-19 infection.

Repeat testing (especially of lower respiratory tract specimens) in clinically compatible cases should be performed if initial results are negative and there remains a high index of suspicion of infection. In unwell patients, consideration should also be given to a respiratory virus panel test, especially if the first COVID-19 test is negative.

Clearance testing of all close contacts is recommended at Day 11 of quarantine, as directed by the department.

There is no strong evidence to support a required time interval between exclusion swabs or the need for multiple practitioners performing the swab. Health services should apply discretion and consider the need for this on a case by case basis.

A patient who developed symptoms while in self-quarantine, for example because of recent overseas travel or contact with a confirmed case, who has then tested negative for COVID-19 should continue their quarantine period but be considered for a second test if they deteriorate and require hospitalisation.

Outbreak definition

The department's current definition of an outbreak of COVID-19 for the purposes of outbreak management is:

- A **single** confirmed case of COVID-19 in a resident, staff member or frequent attendee of residential and aged care facilities (RACF), OR
- **Two or more** epidemiologically linked cases outside of a household with symptom onset within 14 days.

Note: Transmission within one household does not constitute an outbreak but will become part of an outbreak response if linked to a high priority setting. Also, in some circumstances, the department may identify other settings that are sensitive and where a single confirmed case will trigger an outbreak response. Relevant parties will be informed if this occurs.

Determining whether a person is a frequent or infrequent visitor may be based on frequency of visits, time spent in the setting, and number of contacts within the setting.

PCR positive tests in asymptomatic or pre-symptomatic persons

The department may undertake enhanced testing of asymptomatic people in the community (that is, not in an outbreak setting). This may identify asymptomatic or pre-symptomatic PCR positive cases. The following steps should be taken:

- Isolate the case while investigations are underway
- Confirm the interpretation of the test in close liaison with the laboratory.
- Undertake a thorough investigation of the past 4-6 weeks to determine if the individual has recently had clinically compatible symptoms.
- If historical symptoms are identified, then for the purposes of contact tracing, the duration of infectivity is regarded as commencing 48 hours prior to symptom onset.
- If no historical symptoms are identified, then for the purposes of contact tracing, the case is considered to have been infectious for 48 hours from the initial positive test.
- Follow the case prospectively for 10 days from the initial test, where feasible, to determine if symptoms develop. If symptoms develop, the case is considered to have been pre-symptomatic and the case and contacts should be managed according to the time of symptom onset.

Note: any test that is reported by a lab as having detected SARS-CoV-2 on PCR will be treated as a positive, regardless of repeat testing of the sample at a separate lab or further swabs. Clinicians are requested NOT to suggest to patients that a test may be a false positive unless this has been directed by the lab. Such information compromises public health action.

Clinical management of confirmed cases

This is at the discretion of the treating team and at the present time is supportive care only.

Admission to hospital should occur when medically necessary or when directed by the department in order to reduce the risk of transmission or facilitate testing for clearance, such as if the case resides in a

communal environment. Emerging information suggests COVID-19 may be associated with a delayed deterioration in clinical status in some cases.

Interim clinical guidelines for the management of patients with COVID-19 have been released by the following peak professional bodies:

- The Australasian Society for Infectious Diseases (ASID)
- The Australian and New Zealand Intensive Care Society (ANZICS)

Further advice on clinical management is available from:

- WHO
- National COVID-19 Clinical Evidence Taskforce: <https://covid19evidence.net.au/>
- Cochrane Library: Coronavirus (COVID-19): <https://www.cochranelibrary.com/covid-19>

Persons not requiring hospitalisation who have confirmed COVID-19 can be managed at home. The United States Centers for Disease Control and Prevention (USCDC) has developed principles for such home care management at https://www.cdc.gov/coronavirus/COVID-19/guidance-home-care.html.

Education

Cases should be educated about the nature of the illness, importance of isolation and infection control measures that prevent the transmission of COVID-19. A fact sheet for confirmed cases is available on the department's website. Household contacts should be given the close contacts fact sheet.

Criteria for inpatient discharge

A confirmed case may be discharged from hospital 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

Consideration should be given for the requirement to be PCR negative on at least two consecutive respiratory specimens collected at least 24 hours apart and at least 7 days after symptom onset, prior to patients going into an **at-risk setting**. This can be discussed with the department on a case-by-case basis if required.

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

Release from isolation of a confirmed case

The following information details the circumstances under which confirmed and probable cases can be released from isolation. Cases can be released from isolation if they meet the appropriate criteria in either point 1, 2, or 3 – whichever is applicable. Significantly immunocompromised cases can be released from isolation if they meet the appropriate criteria in point 1, 2, or 3 and the additional criterion in point 4.

Healthcare workers and workers in aged care facilities who meet the above criteria can be released from isolation and **do not require further testing to return to work or an at-risk setting**.

1. Confirmed cases who are asymptomatic.

The case can be released from isolation if at least 10 days have passed since the first respiratory specimen positive for SARS-CoV-2 by PCR was taken and no symptoms have developed during this period.

2. Confirmed or probable cases with mild illness who did not require hospitalisation.

The case can be released from isolation if they meet all of the following criteria:

- at least 10 days have passed since the onset of symptoms; and
- there has been resolution of all symptoms of the acute illness for the previous 72 hours[1,2,3]

3. Confirmed or probable cases with more severe illness who have been in hospital.

   a. Confirmed and probable cases clinically ready for hospital discharge.

If the case is ready clinically for hospital discharge then they can be discharged to isolation at home or another facility.

The case can be released from home isolation if they meet all of the following criteria:

- at least 10 days have passed since hospital discharge; and
- there has been resolution of all symptoms of the acute illness for the previous 72 hours[1,2,3]

   b. Confirmed and probable cases who will be remaining in hospital.

A case that remains in hospital can be released from isolation if they meet all the following criteria:

- at least 10 days have passed since the onset of symptoms; and
- there has been resolution of all symptoms of the acute illness for the previous 72 hours[1,2,3]; and
- the case has had two consecutive respiratory specimens negative for SARS-CoV-2 by PCR taken at least 24 hours apart at least 7 days from symptom onset.

4. Significantly immunocompromised persons.

In **addition** to meeting the appropriate criteria described in points 1, 2, or 3 above, persons who are significantly immunocompromised and are identified as confirmed or probable cases must meet a higher standard requiring additional assessment. They can be released from isolation when they meet the following additional criterion:

- PCR negative[4] on at least two consecutive respiratory specimens collected at least 24 hours apart at least 7 days after symptom onset [5].

Notes:

[1] Some people may have pre-existing illnesses with chronic respiratory signs or symptoms, such as chronic cough. For these people, the treating medical practitioner should make an assessment as to whether the signs and symptoms of COVID-19 have resolved.

[2] If individuals have a persistent post-viral cough with negative test results, they are eligible for release from isolation. If individuals with a persistent post-viral cough are persistently PCR positive, they can be managed as per note 4 below.

[3] If a case who meets these criteria is additionally swabbed and tests positive, then the case can still be released from isolation based on current evidence from the literature and Australian public health experience that indicates these people are unlikely to be infectious.

[4] In lieu of PCR negative test results, results with high cycle threshold (Ct) values may also be used to inform release from isolation for significantly immunocompromised persons, after discussion between the

treating medical practitioner, the testing laboratory and public health. Viral culture, where available, may also be considered.

[5] If the patient has a productive cough due to a pre-existing respiratory illness or other ongoing lower respiratory tract disease, then the sputum or other lower respiratory tract specimens must be PCR negative for SARS-CoV-2. Otherwise upper respiratory tract specimens (deep nasal and oropharyngeal swabs) must be PCR negative.

Routine PCR testing post-release from isolation is not recommended unless the person re-develops clinical features consistent with COVID-19. If there is recrudescence of symptoms, the person should be tested for SARS-CoV-2 and other relevant medical conditions and managed accordingly.

If a case is identified retrospectively through serology, clinical and public health judgement should be used in determining case management and whether or not a case requires isolation. If the case had a clinically compatible illness some time ago, it may not be necessary to isolate. If isolation is required, the case can be released from isolation when the appropriate criteria (above) is met.

Based on a review of current evidence, persons who fulfil the appropriate criteria above are not considered to be infectious. Cases returning to a high risk setting can be released from isolation based on the clinical criteria above and **do not need to meet** a higher standard or undergo additional assessment before going into any high-risk settings. This includes persons returning to work in a health care setting, living in a residential age care setting, or who regularly attend healthcare settings for any other reason. Note that for patients who are being transferred to another ward or hospital, they should remain in isolation with transmission-based precautions and appropriate PPE until the above criteria (point 3) is met.

People who have recovered from COVID-19 and have been released from isolation based on the criteria above do not require COVID-19 testing if they are hospitalised for a non-COVID-19 related condition.

Persons who have been released from isolation should adhere to hygiene and physical distancing measures, as the extent of acquired immunity is unknown. If a recently recovered COVID-19 case becomes a close contact of a confirmed or probable case, they do not need to self-quarantine again. However, the recovered case should not attend high-risk settings (refer to Outbreak investigation and management in high-risk settings for examples of settings) until 14 days after the last unprotected contact with the confirmed case and should self-monitor for symptoms clinically consistent with COVID-19. If symptoms reappear, they should immediately self-isolate and be retested for SARS-CoV-2. If the recently recovered case is a household contact of a currently isolated case, particular care should be taken with regards to consistent hand hygiene. If the recently recovered case needs medical attention, they should follow the processes outlined in Medical care for quarantined individuals. As further evidence becomes available on the duration of immunity, these recommendations may be amended.

Faecal sampling is not recommended as a standard test, however, it may be done for patients with gastrointestinal symptoms. For cases who do have faecal samples tested, and remain persistently PCR positive in these samples after all the release from isolation criteria (above) are met, further or extended precautions and exclusions should be implemented on a case-by-case basis:

- All cases with diarrhoea should be advised not to prepare food for others until 48 hours after symptoms have resolved.
- Cases who are employed in a role where there is an increased risk of onward transmission (e.g. healthcare workers, restaurant workers and food handlers), should be excluded from work until 48 hours after any symptoms of diarrhoea have resolved.
- Cases with ongoing diarrhoea or faecal incontinence who may have limited capacity to maintain standards of personal hygiene should be isolated until 48 hours after the resolution of these symptoms.

Patients do not require repeat testing until they are PCR negative in faecal samples. It is recommended that people who remain persistently PCR positive in faecal samples use soap and water for hand hygiene. If this is unavailable, alcohol hand gel should be used. Education emphasising the importance of proper hand hygiene should be provided to **all** cases upon release from isolation.

The department will determine when a confirmed case no longer requires to be isolated in their own home. Persons who have been released from isolation should still adhere to hygiene and physical distancing measures, as the extent of acquired immunity is unknown.

Checklist of key actions for the department for confirmed cases

- Confirm the diagnosis with testing laboratory.
- Contact the treating team/GP to confirm that the confirmed case is isolated and agree the management of the patient.
- Contact the confirmed case +/- parent/guardian (for cases under 18 years) to collect relevant social, clinical and epidemiological information.
- Identify close contacts and recommend immediate quarantining of any close contacts.
- Identify any potential exposure sites and assess whether any further action is required.
- Undertake all public health response activities including risk communication and sharing of relevant resources.

Checklist of key actions for the clinical team for confirmed cases

- If a patient is in the community at the time of diagnosis and if clinically necessary, the department will organise with the nearest appropriate health service to admit the patient, in order for care to be provided in hospital or via Hospital in the Home.
- For patients who do not require admission to hospital or Hospital in the Home, clinical teams only need to provide patients with the initial feedback of their results, information and counselling and usual advice to seek medical attention if their condition deteriorates. Clinical teams do not need to routinely contact cases unless clinically appropriate.
- Notify the department on 1300 651 160 as soon as possible (within 24 hours) if a patient becomes critically unwell, in the case of intensive care admission, or death.
- Commence list of all HCWs and visitors who enter the case's room. (If the case is at home and being visited by Hospital in the Home only a list of HCWs required.)
- Advise HCWs who provide care for the case (even with appropriate use of PPE) to self-monitor for symptoms of COVID-19 for 14 days after their last contact with the case.

Signage and triage of people presenting to health and other services

Diagnosis and management of COVID-19 must be undertaken by medical practitioners in accordance with the current guidelines from the Victorian Department of Health and Human Services. This will occur primarily in general practice and hospitals.

However, to reduce risks to service providers and detect people with COVID-19 risk factors, rapid pre-assessment is indicated by a broader range of service providers prior to the provision of a service. This pre-assessment may include enquiring about recent travel history and relevant symptoms. Only health-care services who manage unwell patients (such as general practice, hospitals and ambulance services) are expected to assess for symptoms.

For examples of posters that can be used, see the department's website <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>

Contact management

The department will conduct contact tracing for confirmed cases in the community and will seek assistance from a health service in relation to any contact tracing required for health service staff.

Close contacts

Self-quarantine

The following groups are now required to self-quarantine:

- Close contacts of confirmed cases until 14 days after last close contact with the confirmed case.
- As of midnight, 28 March 2020, all travellers arriving into Melbourne from overseas will be quarantined for two weeks in hotel rooms and other accommodation facilities after submitting an Isolation Declaration Card. Interstate travellers can return to their home states after fulfilling the mandatory quarantine requirements.

Self-quarantine means remaining at home except in cases of medical emergency. This means a person recommended to self-quarantine:

- must not visit public settings or mass gatherings.
- must not use public transport.
- must not attend settings like health services, residential aged care facilities or educational settings.

This requirement for people who are in quarantine not to attend health services, includes a requirement that they do not attend a family member who is a confirmed case in a Victorian health service.

If a recently recovered COVID-19 case becomes a close contact of a confirmed or probable case, they do not need to self-quarantine again.

Health services and GPs are not required to provide a certificate of medical clearance to those who have completed the required 14 days self-quarantine.

Close contacts should not travel within Australia or internationally within the 14 days after last contact with the infectious case.

Testing

All close contacts and international returned travelers will be tested prior to the end of their quarantine period (generally at day 11). A negative test result will be required prior to the department issuing clearance for a person to exit quarantine.

Identification of potential source (‘upstream’) contacts

A close contact may also be tested as part of potential source or ‘upstream’ contact tracing.

Where a confirmed case has no identified source of infection, potential source contact tracing of the ‘first reported case’ (or in an outbreak, index case) should be undertaken. The aim is to identify potential unrecognized chains of transmission, and may be particularly useful to identify the source of introduction of disease in a setting where there is potential for rapid transmission (see section ‘Priority groups for testing’). In such settings, potential source contact tracing whould be done for the ‘first reported case’ or index case.

Potential source contacts:

- are people who had close contact with the case during the time the case is likely to have acquired the infection
- may be both close contacts and potential source contacts
- close contact will have occurred between 24 hours and 14 days (usually 5-7 days) before symptom onset in the first reported case
- may be unidentified cases, so should be:

screened for possible symptoms

have their temperature measured

undergo PCR testing for SARS-CoV-2 infections

Considered for serological testing if well, and a validated serological assay is available

- if they test positive by PCR, clinical and public health judgement should be used to determine if they are currently infectious
- if deemed to be infectious, should be managed as any other confirmed case, including rapid contact tracing
- should be assessed as to whether they are likely to be:
  - the primary case who infected the first reported case (index case in an outbreak)
  - a secondary case infected by the first reported case
  - a separate transmission chain.

Symptomatic close contacts

The approach to a symptomatic close contact requires an assessment by a treating clinician. The next steps depend on whether a treating clinician has identified the patient as having a non-infectious cause, a likely non-respiratory infectious cause, or an acute respiratory illness.

For a symptomatic close contact during the 14-day quarantine period, the department will:

- Advise the close contact to attend a suitable general practice, emergency department or coronavirus assessment centre for evaluation with a single-use face mask on and to identify themselves immediately on arrival.

Where a close contact has an illness during the 14-day period of quarantine after the step above, the treating clinician will:

- use a single room and appropriate PPE as for a suspected case
- test for COVID-19 and manage the person as a suspected case.
- If the test is positive, the person will be managed as a confirmed case. Notify the department.

Where the illness is diagnosed as acute respiratory illness:

- if testing for COVID-19 is negative and the treating clinician has diagnosed an acute respiratory illness or an illness that is highly compatible with COVID-19, the close contact may then require a subsequent test at a short period thereafter.
- if the second PCR test is also negative, another test may be conducted on day 14 of the quarantine period.
- they will still need to be monitored for 14 days after their last contact with a confirmed or probable COVID-19 case.

Where the illness is diagnosed as likely to be some other form of infection or is not an infection:

- If testing for COVID-19 is negative and the treating clinician has diagnosed some other infection or a non-infectious cause, then the treating team should consider, in conjunction with an infectious

disease specialist, whether testing of relevant specimens such as urine and faeces for COVID-19 might be of value or whether evidence is now clear for an alternative cause, including legionellosis.
- The close contact can be advised to continue to self-quarantine until a full 14 days have expired from date of last close contact with confirmed case.

Checklist of key actions for the department for close contacts

For all close contacts the department will:

- Advise self-quarantine including restriction on travel until 14 days from the last contact with confirmed case.
- Counsel close contacts about risk and awareness of potential symptoms.
- Provide a close contact fact sheet
- Make regular contact with the close contact to monitor for any symptoms, either through SMS, email or telephone call.
- If after 14 days of quarantine (from the last contact with a confirmed case), the contact remains asymptomatic, the individual is cleared and may cease quarantine.
- If a school or employer requests confirmation from the department that the quarantine period has been met, the department will provide evidence with the consent of the individual.

Healthcare workers

HCWs and other contacts who have taken recommended infection control precautions, including the use of recommended PPE, while caring for a confirmed case of COVID-19 are not considered to be close contacts. However, they should be advised to self-monitor and if they develop symptoms consistent with COVID-19 infection they should isolate themselves. See also Infection prevention and control.

Any healthcare workers who is unwell with a compatible illness should not attend work and should seek appropriate medical care. All healthcare workers with fever or symptoms of acute respiratory infection should be tested for COVID-19, as per the testing criteria.

Hospital workers currently must not enter or remain at a hospital in Victoria if:

- the person has been diagnosed with COVID-19, and has not yet met the criteria for discharge from isolation OR
- if the person has travelled/arrived in Australia from any country in the past 14 days OR
- has had known contact with a person who is a confirmed COVID 19 case in the previous 14 days OR
- has a fever or symptoms of acute respiratory infection.

The current Directions and accompanying frequently asked questions can be viewed on the department's website at <https://www.dhhs.vic.gov.au/coronavirus>

Further criteria apply to healthcare workers who become confirmed cases before they can return to work in healthcare settings (see section Return-to-work criteria for health care workers and workers in aged care facilities who are confirmed cases).

Infection prevention and control

Consult the COVID-19 infection prevention and control guidelines available on the department's website <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>

This guidance covers issues including:

- healthcare and non-healthcare sector
- standard, transmission, contact and airborne precautions
- personal protective equipment (PPE)
- environmental and equipment management
- care of the deceased.

Laboratory testing for COVID-19

A number of Victorian laboratories are undertaking testing for COVID-19 in Victorian patients. There is significant pressure on supply of swabs and reagent kits for COVID-19 testing as well as laboratory capacity.

- Use the **current testing criteria** to guide patient investigation
- Use **only one swab** when testing, unless testing for other respiratory viruses is indicated (for example, multiplex PCR) **and** your local testing laboratory is unable to undertake this on the same specimen. Contact your laboratory to clarify if an additional specimen needs to be collected.

Testing advice for clinicians in an outbreak setting

When any symptomatic patient presents for testing, all clinicians must ask if that patient has had previous exposure to a known COVID-19 case within the past 14 days. If the patient confirms there has been an exposure of that kind, and the outbreak definition is met (see Outbreak definition section), the test sample is to be treated as an 'outbreak sample'

Sample labelling – prioritisation

On request slips:

- Provide **clinical details**
- copy results to the patient's treating physician
- include the patient's mobile number so that they can be contacted quickly.

To ensure all outbreak samples and other urgent priority samples are prioritised for testing in laboratories please follow these instructions:

1. The outside of the **sample bag/s** must be clearly labelled with a **red sticker** and marked for URGENT PRIORITY sample
2. The **pathology slip** must be clearly labelled with a **red sticker** and marked as **URGENT PRIORITY** sample with the **PRIORITY GROUP 1, 2 or 3**. For example, Priority 1 - OUTBREAK to clearly identify the reason why the sample is urgent. See below for list of priority groups.
3. The **sample** should be clearly labelled with the patients name and date of birth and marked as **P1, P2 or P3** to indicate the priority groups as below.
4. Samples should then be forwarded on for laboratory testing using normal processes.

This will ensure that certain samples are prioritised for testing in laboratories and results returned within a 24 to 48-hour turnaround time. Labelling becomes particularly important for laboratories in time of high-volume testing workloads.

Samples from outbreaks will be processed at the **Victorian Infectious Diseases Reference Laboratory (VIDRL)** at the Doherty Institute. Outbreak samples may be sent to your usual pathology provider who will forward it on to VIDRL.

If an outbreak occurs within a **healthcare setting which has capacity for on-site COVID-19 testing**, then the testing can be conducted at these laboratories with appropriate liaison with VIDRL as required.

Priority groups for testing

Current as of 19 May 2020.

The following samples are considered URGENT PRIORITY samples and are listed in priority order:
Priority 1 (P1) OUTBREAK

- including CLOSE CONTACT(s) OF CONFIRMED CASE
- people located in QUARANTINE HOTEL(s)
- SYMPTOMATIC resident or staff member of a known RACF OUTBREAK

Priority 2 (P2)

- SYMPTOMATIC HEALTH CARE WORKERS including AGED CARE WORKERS
- SYMPTOMATIC aged care residents and hospital patients.

Priority 3 (P3) OTHER 'AT-RISK SETTINGS'

- for SYMPTOMATIC people identified to be from other 'at-risk' settings as determined by the referring clinician.

Clinicians may determine other 'AT-RISK' SETTINGS to be:

- Prison/Justice settings (correctional facilities, detention centres)
- Aboriginal rural and remote communities
- Accommodation with shared facilities
- Defence force operational settings
- Boarding schools
- Other group residential settings (eg. disability)
- 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)
    - Critical infrastructure dependent workplaces – such as electricity worker

Specimens for testing

Guidance from the Public Health laboratory Network on laboratory testing for SARS-CoV-2 can be found at <https://www1.health.gov.au/internet/main/publishing.nsf/content/Publications-13>

For initial diagnostic testing for COVID-19, the department recommends collection of the following samples:

1. upper respiratory tract specimens.
2. lower respiratory tract specimens (if possible).
3. serum, where possible (to be stored for later analysis at VIDRL).

Respiratory specimens

Collection of upper respiratory specimens is recommended for all patients – these would be oropharyngeal **and** deep nasal to optimise the chances of virus detection. In addition, lower respiratory specimens (sputum, if possible) are recommended for patients with a productive cough. For PPE recommendations, see .Coronavirus disease 2019 (COVID-19) infection prevention and control guideline, available on the department's website.

If the patient has severe symptoms suggestive of pneumonia, for example, fever and breathing difficulty, or frequent, severe or productive coughing episodes then **airborne and contact precautions** should be observed. This means that a P2 respirator must be used instead of a single-use surgical mask.

Patients with symptoms suggestive of pneumonia should be managed in hospital, and sample collection conducted in a negative pressure room, if available. If referral to hospital for specimen collection is not possible, specimens should be collected in a single room. The door should be closed during specimen collection and the room left vacant for at least 30 minutes afterwards (cleaning can be performed during this time by a person wearing PPE for airborne and contact precautions).

Serum and other specimens

See section on serology testing (above)

The department is continuously reviewing whether there is a requirement for other specimens such as stool or urine to be sent to VIDRL. At the current time this is not routinely recommended in cases of respiratory illness. A stool specimen may be recommended by the department to provide additional reassurance before a confirmed case is released from isolation.

Specimen collection and transport

Preparation for specimen collection

- Obtain the following equipment:
  - Personal protective equipment (PPE). For PPE recommendations, see Coronavirus disease 2019 (COVID-19) Infection Prevention and Control guidelines on the department's website.
  - A single swab for oropharynx and deep nasal sampling (one swab per patient only – unless your laboratory requires a second swab for other respiratory virus testing).

Sampling **both the oropharynx and deep nose** is recommended to optimise the chances of virus detection; both sites should be sampled with a single swab

- Use a **swab with a synthetic tip** (e.g. Dacron® or Rayon; flocked preferred) and aluminium or plastic shaft. Do not use calcium alginate swabs or swabs with wooden shafts, as they may contain substances that inactivate some viruses and inhibit PCR testing
- Swabs should be placed in **transport medium**, which may be viral transport medium (VTM) or Liquid Amies
- **Label tube** appropriately (patient's ID number, specimen type and swab date). Request slips should include clinical details identifying high-risk patients and healthcare workers.

Specimen collection process

Upper respiratory tract

Collection of upper respiratory specimens (that is, deep nasal and oropharyngeal samples) can be performed using **droplet and contact** precautions.

- Perform hand hygiene before donning gown, gloves, eye protection and single-use surgical mask. See How to put on and take off your PPE poster on the department's website <https://www.dhhs.vic.gov.au/how-put-and-take-your-ppe>.
- Stand slightly to one side of the patient to reduce exposure to respiratory secretions should the patient cough or sneeze.
- Swab the oropharynx (throat) first: swab tonsillar beds and the back of the throat, avoiding the tongue (see figure 1).
- Using the **same** swab, sample the deep nasal area (see figure 2):
  - using a pencil grip and while gently rotating the swab, insert the tip 2–3 cm (or until resistance is met), into the nostril, parallel to the palate, to absorb mucoid secretion.
  - rotate the swab several times against the nasal wall.
  - withdraw the swab and repeat the process in the other nostril. To conserve swabs the same swab that has been used to sample the oropharynx should be utilised for nasal sampling
- Place the swab(s) back into the accompanying transport medium. Avoid repeated freezing and thawing of specimens.
- At the completion of the specimen collection process, remove all PPE and perform hand hygiene after removing gloves and when all PPE has been removed. See How to take off your PPE poster on the department's website <https://www.dhhs.vic.gov.au/how-put-and-take-your-ppe>.
- Clean room after sample collection -droplet and contact precautions PPE must be worn when cleaning the room. See the COVID-19 infection prevention and control guidelines available on the department's website <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19> for further information. Note that, for droplet and contact precautions, the room does not need to be left empty after sample collection.

Figure 1: Swabbing the oropharynx

Figure 2: Swabbing the deep nose

Self-collected nasal and oropharyngeal swab

These are interim recommendations and may be subject to change as more information becomes available and the epidemiology of the pandemic changes.

Self-collected nasal and throat swabs, taken under supervision and direct observation of a trained healthcare worker (HCW), may be a viable option in the current COVID-19 outbreak in limited circumstances.

The Department of Health and Human Services refers laboratories and collection services to the new advice of the Therapeutic Goods Administration that the 'use of self-collected samples for SARS-CoV-2 requires validation by the laboratory as an in-house IVD (if the test kit being used isn't validated by the manufacturer for use with these specimen types).' https://www.tga.gov.au/legal-supply-covid-19-test-kits (date accessed 2/6/2020).

Therefore, a validated self-collected swab for SARS-CoV-2 testing should only be used provided the following conditions are met:

- If self-collection of swabs is used, it should only be done under the supervision and direct observation of a trained HCW to maximise control and quality assurance of the whole collection process. Clear instructions are to be provided to the patient.
- The request form should identify that the specimen has been self-collected.
- If a person does not choose self-collection or does not feel comfortable about their ability to self-collect, sampling should be performed by a trained HCW using PPE.
- A self-collected, combined deep nasal (deep from both nostrils) and oropharyngeal specimen is collected using a single swab. The swab is then sent for polymerase chain reaction (PCR) testing for the acute diagnosis of SARS-CoV-2 infection, in an accredited laboratory.

Note:

- Decisions concerning self-collection should be made in response to clinical and public health imperatives with Public Health advice.
- Self-collected swabs are not appropriate for patients with severe symptoms or in hospital settings (i.e. emergency departments and wards). In these situations, collection of a specimen should be performed by a trained HCW using appropriate PPE.
- Self-collected swabs are also not appropriate in home environments and are not supported.
- Self-collection should only be offered to people over 18 years of age who are considered to have the capability to perform the test correctly and safely.

- Swabbing of infants and children should only be conducted by a trained HCW, not a parent or carer.

Guiding documents on the use of self-collected swabs can be found at:

Public Health Laboratory Network – PHLN guidance on laboratory testing for SARS-CoV-2
https://www1.health.gov.au/internet/main/publishing.nsf/Content/Publications-13

Communicable Diseases Network Australia – COVID-19 SoNG
https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm

Lower Respiratory tract

If possible, obtain lower respiratory tract specimens as they are likely to contain the highest virus loads, based on experience with SARS and MERS coronaviruses

- **Sputum** – have the patient rinse the mouth with water and then expectorate deep cough sputum directly into a sterile, leak-proof, screw-cap sputum collection cup or sterile dry container. Refrigerate specimen at 2-8°C. If sending to Victorian Infectious Diseases Reference Laboratory (VIDRL), send on an ice pack.
- **Bronchoalveolar lavage, tracheal aspirate** – collect 2-3 mL into a sterile, leak-proof, screw-cap sputum collection cup or sterile dry container. Refrigerate specimen at 2-8°C - if sending to VIDRL, use ice pack.

Blood

Blood (serum) for storage for serology at a later date:

- Children and adults: Collect 1 tube (5-10mL) of whole blood in a serum separator tube.
- Infant: A minimum of 1ml of whole blood is needed for testing paediatric patients. If possible, collect 1mL in a serum separator tube.

There are no special requirements for transport of samples. They can be transported as routine diagnostic samples for testing (that is, Biological substance, Category B).

Referral of positive samples

All positive samples are to be labelled as “POSITIVE SAMPLE FOR STORAGE” and couriered to the Victorian Infectious Diseases Reference Laboratory (VIDRL) for ongoing storage and genomics.

Handling of specimens within diagnostic laboratories

All diagnostic laboratories should follow appropriate biosafety practices, and testing on clinical specimens, including for other respiratory viruses, should only be performed by adequately trained scientific staff.

Current advice from the WHO is that respiratory samples for molecular testing should be handled at Biosafety Level 2 (BSL2), with the USCDC recommending that the following procedures involving manipulation of potentially infected specimens are performed at BSL2 within a class II biosafety cabinet:

- aliquoting and/or diluting specimens
- inoculating bacterial or mycological culture media
- performing diagnostic tests that do not involve propagation of viral agents in vitro or in vivo
- nucleic acid extraction procedures involving potentially infected specimens
- preparation and chemical- or heat-fixing of smears for microscopic analysis.

Indeterminate test results

Indeterminate test results have been reported from a number of Victorian laboratories. These are usually samples that have had one gene detected in the assay but not both genes.

Indeterminate results may be referred to VIDRL for further testing, although **these samples should be considered as positive**. Confirmatory testing may not be possible as the sample may already be low titre and degradation due to processing may mean that VIDRL's PCR may not be sufficiently sensitive to offset loss of titre in the sample.

Cases with indeterminant results should be managed as confirmed cases. If the treating clinician feels that the pre-test probability for COVID-19 is low, another sample may be collected for further testing. If the second sample tests negative, the department will discuss the case with the treating doctor and the testing laboratory to determine whether the case should continue to be managed as a confirmed case.

Healthcare services – management of healthcare workers with suspected or confirmed COVID-19

Summary

This guidance outlines the roles and responsibilities of healthcare services in the event of a suspected or confirmed case or suspected or confirmed outbreak of COVID-19 among staff (and/or patients). It is primarily intended for use by hospitals but could be applied to other healthcare settings where appropriate.

For the purposes of this guide, healthcare workers are defined as people in contact with patients or the patient space. For example, doctors and nurses and cleaners who enter the patient's room or cubicle and frontline administrative staff would be included as healthcare workers. Staff who work in non-clinical areas and who do not enter patient rooms are not included as healthcare workers for this purpose.

An outbreak is defined as two or more epidemiologically linked cases of COVID-19 with symptom onset within 14 days. To be considered linked (and therefore constitute an outbreak), cases must be linked in both time (symptom onset dates within 14 days) and place (a common geographical link, such as staff who work in the same ward, patients who are cared for by the same staff member). However, even a single confirmed case of COVID-19 in a sensitive setting such as a healthcare service requires immediate control measures and the active involvement (resources permitting) of the Department of Health and Human Services (the department).

Roles and responsibilities

Directions

The current State of Emergency in Victoria provides the Chief Health Officer with additional powers to issue directions to help contain the spread of COVID-19 and keep Victorians safe. Hospital Visitor Directions that restrict entry into hospitals to minimise the risk of spreading COVID-19 among hospital patients and staff are currently in place. Please see the department's website for the latest details.

Role of Department of Health and Human Services (the department)

The department will assist with:

- Performing a situation assessment and confirming the presence of an outbreak (if relevant).
- Notifying the employer if a staff member attended work while potentially infectious.
- Providing advice on measures to prevent further transmission in the workplace.
- Providing other specialist public health advice on other topics as needed.
- Conducting interviews with confirmed cases (or their next of kin or healthcare provider where relevant) and contact tracing in parallel with and supported by the healthcare service's investigation.
- Providing the healthcare service with a "Case and contact data spreadsheet template" to assist them in collecting information about patients and staff who have been in close contact with a case.
- Consolidating information collected by the department with that obtained by the healthcare service.
- Information management of test results and clinical information of close contacts and confirmed cases in the Public Health Events Surveillance System (PHESS).
- Making daily contact with cases (through SMS, email or telephone call) until they are judged to meet release from isolation / return-to-work criteria

- Making regular contact with close contact(s) of the case (through SMS, email or telephone call) to monitor for symptoms and advise on the need for testing, if relevant.
- Determining when healthcare workers should be tested for return-to-work clearance in consultation with the patient and their treating doctor. 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.
- Follow-up of clearance testing results and determining when the return-to-work criteria have been met
- Provision of a letter (via email) to cases once they are judged to meet the return-to-work criteria that the healthcare worker can provide to their employer.
- Monitoring outbreaks.

Role of healthcare service

In the event of a confirmed case *or* confirmed outbreak involving a staff member or patient, the healthcare service is responsible for the following:

- Notifying the department immediately on 1300 651 160 (including after hours).
- Nominating a staff member (usually the infection prevention and control lead) to be the point of contact with the department.
- In the event of a confirmed case or confirmed outbreak in a healthcare service (including among staff members), it is the expectation that the healthcare service will perform a rapid assessment of risk in the workplace and commence contact tracing functions where possible. Healthcare services should also implement immediate infection prevention and control measures (as per the section on Control of exposure risks to staff and patients).
- Assess practices are aligned to policies and procedures in order to identify potential breaches and shortfalls.
- In the event that a healthcare worker has worked while infectious, it is the expectation that healthcare services in which they worked perform thorough contact tracing of all **patients**, **staff and visitors** who have been in close contact with the case during their infectious period. The healthcare service should also inform these people that they have been in close contact with a case and provide them with the necessary advice and information. While the healthcare service will need to identify all close contacts, the department can assist with contacting them.
- Providing the department with the information obtained from their risk assessment and contact tracing.
- Maintaining an up-to-date case and contact list and sending this to the department at agreed times (e.g. every second day, depending on the situation). Use the "Case and contact data spreadsheet template" provided by the department.
- Notifying the department on 1300 651 160 as soon as possible (within 24 hours) if a confirmed case becomes critically unwell, requires intensive care admission or dies, or in the event of additional suspected or confirmed cases.
- The caller should specify that they need to speak to the **Case and Contact Sector Lead**.
- Facilitate testing of their healthcare worker for return-to-work clearance, where possible.
- Provide psychological support to the healthcare worker if required.
- Engage with and share findings of internal review of confirmed cases with Safer Care Victoria

Role of the treating doctor / doctor who has requested COVID-19 testing

- It is the responsibility of the testing doctor (and the testing laboratory) to notify the department of any confirmed case of COVID-19 on **1300 651 160**.

- It is the responsibility of the treating doctor to inform the case of their test result and advise them of the appropriate actions they must take (i.e. isolation, and if appropriate, the need for medical treatment).
- Clearance testing should be arranged by the healthcare worker's employer, the healthcare worker's treating doctor, or at a coronavirus assessment centre if testing by the treating doctor is not feasible.

Role of Safer Care Victoria

Safer Care Victoria is responsible for the oversight of quality and safety in Victorian health services. This includes a role in supporting and assisting health services to review clinical incidents.

In the event of a confirmed case or confirmed outbreak involving a staff member or patient, Safer Care Victoria has a responsibility for:

- providing guidance and support to health services regarding review processes and where required participation in conducting reviews for a confirmed case or outbreak.
- to share findings for the purpose of learning with the health sector and the Department of Health and Human Services.
- to update any relevant Safer Care Victoria guidance based on findings and recommendations of review.

Safer Care Victoria can be contacted by phone on 1300 650 172 or email at info@safercare.vic.gov.au.

Healthcare service staff responsible for managing a case or an outbreak

A single confirmed case (either a staff member or patient) in a sensitive setting such as healthcare requires the active involvement of the department. Where there is an infection prevention and control (IPC) unit or an infectious diseases department, they should be involved as soon as possible. Ideally, a member of staff from the IPC team should be designated the **outbreak lead** as a point of contact between the healthcare service and the department. The outbreak lead should:

- Coordinate contact tracing, particularly in staff and patients of the healthcare service.
- Keep a case list of confirmed cases, suspected cases and deaths, and a close contacts list.
- They should update the department regularly (timeframe to be agreed between the department and the IPC lead) and email the updated case list through where necessary.
- The department must be notified immediately on **1300 651 160** (including after hours) if:
  - an outbreak is suspected
  - a new confirmed case of COVID-19 is identified
  - a death due to confirmed or suspected COVID-19 occurs.

Contact the Case and Contact Sector Lead on **1300 651 160.**

Responsibilities of the healthcare service as an employer

Employers (including healthcare services) have a duty to provide and maintain, so far as is reasonably practicable, a working environment that is safe and without risks to health. This includes a responsibility to:

- identify whether there is a risk to health of employees from exposure to COVID-19 at their workplace
- implement appropriate measures to reduce or eliminate risk (for example, by implementing social distancing initiatives, providing adequate facilities or products to allow employees to maintain good hand hygiene, and providing appropriate personal protective equipment and training on how to use it)

- facilitating testing of employees who meeting current testing criteria for COVID-19
- ensure employees understand when to stay away from the workplace and advise them of the requirement to self-quarantine for 14 days following return from overseas travel or contact with a confirmed case of COVID-19.

When should a healthcare worker be tested?

All healthcare workers who meet the criteria for testing as described on the department's health services and general practitioners COVID-19 webpage <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19> should be tested.

If testing healthcare workers, doctors are reminded to clearly mark pathology slips with **'Urgent - HCW'** (healthcare worker) to ensure the swabs can be easily identified for priority testing, and to include the healthcare worker's mobile number so they can be promptly contacted.

Healthcare workers should NOT be their own testing or treating doctor.

Immediate management of a suspected or confirmed case

Any symptomatic healthcare worker who meets the testing criteria for COVID-19 should be advised to isolate immediately and testing for COVID-19 should be facilitated. While they are awaiting test results they should remain in isolation until they have been notified of the test result and the appropriate course of action is subsequently determined. The following steps should be taken by the healthcare service:

- Ensure that the staff member is currently self-isolating.
- If the staff member is not currently in self-isolation, they must remove themselves from the workplace immediately with the least possible risk of transmission to others. This may include the following:
  - if possible, they should wear a single-use surgical mask
  - they should avoid public transport and return home immediately without detour
  - if possible, they should take a private car
  - if they are not driving, they should sit in the rear seat
  - they should minimise contact with any other persons and should practise strict physical distancing.
- Ensure that the staff member has had testing arranged.
- Ensure they have the appropriate information. Inform them that they must remain in isolation until they have been notified of the test result and they must **not** attend work during this time.
- Consider whether the member of staff shares a house with other healthcare workers or older or vulnerable people. In these circumstances it may be preferable for the case to isolate in another location to reduce the risk of transmission. They may be eligible for free accommodation provided by the department. Contact **covid19.hcwaccom@dhhs.vic.gov.au**.
- If the healthcare worker was tested for COVID-19 within your institution and returns a positive result, ensure that the doctor requesting the test has notified the department of the confirmed case (notifications should be directed to **1300 651 160**).
- Instruct any healthcare worker diagnosed with COVID-19 to remain in self-isolation until cleared by the department and encourage them to seek urgent medical attention if they become very unwell.

Further information for individuals diagnosed with COVID-19 and close contacts can be found here: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

Rapid workplace risk assessment and contact tracing

A rapid assessment of the workplace risk should be performed as soon as is practicable following identification of a confirmed case in a staff member. Nominate a dedicated member of staff to manage staff COVID-19 cases and to serve as a point of contact between the department and the healthcare

service. The point of contact in the department will be an appointed member of the **Case and Contact Management Team**.

For a full list of actions and processes which should be undertaken in the event of a confirmed case in a staff member, please see the checklist below.

Immediate actions

- Perform a rapid workplace risk assessment and contact tracing (see below).
- Ensure you provide the department with the completed "Case and contact data spreadsheet template" as soon as possible.
- Notify and quarantine any close contacts from the hospital – including staff, clients, patients and visitors. Provide close contacts with a copy of the "Factsheet – close contact" available under "Factsheets for patients" on the department's website (see: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19). Triage them for symptoms and test for COVID-19 if indicated. For guidance on whether testing is indicated, please refer to the *'Cases and contact management guidelines for health services and general practitioners'* available here: https://www.dhhs.vic.gov.au/coronavirus-disease-2019-covid-19-guideline-health-services-and-general-practitioners

Ongoing actions

- Maintain an outbreak case list using the "Case and contact data spreadsheet template".
- Provide the department with regular updates; - how frequently this will be required depends on the level of risk and size of the outbreak.
- Consider enhanced surveillance for symptoms of COVID-19 within the workplace and among patients other than the identified contacts.
- Notify the department of any COVID-related deaths as soon as possible, including after hours.
- Ensure that confirmed cases who are healthcare workers do not return to work until the department has determined that they meet the current return-to-work criteria for healthcare workers.
- Ensure that close contacts who are healthcare workers do not return to work until the department has determined that their quarantine period has ended.

Case interview and contact tracing

Infectious period and close contacts

The department will conduct a comprehensive case interview with all confirmed cases to confirm the date and timing of symptom onset as well as their infectious period. This does not preclude the health services from doing their own interview and urgently instituting appropriate isolation of close contacts.

- Cases are considered infectious from 48 hours prior to symptom onset until they meet the criteria for release from isolation or return to work.

The health service should compile a list of people who the case has been in close contact with while infectious using the "Case and contact data spreadsheet template".

- A **close contact** is defined as a person who has spent, cumulatively over the course of a week, at least 15 minutes face-to-face OR at least 2 hours in the same closed space as the confirmed case during their infectious period without wearing appropriate PPE.
- A review of medical records/charts may be helpful to determine what staff/patients are possible contacts.

- Consideration should be given as to whether a potential close contact is immunocompromised and may be more likely to become infected with shorter periods of exposure.

Ensure all sections of the spreadsheet are completed including accurate and up to date contact information for all close contacts.

If you have identified multiple confirmed cases within your institution, ensure each confirmed case has a separate form/tab completed.

Source of infection

Consider whether the staff member's infection may have been acquired within your health service (via another patient or staff member) or via an external exposure event.

- Ask whether the healthcare worker has had contact with anyone with apparent or reported fever or acute respiratory symptoms in the 14 days prior to their symptom onset (i.e. potential source of infection).
- Consider whether the staff member engaged in any recent aerosol generating procedures (AGPs) that may have increased their exposure risk.
- Consider whether the staff member may have had a breach of personal protective equipment (PPE) which may have led to an exposure.
- Document any recent travel (international or domestic) and consider whether the staff member had been in close contact with any confirmed cases prior to diagnosis.
  - Determine whether the staff member was in quarantine at the time of symptom onset.
  - Document date from which staff member has been in isolation/quarantine.
  - Document attendance at any other sensitive settings during the staff member's infectious period (from 48 hours prior to onset of symptoms until appropriately isolated) including: other healthcare services, clinics, education or learning centres, residential and aged care facilities, correctional facilities or attendance at patients' homes for home visits.

Workplace risk assessment

As part of the risk assessment, the following should be taken into consideration:

- Whether the case was infectious while at the workplace.
- Whether cleaning and disinfection of certain areas are required.
- Whether closure of certain areas is required to facilitate cleaning and allow for the investigation to be completed.
- Whether there are at risk/vulnerable patients for which enhanced surveillance for symptoms and possibly enhanced use of PPE could be considered (e.g. immunocompromised patients).

Control of exposure risks to staff and patients

The following actions should be taken immediately to reduce the risk of exposure to staff and patients:

- Ensure staff are adhering to current guidelines relating to the use of PPE in healthcare settings and that appropriate PPE is accessible. https://www.dhhs.vic.gov.au/coronavirus-covid-19-healthcare-workers-ppe-guidance-0
- Arrange for thorough cleaning and disinfection of areas which may pose an infection risk.
- Remove healthcare worker/staff close contacts from the workplace and advise them to quarantine for 14 days from last close contact with the case.
- If any close contact develops symptoms of COVID-19 while in quarantine, they should be tested.

- Place any patients identified as close contacts into quarantine (for 14 days from last close contact with the case) and ensure that droplet and contact precautions (or airborne and contact precautions for AGPs) are followed when caring for these patients.
- Ensure staff are provided with information and support during this process. Access to services and additional fact sheets can be found here: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

Checklist for healthcare service when there is a confirmed case in a staff member

This process should be managed by the IPC lead, who can delegate the following activities to members of the outbreak management team with the support of local staff.

Checklist	☑
Detection and confirmation of case(s)	
Support staff with fever or acute respiratory infection to self-isolate. Facilitate testing for symptomatic staff where possible. Confirm diagnosis. Determine the symptom onset date and determine whether the staff member attended work during the infectious period.	
Management of case(s)	
Ensure that the staff member is currently self-isolating and reiterate that they should not return to work until the department has determined that they meet the return-to-work criteria. Ensure the staff member knows where to seek psychological support as well as medical advice if they become more unwell. Facilitate clearance testing for the staff member where possible.	
Contact tracing	
Enter the staff member's details in the "Case and contact data spreadsheet template".	
If you have identified multiple confirmed cases within your institution, ensure each confirmed case has a separate form/tab completed. Ensure accurate contact details for each person you record in the spreadsheet.	
Immediately compile a list of all **staff** (paid and unpaid) who may be contacts of the staff member. Check rosters, sign-in sheets and other records as necessary. Liaise with staff member's manager and medical workforce.	
Immediately compile a list of all **patients** who may be contacts of the staff member. Check ward lists, admissions, discharges and transfers for the relevant ward / department.	
Immediately compile a list of all **visitors** who may have been exposed to the staff member. Check visitor sign-in sheets and other records.	
Review **medical records** to determine if the staff member documented contact with patients.	
From the above lists, identify *potential* **close contacts** from the available evidence (see definition of close contact above).	

Discuss with the staff member (case) to **confirm** the type and duration of contact they had with the above contacts and identify any further people who qualify as **close contacts** of the case.	
Record all information in the case and contact spreadsheet and provide this to a case and contact officer (CCO) at the department.	
Quarantine contacts and isolate cases	
For all close contacts of the confirmed case identified within the healthcare setting (staff members, patients or visitors): • Notify them that they have been identified as a contact of a confirmed case and inform them of the next steps required (please note that an employer cannot disclose confidential information about the confirmed case, and should only notify close contacts that they have been identified as a close contact with a confirmed case). • Distribute close contact information as provided by the department, including information on psychological support.	
For staff members and visitors, additionally: • Ensure they are excluded from work and are self-quarantining for 14 days after last contact with the case • Encourage them to seek testing if they develop symptoms and further medical advice if they become more unwell.	
For patients, additionally: • Implement droplet and contact precautions, including if patient is readmitted during quarantine/ isolation period • Advise isolation at home if already discharged • Facilitate testing if they develop symptoms	
Keep a record of each close contact and when they were informed of their potential exposure.	
Implement infection control measures	
Quarantine patients who are close contacts of the case (cohort patients if necessary).	
Consider temporary closures (e.g. rooms, wards) to facilitate investigation of the positive case and allow terminal cleaning. This decision can be made in consultation with the department	
Implement droplet and contact precautions (e.g. masks, gloves, gowns, eye protection) for all patients identified as a case or close contact of a case.	
Provide PPE outside rooms / wards / facility.	
Display sign outside rooms / wards.	

Reinforce standard precautions (hand hygiene, cough etiquette) throughout facility.	
Increase frequency of environmental cleaning (minimum twice daily where there are confirmed cases in patients).	
Monitor/update	
Arrange for daily symptom check and observations for inpatients who are close contacts. Arrange prompt testing for those who develop symptoms of COVID-19 whilst in quarantine as a close contact. Ensure the IPC lead is informed of all positive results as soon as possible.	
The IPC lead must update the department (via the designated contact) on an agreed basis (daily, every second day, etc.) or when there is a significant issue (e.g. a cluster, a death). Update the case list with both positive and negative test results.	
Notify	
Contact the department on **1300 651 160**, when there is an outbreak or a COVID-related death (24 hours, 7 days a week).	
Email case and contact spreadsheet to publichealth.operations@dhhs.vic.gov.au	
Keep patients, staff and families informed.	
Restrict	
Restrict movement of staff between areas of facility.	
Avoid patient transfers if possible.	
Restrict visitors where practical and in compliance with most recent direction on hospital visitors (if applicable).	
Consider cohorting of staff (during shift work).	
Do not allow HCWs to return to work until they have met the DHHS HCW clearance criteria.	
Declare and review	
Declare the outbreak over when there have been no new cases for a defined period of time (in consultation with the department).	
Review and evaluate case and outbreak management – amend outbreak management plan if needed.	

Governance

International response

The WHO declared COVID-19 a Public Health Emergency of International Concern (PHEIC) under the *International Health Regulations 2005* and on 30 January 2020. A pandemic has now been declared.

A State of Emergency was declared in Victoria on 16 March 2020.

Public Health Incident Management Team

The Department of Health and Human Services (the department, DHHS) has formed a Public Health Incident Management Team, led by a Public Health Commander, to coordinate the public health and sector response. A Class 2 Emergency, or public health emergency, was declared on 1 February 2020.

The Infection Clinical Network of Safer Care Victoria will be a network that is requested to provide comment and advice to the department, alongside national committees including the Communicable Diseases Network Australia (CDNA).

Communications and media

The department will coordinate communications and media in relation to suspected and confirmed cases of COVID-19. In some instances, the department may – in collaboration with a Victorian health service – request a service to provide media responses in relation to one of more cases associated with that service. A health service should contact the department's Media Unit with any queries.

Role of Ambulance Victoria

Where clinically appropriate, Ambulance Victoria can be used to transport any suspected cases of COVID-19 from a port of entry or unwell suspected cases from general practice or other settings to an emergency department. Triple 000 should be called in the normal manner but advise that the patient may have suspected COVID-19 infection.

Prevention

From midnight, 28 March 2020, all travellers arriving into Melbourne from overseas will be quarantined for two weeks in hotel rooms and other accommodation facilities

- Follow physical distancing advice
- Follow advice on influenza vaccination.
- Ensure adherence to good hand and respiratory hygiene practices.
- Adhere to good food safety practices.
- Consider avoiding live animal markets.

At the present time, travel within Australia is not recommended, and a ban on overseas travel is currently in place. Check for overseas travel advice or restrictions at Smartraveller <https://www.smartraveller.gov.au>.

Advice on physical distancing and other transmission reduction measures is available on the department's website <https://www.dhhs.vic.gov.au/coronavirus-covid-19-transmission-reduction-measures>.

Risk management at ports of entry

Infection with COVID-19 was designated a Listed Human Disease (LHD) under the *Biosecurity Act 2015* on 21 January 2020.

As of 18th March, the Australian Government advises all Australians not to travel overseas to any country at this time.

Currently all passengers from every arriving international aircraft are health screened. The department's healthcare workers are also conducting health checks on passengers from any international flight if required by the biosecurity officer. Single-use facemasks are provided to arriving passengers who have been identified as unwell. As of midnight, 28 March 2020, all travellers arriving into Melbourne from overseas will be quarantined for two weeks in hotel rooms and other accommodation facilities after submitting an Isolation Declaration Card. Interstate travellers can return to their home states after fulfilling the mandatory quarantine requirements.

The disease

Infectious agent

Severe Acute Respiratory Syndrome coronavirus 2 (SARS-CoV-2) has been confirmed as the causative agent. Coronaviruses are a large and diverse family of viruses that include viruses that are known to cause illness of variable severity in humans, including the common cold, severe acute respiratory syndrome (SARS-CoV), and Middle East Respiratory Syndrome (MERS-CoV). They are also found in animals such as camels and bats.

First termed 2019 novel coronavirus (2019-nCoV), the virus was officially named Severe Acute Respiratory Syndrome coronavirus 2 (SARS-CoV-2) 11 February 2020. The disease it causes is now called coronavirus disease 2019 (COVID-19).

Reservoir

It is highly likely that the virus has come from an animal source. Genomic analysis suggests that bats appear to be the reservoir of SARS-CoV-2 but the intermediate host has not yet been identified.

Mode of transmission

Human-to-human transmission of SARS-CoV-2 is via droplets and fomites from an infected person.

There is some evidence that COVID-19 infection may lead to intestinal infection and virus can be present in the faeces of infected persons. Additionally, airborne transmission of COVID-19 may occur during aerosol-generating procedures. Despite this, current evidence does not support faecal-oral or airborne spread as major drivers in transmission; however, aerosol-generating procedures should be undertaken with appropriate precautions (refer to Aerosol-generating procedures).

Estimates for the basic reproductive number (R0) of SARS-CoV-2 range from 2–4, with R0 for confined settings, e.g. cruise ships, at the higher end of this range. Estimates of the effective reproductive number (Reff) vary from between settings and at different time points are dependent on a range of factors, including, public health interventions such as isolation, quarantine and physical distancing to limit close contact between people.

Incubation period

The median incubation period is estimated to be 5 to 6 days, with a range of 1 to 14 days.

Infectious period

Evidence on the duration of infectivity for COVID-19 infection is evolving. Epidemiological data suggests that the majority of transmission occurs from symptomatic cases, however there is evidence of pre-symptomatic and possibly asymptomatic transmission. Viral loads appear to be highest at the time of symptom onset and decreased quickly within 7 days. As a precautionary approach, cases are considered to be infectious from 48 hours prior to onset of symptoms until they meet the criteria for release from isolation. Infection control precautions should be applied throughout any admission and until the department has declared the confirmed case to be released from isolation.

Given that little information is currently available on viral shedding and the potential for transmission of COVID-19, testing to detect the virus may be necessary to inform decision-making on infectiousness. Patient information (for example age, immune status and medication) should also be considered. Criteria for release from isolation are described in this guideline.

Clinical presentation

For 80% of cases, COVID-19 presents as a mild illness. Common signs of COVID-19 infection include respiratory symptoms, fever, cough, shortness of breath and breathing difficulties. Other symptoms include sore throat, coryzal symptoms, headache, fatigue, myalgia, anosmia, dysgeusia, chills and vomiting.

In more severe cases, it appears that infection can cause pneumonia, severe acute respiratory syndrome and multi-organ failure (including renal failure). Severe and fatal outcomes occur more frequently in the elderly and individuals with comorbid conditions. Some individuals remain asymptomatic. In summary, the clinical spectrum varies from mild cases, through to severe acute respiratory infection (SARI) cases.

For confirmed cases reported globally, the case fatality rate is approximately 6%; however, this is likely an overestimate for the Australian health setting. The true case fatality rate for COVID-19 is difficult to estimate due to variable case ascertainment, especially in regards to mild cases, and the impact of health systems on patient outcomes. Mortality of cases is, to a significant extent, determined by individual risk factors and healthcare quality and access. Based on surveillance data notified in Australia as of 04 June 2020, the crude national case fatality rate is 1.4% (102 deaths/7,229 confirmed cases).

Information resources

The department places resources for health professionals on the department's coronavirus (COVID-19) website <https://www.dhhs.vic.gov.au/coronavirus>.

It is important that health professionals consult this website frequently, as case definitions and content of this guideline change regularly during the response to this outbreak.

Keeping informed of emergencies affecting the health sector and critical public health issues impacting your work is made easier if you:

- Subscribe now to information including Chief Health Officer updates and emergency advice from the Department of Health and Human Services.
- Follow the Chief Health Officer on Twitter
- Subscribe to the COVID-19 stakeholder newsletter

Coronavirus disease 2019 (COVID-19)

Case and contact management guidelines for health services and general practitioners

25 April 2020

Version 20

VICTORIA State Government | Health and Human Services

Contents

Background

Coronavirus disease 2019 (COVID-19) was first identified in Wuhan City, Hubei Province, China in December 2019. Updated epidemiological information is available from the World Health Organization (WHO) and other sources. Current information on COVID-19 is summarised in a section at the end of this guideline entitled 'The disease'.

These guidelines and a range of other resources for health services and general practitioners can be found at the department's Coronavirus disease (COVID-19) website <https://www.dhhs.vic.gov.au/novelcoronavirus>.

A hotline is available for the general public who have questions or concerns – 1800 675 398.

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 and subsequent Directions, the Department of Health and Human Services' (the department) public health response 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 physical 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.

Checklist for general practitioners

The following actions should be undertaken when a patient presents to a general practice or community health service who may be a case of COVID-19:

1. Provide a single-use surgical mask for the patient to put on.
2. Isolate the patient in a single room with the door closed.
3. Any person entering the room should don droplet and contact precautions personal protective equipment (single-use surgical mask, eye protection, gown and gloves).
4. Conduct a medical assessment, and focus on:
   a) the date of onset of illness and especially whether there are symptoms or signs of pneumonia
   b) contact with confirmed cases of COVID-19
   c) precise travel history and occupation
   d) history of contact with sick travellers or other people or overseas health care facilities
   e) work or residence in a moderate or high risk setting for transmission
   f) residence in a geographically localised area with elevated risk of community transmission, as defined by the department.
5. Determine:
   (a) Does the patient need testing for COVID-19? Refer to *Who should be tested for COVID-19*
   (b) Does the patient require further assessment in an emergency department? Where there is suspicion of pneumonia or the patient is quite unwell, a suspected case of COVID-19 should be tested and managed in hospital.
   (c) If further assessment is required, how will the patient be transferred?

   The department no longer needs to be notified about suspected cases (only confirmed cases).

   If the patient is not tested – advise them to stay at home until their symptoms have resolved, 72 hours have elapsed since the last fever and they feel well.
6. If a suspected case of COVID-19 is unwell enough to require ambulance transfer to hospital, call Triple Zero (000) in the normal manner but advise that the patient may have suspected COVID-19 infection. Ambulance transfers do not need to be approved by the department. Where there is no clinical need for ambulance transfer, alternative means of transport should be used including private car driven by the case or an existing close contact (not bus, taxi or Uber).
7. Remember to provide a surgical face mask for the patient and driver if being transferred to an emergency department by any means.
8. If a patient is tested in the community by a general practitioner, the general practitioner should **undertake testing** as indicated in this guide. Ensure arrangements are in place for contacting the patient with the test result – this is the responsibility of the general practitioner.
9. **Advise a suspected case they must self-isolate at home**, and provide a factsheet for suspected cases from the department's COVID-19 webpage.
10. Undertake **cleaning and disinfection** of the room as detailed in this guide.
11. When the test result is available:
    a) **If the test is negative** for COVID-19 provide the negative result from the laboratory to the patient and manage any other cause of illness you have assessed as requiring treatment. Consider advising the patient in the normal manner that admission to hospital and further testing may be required if they deteriorate.

b) **If the test is positive** for COVID-19, call the department on 1300 651 160 to confirm that the department is aware of the result and agree on next steps for management of the patient.

Checklist for health services

The following actions should be undertaken when a patient presents to an emergency department or urgent care centre who may be a suspected case of COVID-19:

1. Staff at triage points should wear personal protective equipment for droplet and contact precautions (single-use surgical mask, eye protection, gown and gloves).
2. Triage high risk patients to a separate isolated waiting area away from low risk patients, staff and general public.
3. Provide a single-use surgical mask for the patient to put on.
4. Isolate the patient in a single room with the door closed.
5. Any person entering the room should don droplet and contact precautions personal protective equipment (single-use surgical mask, eye protection, gown and gloves).
6. Conduct a medical assessment, and focus on:
   (a) the date of onset of illness and especially whether there are symptoms or signs of pneumonia
   (b) contact with confirmed cases of COVID-19
   (c) precise travel history and occupation
   (d) history of contact with sick travellers or other people or overseas health care facilities
   (e) work or residence in a moderate or high risk setting for transmission
   (f) residence in a geographically localised area with elevated risk of community transmission, as defined by the department.
7. Determine whether the patient fits the current criteria for testing. Refer to *Who should be tested for COVID-19*
8. If admission is not required and the patient can return to the community:
   a) for patients that do **not** fit the current criteria for testing for COVID-19 – advise the patient to stay at home until their symptoms have resolved and they feel well. Those with fever should stay at home until at least 72 hours (3 days) after the last fever.
   b) for patients that fit the current criteria for testing - the notifying clinician should **advise the patient to self-isolate at home** (if not already) and minimise contact with other people. Provide a factsheet for suspected cases from the department's coronavirus disease (COVID-19) website <https://www.dhhs.vic.gov.au/information-health-services-and-general-practitioners-novel-coronavirus>
   c) consider advising the patient in the normal manner that admission to hospital and further testing may be required if they deteriorate
   d) ensure **arrangements are in place for the patient to be contacted with the test result** – this is the responsibility of the testing clinician and health service.
9. If admission is required:
   a) maintain infection control precautions and actively consider taking multiple samples for testing including from lower respiratory tract specimens.
10. When the test result is available:
    a) **if the test is positive** for COVID-19, provide the result to the patient. The health service infectious diseases lead, or senior clinician should call the department on 1300 651 160 to

confirm that the department is aware of the result and to provide any additional clinical information.

b) **if the test is negative** for COVID-19, provide the negative result to the patient and manage any other cause of illness you have assessed as requiring treatment.

c) consider advising the patient in the normal manner that admission to hospital and further testing may be required if they deteriorate and no other cause is found.

Who should be tested for COVID-19?

People without symptoms should not be tested except in special circumstances such as recovered cases wishing to return to work in a healthcare facility or aged care facility or where requested by the department as part of outbreak management or enhanced surveillance.

Patients who meet the following clinical criteria should be tested:

Fever OR chills in the absence of an alternative diagnosis that explains the clinical presentation*

OR

Acute respiratory infection (e.g. cough, sore throat, shortness of breath, runny nose or anosmia)

Note: In addition, testing is recommended for people with new onset of other clinical symptoms consistent with COVID-19** AND who are close contacts of a confirmed case of COVID-19; who have returned from overseas in the past 14 days; or who are healthcare or aged care workers

*Clinical discretion applies including consideration of the potential for co-infection (e.g. concurrent infection with SARS-CoV-2 and influenza)
**headache, myalgia, stuffy nose, nausea, vomiting, diarrhoea

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.

Only confirmed cases need to be notified to the department. Notify the department of confirmed cases as soon as practicable by calling 1300 651 160, 24 hours a day.

General comments:

- All patients being tested for COVID-19 should home isolate until test results are available. All patients should attend an emergency department if clinical deterioration occurs.

Definition of close contact

For the purposes of testing, the department advises a precautionary understanding of close contact. In keeping with definitions of close contact developed in other jurisdictions, 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). Recommended PPE includes 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 to be deemed close contact.

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 taken 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.

Triaging and managing high risk patients on arrival to hospital

A patient is considered high-risk for COVID-19 if:

- presenting with acute respiratory tract infection
- presenting with fever (≥38 degrees), without another immediately apparent cause (e.g. UTI or cellulitis)
- they have travelled overseas and have onset of symptoms within 14 days of return
- they have been in close contact with a confirmed coronavirus (COVID-19) case with onset of symptoms within 14 days
- they are a confirmed coronavirus (COVID-19) case (this includes healthcare workers who are known confirmed cases and are attending for clearance testing to determine when they can return to work).

Patient transfer and destination health service

The following is advice on where patients should be managed:

- patients should be assessed and managed by the health service they present to
- transport of patients to other facilities should be avoided unless medically necessary
- ambulance transfer should be reserved for cases where there is clinical need; alternative means of transport should be used for other cases including a private car driven by the case or an existing close contact (not bus, taxi or Uber).
- suspected or confirmed cases in the community who require assessment or admission at a hospital should be seen and assessed at the nearest emergency department

Arrival to hospital and triage

Upon arrival to the emergency department, patients assessed as high-risk should be triaged to a separate isolated section of the waiting area, away from the general public and provided with a surgical mask. Assessment centres can support the management of high-risk patients if they are in place at the health service. All staff at triage points and assessment centres should be wearing PPE required for suspected or confirmed cases of coronavirus (COVID-19).

Ambulance triage

Patients assessed as high-risk and arriving by ambulance should be triaged to an isolated section of the waiting area away from the general public and be provided with a surgical mask as appropriate. For patients who cannot go to the waiting area (for example, stretcher, ongoing clinical care), they should remain in the ambulance vehicle until their triage and cubicle allocation is completed. Once allocated, the patient should move directly from the ambulance to the cubicle, and not stop in the corridors.

Emergency department admissions

A dedicated floor plan should be established that clearly designates areas assigned for high-risk patients within the emergency department. If able, rostering of staff to these areas to support the separation and resourceful use of PPEs should be considered. For staff working directly in the area of suspected or confirmed cases of coronavirus (COVID-19), PPE should be worn accordingly. Designated areas for donning and removing PPE should be in place.

Patient transfers

Should high-risk patients need to be moved outside of the initial isolation section, they should be transferred using a route that minimises contact with the general hospital population including clinicians (for example, dedicated lift service, external path). Staff involved in patient transfer should wear PPE required for suspected or confirmed cases of coronavirus (COVID-19). Physical distancing rules apply during all stages of the transfer.

Case management

Assessment and management of patients for COVID-19 testing

A checklist above indicates key actions for the assessment of patients for testing.

Victorian health services and general practitioners are only required to notify the department of **confirmed** cases.

The medical assessment of the patient should focus on the following:

- the date of onset of illness and especially whether there are symptoms or signs of pneumonia.
- contact with confirmed cases of COVID-19
- precise travel history and occupation
- history of contact with sick travellers or other people or overseas health care facilities.
- work or residence in a high risk setting for transmission.

People awaiting results of tests for COVID-19 should be isolated until COVID-19 is excluded.

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.

Further information is available for healthcare services managing healthcare workers with suspected or confirmed COVID-19 in the "Interim guide for healthcare services managing healthcare workers with suspected or confirmed COVID-19" on the department website < https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>.

Exclusion of COVID-19

For patients with fever or respiratory tract infection who are not hospitalised, a single negative nasopharyngeal/oropharyngeal swab (plus sputum if possible) is sufficient to exclude COVID-19 infection.

Repeat testing (especially of lower respiratory tract specimens) in clinically compatible cases should be performed if initial results are negative and there remains a high index of suspicion of infection.

There is no strong evidence to support a required time interval between exclusion swabs or the need for multiple practitioners performing the swab. Health services should apply discretion and consider the need for this on a case by case basis.

A patient who developed symptoms while in self-quarantine, for example because of recent overseas travel or contact with a confirmed case, who has then tested negative for COVID-19 should continue their quarantine period but be considered for a second test if they deteriorate and require hospitalisation.

Clinical management of confirmed cases

This is at the discretion of the treating team and at the present time is supportive care only.

Admission to hospital should occur when medically necessary or when directed by the department in order to reduce the risk of transmission or facilitate testing for clearance, such as if the case resides in a communal environment. Emerging information suggests COVID-19 may be associated with a delayed deterioration in clinical status in some cases.

Interim clinical guidelines for the management of patients with COVID-19 have been released by the following peak professional bodies:

- The Australasian Society for Infectious Diseases (ASID)
- The Australian and New Zealand Intensive Care Society (ANZICS)

Persons not requiring hospitalisation who have confirmed COVID-19 can be managed at home. The United States Centers for Disease Control and Prevention (USCDC) has developed principles for such home care management at https://www.cdc.gov/coronavirus/COVID-19/guidance-home-care.html.

Criteria for inpatient discharge

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

If a patient is returning to a high-risk setting, consideration should be given for the requirement to be PCR negative on at least two consecutive respiratory specimens collected at least 24 hours apart at least 7 days after symptom onset, prior to going into the higher risk setting. This can be discussed with the department on a case-by-case basis if required.

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

Release from isolation of a confirmed case

The department will determine when a confirmed case no longer requires to be isolated in their own home.

Release from isolation will be actively considered 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

In the event that a confirmed case meets the above criteria during an inpatient hospital stay, the department will consult with the patient's treating clinician (and if applicable the infectious diseases or infection prevention and control team) to determine whether release from isolation is appropriate. For patients with severe disease, requiring hospital admission, consideration will be given to the need for testing prior to release from isolation or a longer period of isolation.

Healthcare workers and workers in aged care facilities who meet the above criteria can be released from isolation. However, these individuals must meet the following additional criteria before they can return to work.

Return-to-work criteria for health care workers and workers in aged care facilities who are confirmed cases

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 at least 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 on either of their first two consecutive clearance tests (performed at least 24 hours apart), wait 3 days before performing another "round" of two tests, at least 24 hours apart. If a positive PCR result is returned in this "second round" of testing, a third round of testing 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) and whether the healthcare worker is immunosuppressed. 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.

Checklist of key actions for the department for confirmed cases

- Confirm the diagnosis with testing laboratory.
- Contact the treating team/GP to confirm that the confirmed case is isolated and agree the management of the patient.
- Contact the confirmed case +/- parent/guardian (for cases under 18 years) to collect relevant social, clinical and epidemiological information.
- Identify close contacts and recommend immediate quarantining of any close contacts.
- Identify any potential exposure sites and assess whether any further action is required.
- Undertake all public health response activities including risk communication and sharing of relevant resources.

Checklist of key actions for the clinical team for confirmed cases

- If a patient is in the community at the time of diagnosis and if clinically necessary, the department will organise with the nearest appropriate health service to admit the patient, in order for care to be provided in hospital or via Hospital in the Home.
- For patients who do not require admission to hospital or Hospital in the Home, clinical teams only need to provide patients with the initial feedback of their results, information and counselling and usual advice to seek medical attention if their condition deteriorates. Clinical teams do not need to routinely contact cases unless clinically appropriate.
- Notify the department on 1300 651 160 as soon as possible (within 24 hours) if a patient becomes critically unwell, in the case of intensive care admission, or death.
- Commence list of all HCWs and visitors who enter the case's room. (If the case is at home and being visited by Hospital in the Home only a list of HCWs required.)
- Advise HCWs who provide care for the case (even with appropriate use of PPE) to self-monitor for symptoms of COVID-19 for 14 days after their last contact with the case.

Signage and triage of people presenting to health and other services

Diagnosis and management of COVID-19 must be undertaken by medical practitioners in accordance with the current guidelines from the Victorian Department of Health and Human Services. This will occur primarily in general practice and hospitals.

However, to reduce risks to service providers and detect people with COVID-19 risk factors, rapid pre-assessment is indicated by a broader range of service providers prior to the provision of a service. This pre-assessment may include enquiring about recent travel history and relevant symptoms. Only health-care services who manage unwell patients (such as general practice, hospitals and ambulance services) are expected to assess for symptoms.

For examples of posters that can be used, see the department's website <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>

Contact management

The department will conduct contact tracing for confirmed cases in the community and will seek assistance from a health service in relation to any contact tracing required for health service staff.

Close contacts

Self-quarantine

The following groups are now required to self-quarantine:

- close contacts of confirmed cases until 14 days after last close contact with the confirmed case.
- As of midnight, 28 March 2020, all travellers arriving into Melbourne from overseas will be quarantined for two weeks in hotel rooms and other accommodation facilities after submitting an Isolation Declaration Card. Interstate travellers can return to their home states after fulfilling the mandatory quarantine requirements.

Self-quarantine means remaining at home except in cases of medical emergency. This means a person recommended to self-quarantine:

- must not visit public settings or mass gatherings.
- must not use public transport.
- must not attend settings like health services, residential aged care facilities or educational settings.

This requirement for people who are in quarantine not to attend health services, includes a requirement that they do not attend a family member who is a confirmed case in a Victorian health service.

Health services and GPs are not required to provide a certificate of medical clearance to those who have completed the required 14 days self-quarantine.

Close contacts should not travel within Australia or internationally within the 14 days after last contact with the infectious case.

Symptomatic close contacts

Testing for COVID-19 is not indicated unless symptoms develop.

The approach to a symptomatic close contact requires an assessment by a treating clinician. The next steps depend on whether a treating clinician has identified the patient as having a non-infectious cause, a likely non-respiratory infectious cause, or an acute respiratory illness.

For a symptomatic close contact during the 14-day quarantine period, the department will:

- Advise the close contact to attend a suitable general practice, emergency department or coronavirus assessment centre for evaluation with a single-use face mask on and to identify themselves immediately on arrival.

Where a close contact has an illness during the 14-day period of quarantine after the step above, the treating clinician will:

- use a single room and appropriate PPE as for a suspected case
- test for COVID-19 and manage the person as a suspected case.
- If the test is positive, the person will be managed as a confirmed case. Notify the department.

Where the illness is diagnosed as acute respiratory illness:

- If testing for COVID-19 is negative and the treating clinician has diagnosed an acute respiratory illness or an illness that is highly compatible with COVID-19, the close contact may then require a subsequent test at a short period thereafter.

Where the illness is diagnosed as likely to be some other form of infection or is not an infection:

- If testing for COVID-19 is negative and the treating clinician has diagnosed some other infection or a non-infectious cause, then the treating team should consider, in conjunction with an infectious disease specialist, whether testing of relevant specimens such as urine and faeces for COVID-19 might be of value or whether evidence is now clear for an alternative cause, including legionellosis.
- The close contact can be advised to continue to self-quarantine until a full 14 days have expired from date of last close contact with confirmed case.

Checklist of key actions for the department for close contacts

For all close contacts the department will:

- Advise self-quarantine including restriction on travel until 14 days from the last contact with confirmed case.
- Counsel close contacts about risk and awareness of potential symptoms.
- Provide a close contact fact sheet
- Make regular contact with the close contact to monitor for any symptoms, either through SMS, email or telephone call.
- If after 14 days of quarantine (from the last contact with a confirmed case), the contact remains asymptomatic, the individual is cleared and may cease quarantine.
- If a school or employer requests confirmation from the department that the quarantine period has been met, the department will provide evidence with the consent of the individual.

Healthcare workers

HCWs and other contacts who have taken recommended infection control precautions, including the use of recommended PPE, while caring for a confirmed case of COVID-19 are not considered to be close contacts. However, they should be advised to self-monitor and if they develop symptoms consistent with COVID-19 infection they should isolate themselves. See also Infection prevention and control.

Any healthcare workers who is unwell with a compatible illness should not attend work and should seek appropriate medical care. All healthcare workers with fever or symptoms of acute respiratory infection should be tested for COVID-19, as per the testing criteria.

Hospital workers currently must not enter or remain at a hospital in Victoria if:

- the person has been diagnosed with COVID-19, and has not yet met the criteria for discharge from isolation OR
- if the person has travelled/arrived in Australia from any country in the past 14 days OR
- has had known contact with a person who is a confirmed COVID 19 case in the previous 14 days OR
- has a fever or symptoms of acute respiratory infection.

The current Directions and accompanying frequently asked questions can be viewed on the department's website at <https://www.dhhs.vic.gov.au/coronavirus>

Further criteria apply to healthcare workers who become confirmed cases before they can return to work in healthcare settings – see Return-to-work criteria for health care workers and workers in aged care facilities who are confirmed cases.

Infection prevention and control

Background

Infection prevention and control recommendations are based on the *Communicable Diseases Network Australia Series of National Guidelines – Coronavirus Disease 2019 (COVID-19) guideline*, and WHO guideline *Infection prevention and control during health care when novel coronavirus (nCoV) infection is suspected: Interim guidance January 2020* <https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-(ncov)-infection-is-suspected>.

Nationally consistent advice regarding the management of COVID-19 suspected and confirmed cases has evolved as further information regarding the specific risks of transmission associated with this infection have become known. As it becomes available, this advice has been incorporated into this guideline.

To reduce transmission of COVID-19, there are now general restrictions on who can visit or work at a Victorian hospital and how long visits can last. Screening procedures to prevent unwell visitors entering hospitals are also being implemented. The current restrictions are available on the department's website <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>.

Healthcare workers

Healthcare workers are required to self-quarantine for 14 days after overseas travel and self-quarantine for 14 days after close contact of a confirmed case of COVID-19 (see Healthcare workers in Contact management section). If a healthcare worker is identified as a confirmed case of COVID-19, they must not return to work until they are advised by the department that they meet return to work criteria (see section 'Return-to-work criteria for health care workers and workers in aged care facilities who are confirmed cases').

Healthcare workers should only attend work if they are well. Prior to going to work each day, healthcare workers should consider whether or not they feel unwell and should take their own temperature.

Those working in a Victorian public health services are required to report to their manager if they have the following symptoms prior to starting work or at any time while at work:

- temperature higher than 37.5 degrees Celsius
- symptoms of acute respiratory infection, such as shortness of breath, cough, sore throat or nasal congestion.

Some health services may require you to be screened (temperature and/or symptom check) on site prior to starting work.

Looking after yourself when wearing PPE

It is important that healthcare workers look after themselves during this time of increased use of PPE. Upon removal of PPE, healthcare workers should remember to hydrate themselves, practice hand hygiene and avoid touching their faces. Regular application of hand cream should be considered. Healthcare workers who are sensitive to latex should ensure that they wear non-latex gloves.

Using mobile phones in healthcare settings

People touch their phones as frequently as their faces. Mobile phones may be dirty, so please:

- ensure mobile phones are cleaned regularly with disinfectant wipes
- ensure hands are cleaned before and after using mobile phone
- do not answer mobile phones when you are wearing PPE
- consider placing your mobile phone in a clear sealed bag at the commencement of each shift and discarding the bag prior to going home as an additional precaution.

Physical distancing measures in healthcare settings

Physical distancing is to be practiced within clinics and wards, between staff and patients, and between staff and staff. This includes:

- waiting room chairs separated by at least 1.5 metres
- direct interactions between staff conducted at a distance
- staff and patients to remain at least 1.5 metres apart with the exception of clinical examinations and procedures
- hospital cafeterias may only provide takeaways.

Transmission-based precautions

For the purposes of PPE, 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.

Patient placement

The following patient placement options should be used in the following order, according to facility resources:

1. Single room with en suite facilities, negative pressure air handling, with or without a dedicated anteroom
2. Single room with en suite facilities without negative pressure air handling
3. Single room without en suite facilities and without negative pressure air handling
4. Cohorted room

A dedicated toilet / commode should be used where possible, ensuring lid is closed when flushed to reduce any risk of aerosolization.

Suspected cases of COVID-19 infection may be cohorted together where single rooms are not available.

Maintain a record of all persons entering the patient's room including all staff and visitors.

PPE and routine patient care, during the COVID-19 emergency

During the COVID-19 emergency, **all healthcare workers** in Victorian public health services in **high-risk** areas – intensive care units (ICU), emergency departments (ED), Coronavirus (COVID-19) wards, and acute respiratory assessment clinics – are to wear **surgical masks** for **all patient interactions, unless the situations below apply**.

This is in addition to hand hygiene in accordance with the WHO five moments of hand hygiene. Unless damp or soiled, a surgical mask may be worn for the duration of a clinic or shift of up to four hours. Masks must be removed and disposed of for breaks and then replaced.

The risk in birthing suites is unknown, however the use of a surgical face mask and eye protection may be prudent where there is a risk of splashes from body fluids.

Lung function testing should only be performed if it is deemed clinically essential by a respiratory physician, and staff performing testing should followed droplet and contact precautions as outlined in the document Healthcare worker personal protective equipment (PPE) guidance for performing clinical procedures <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>.

For all other areas within Victorian public health services, standard precautions apply.

Caring for suspected and confirmed cases

In line with advice from the WHO and the Communicable Disease Network Australia (CDNA), the department recommends **droplet and contact precautions** for HCWs providing routine care of suspected and confirmed cases of COVID-19 infection, including during initial triaging.

This means that in addition to standard precautions, **all individuals, including family members, visitors and HCWs** should apply droplet and contact precautions. This includes use of the following PPE:

- single-use surgical mask
- eye protection (for example, safety glasses/goggles or face shield. Note that prescription glasses are not sufficient protection.)
- long-sleeved gown
- gloves (non-sterile).

If the gown is disposable and soiled, take it off and dispose of it with clinical waste. If the gown is reusable (non-disposable), take it off and have it reprocessed. Posters showing the order of putting on and taking off PPE (donning and doffing) can be found on the department's website <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>.

Masks, gloves and gowns are not to be worn outside of patient rooms (for example, between wards, break room, reception area) and are to be removed before proceeding to care for patients that are not isolated for COVID-19.

For hand hygiene, use an alcohol-based hand rub with over 60 per cent alcohol if hands are visibly clean, soap and water when hands are visibly soiled.

Visiting confirmed cases of COVID-19 is discouraged due to the high likelihood of contamination of the environment of the room of an infectious confirmed case. If a visitor attends a confirmed case in hospital, the visitor must wear PPE as described above. Staff should educate visitors on appropriate use of PPE, for example, when and where they should apply PPE. Visitors should be helped to carefully don and doff PPE by a person experienced in infection prevention and control requirements.

Airborne and contact precautions

Airborne and contact precautions are now recommended in **specific circumstances** when undertaking aerosol generating procedures (AGPs).

Airborne and contact precautions are:

- P2/N95 respirator (mask) – fit-check with each use
- eye protection (for example, safety glasses/goggles or face shield)
- long-sleeved gown
- gloves (non-sterile)

Total head covering is not required as part of airborne and contact precautions.

P2/N95 respirators (mask) should be used only when required. Unless used correctly, that is with fit checking, they are unlikely to protect against airborne pathogen spread. A poorly fitted P2/N95 respirator/mask should not be used, and the procedure either delayed, or performed by a clinician whom can fit their respirator/mask correctly.

Aerosol generating procedures (AGPs)

For further information regarding which procedures are AGPs see the document Healthcare worker personal protective equipment (PPE) guidance for performing clinical procedures <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>.

Appropriate cleaning and disinfection should be undertaken following an AGP. See Environmental cleaning and disinfection for further information.

Fit checking

Healthcare workers must perform fit checks every time they put on a P2/N95 respirator to ensure a facial seal is achieved. No clinical activity should be undertaken until a satisfactory fit has been achieved. Fit checks ensure the respirator is sealed over the bridge of the nose and mouth and that there are no gaps between the respirator and face. Healthcare workers must be informed about how to perform a fit check.

The procedure for fit checking includes:

- placement of the respirator on the face so the top rests on your nose and the bottom is secured under your chin
- placement of the top strap or ties over the head and position it high on the back of the head. Pull the bottom strap over your head and position it around your neck and below your ears.
- place fingertips from both hands at the top of the nosepiece. Using two hands, mould the nose area to the shape of your nose by pushing inward while moving your fingertips down both sides of the nosepiece.
- checking the negative pressure seal of the respirator by covering the filter with both hands or a non-permeable substance (for example, plastic bag) and inhaling sharply. If the respirator is not drawn in towards the face, or air leaks around the face seal, readjust the respirator and repeat process, or check for defects in the respirator.

Always refer to the manufacturer's instructions for fit checking of individual brands and types of P2/N95 respirators/masks.

Healthcare workers who have facial hair (including a 1–2 day stubble) must be aware that an adequate seal cannot be achieved between the P2/N95 respirator/mask and the wearer's face. The wearer must either shave or seek an alternative protection.

When to discard P2/N95 respirators (masks)

P2/N95 respirators (masks) should be:

- **Discarded** and **replaced** if contaminated with blood or bodily fluids
- **Replaced** if it becomes hard to breathe through or if the mask no longer conforms to the face or loses its shape
- **Removed** outside of patient care areas (for example, between wards, break room, reception area) and are to be removed before proceeding to care for patients that are not isolated for COVID-19.

Undertaking diagnostic testing for COVID-19

For information on the appropriate specimens for testing see the section on Laboratory testing for COVID-19 below.

There is no requirement for airborne precautions when taking a nose and throat swab.

A patient with clinical evidence of pneumonia who requires testing for COVID-19 should be managed in a hospital setting. Management of patients with pneumonia in the hospital setting will also facilitate lower respiratory tract specimen collection.

Table 3: When airborne precautions are recommended for specimen collection

Specimen type	Airborne precautions required?
Nasopharyngeal swab	No
Oropharyngeal swab	No
Sputum (not induced)	No
Nasal wash/aspirate	No
Bronchoalveolar lavage	Yes
Induced sputum	Yes

Ref: Infection Control Advisory Group – 2019-nCoV, *Interim recommendations for the use of PPE during clinical care of people with possible nCoV infection*. CDNA

While patient's faecal samples may be tested under some circumstances where there is capacity to do so, faecal sampling is not recommended as a standard test.

Prioritising PPE for health care workers

To ensure that single-use surgical masks are available to protect health workers and for patients presenting with suspected coronavirus (COVID-19) the following strategies are recommended:

Single-use surgical masks

- Prioritise use to frontline staff (ICU, ED, coronavirus (COVID-19) wards, acute respiratory assessment clinics, theatre and birthing suites).
- Surgical mask supplies are to be stored in secure areas or supervised by a staff member and not accessible to patients

- Unless damp or soiled, a surgical mask may be worn for the duration of a clinic or shift of up to four hours.

General PPE:

- Substitutions that may be considered include:
  - plastic apron instead of a long-sleeved disposable gown where appropriate
  - full-face shield instead of a surgical mask for situations that are appropriate.

PPE training should use expired PPE stock only (if available).

Care of critically ill patients in ICU

- Patients who require admission to ICU with severe COVID-19 infection are likely to have a high viral load, particularly in the lower respiratory tract.
- Contact and airborne precautions (as above) are required for patient care and are adequate for most AGPs. The risk of aerosol transmission is reduced once the patient is intubated with a closed ventilator circuit. There is a potential, but unknown, risk of transmission from other body fluids such as diarrhoeal stool or vomitus or inadvertent circuit disconnection.

ICU staff caring for patients with COVID-19 (or any other potentially serious infectious disease) should be trained in the correct use of PPE, including by an infection control professional.

Case movement and transfers

Where possible, all procedures and investigations should be carried out in the case's room, with exception of AGPs which should be performed in a negative pressure room whenever possible, or a single room with the door closed.

Transfers to other healthcare facilities should be avoided unless it is necessary for medical care. Inter hospital transfers should use routine providers.

Environmental management

Signage

Clear signage should be visible to alert HCWs of required precautions before entering the room, see Australian Commission on Safety and Quality in Health Care <https://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/infection-control-signage>.

Management of equipment

Preferably, all equipment should be either single-use or single-patient-use disposable. Reusable equipment should be dedicated for the use of the case until the end of their admission. If this is not possible, equipment must be cleaned and disinfected (see Environmental cleaning and disinfection below) prior to use on another patient.

Disposable crockery and cutlery may be useful in the patient's room to minimise the number of contaminated items that need to be removed. Otherwise, crockery and cutlery can be reprocessed as per standard precautions.

Environmental cleaning and disinfection

Required agents for cleaning and disinfection

Cleaning of a patient consultation room or inpatient room should be performed using a neutral detergent. Disinfection should then be undertaken using a chlorine-based disinfectant (for example, sodium

hypochlorite) at a minimum strength of 1000ppm, or any hospital-grade, TGA-listed disinfectant with claims against coronaviruses or norovirus, following manufacturer's instructions.

A one-step detergent/chlorine-based product may also be used. Ensure manufacturer's instructions are followed for dilution and use of products, particularly contact times for disinfection.

Wearing PPE whilst undertaking cleaning and disinfection

Droplet and contact precautions should be used during any cleaning and disinfection of a room where there has not been an AGP or if more than 30 minutes has elapsed since the AGP was done.

Airborne and contact precautions should be used during any cleaning and disinfection of a room where there has been an AGP performed within the previous 30 minutes.

Steps for disinfection and cleaning of a patient consultation room or inpatient room

The patient consultation room should be cleaned at least once daily and following any AGPs or other potential contamination.

There is no need to leave a room to enable the air to clear after a patient has left the room unless there was an AGP performed. Nose and throat swabs are not considered AGPs unless performed on a patient who has pneumonia. If an AGP was performed, leave the room to clear for 30 minutes.

The patient consultation room (or inpatient room after discharge of the suspected case) should now be cleaned and disinfected using the agents listed above. In most cases this will mean a wipe down with a one-step detergent disinfectant as listed above. There is no requirement to wait before the next patient is seen. The room is now suitable for consultation for the next patient.

Waste management

Dispose of all waste as clinical waste. Clinical waste may be disposed of in the usual manner.

Linen

Bag linen inside the patient room. Ensure wet linen is double bagged and will not leak.

Reprocess linen as per standard precautions.

Environmental cleaning and disinfection in an outpatient or community setting (for example, a general practice)

Cleaning and disinfection methods as below:

- Clean surfaces with a neutral detergent and water first.
- Disinfect surfaces using either a chlorine-based product at 1000ppm or other disinfectant that makes claims against coronavirus. Follow the manufacturer's instructions for dilution and use.
- A one-step detergent/disinfectant product may be used as long as the manufacturer's instructions are followed re dilution, use and contact times for disinfection (that is, how long the product must remain on the surface to ensure disinfection takes place).

Follow the manufacturer's safety instructions for products used regarding precautions and use of safety equipment such as gloves or aprons.

All linen should be washed on the hottest setting items can withstand.

Wash crockery and cutlery in a dishwasher on the hottest setting possible.

Care of the deceased if COVID-19 is suspected or confirmed

Deaths in healthcare settings

Please refer to the guidance "Handling the body of a deceased person with suspected or confirmed COVID-19" on the department website < https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19> for more details regarding care of the deceased.

Any person having contact with the body of a person with suspected or confirmed COVID-19 must ensure hand hygiene before and after interacting with the body and the environment and wear personal protective equipment (PPE) appropriate for droplet and contact precautions. This includes a gown, disposable gloves, a surgical mask and appropriate eye protection.

Additional precautions may be required, for example airborne and contact precautions, if conducting an autopsy. This will be dependent upon the risk of generation of aerosols.

Deaths in the community

In the event that an unexpected death of a person with suspected or confirmed COVID-19 occurs at home, family members should be advised that:

- they may view the body but must continue the same precautions as when they were living with the person. Family members should not touch or kiss the body.
- relevant authorities should not touch the body unless equipped with appropriate PPE upon arrival at the place of death
- they must leave the room (or vicinity) or maintain a distance greater than 1.5 metres when handling or transferring the body for transportation
- the area of death must be cleaned and disinfected using standard household bleach. Further information can be found in the document: Cleaning and disinfecting tips for non-healthcare settings found here < https://www.dhhs.vic.gov.au/business-sector-coronavirus-disease-covid-19 >

If there is a suspicion that the deceased may have had undiagnosed COVID-19, or on request of paramedics or other first responders, the medical practitioner certifying a death in the community should take a nasopharyngeal AND/OR oropharyngeal swab for PCR testing of the deceased for COVID-19 and advise first responders and the family of the test results. Positive test results must be notified to the department on **1300 651 160**, 24 hours a day, to allow contact tracing to occur.

Advice for funeral workers

Advice for funeral industry workers may be found in the document "Handling the body of a deceased person with suspected or confirmed COVID-19" on the department website < https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>.

Laboratory testing for COVID-19

Prioritisation of testing

A number of Victorian laboratories are undertaking testing for COVID-19 in Victorian patients. There is significant pressure on supply of swabs and reagent kits for COVID-19 testing. It is **critical** that clinicians use the current testing criteria to guide patient investigation and use **only one swab** when testing. Please provide **clinical details** on request slips so high-risk patients and healthcare workers, aged care workers or disability workers can be prioritised where resources allow. Specimens taken from health care workers should be marked URGENT- Health Care Worker (or in the case of testing for return-to-work criteria for healthcare and aged care workers, mark with **'URGENT: HCW CLEARANCE TESTING, please notify result to DHHS**'. Results should be copied to the DHHS COVID-19 Response and the HCW's treating physician.

Specimens for testing

For initial diagnostic testing for COVID-19, DHHS recommends collection of the following samples:

1. upper respiratory tract specimens.
2. lower respiratory tract specimens (if possible).
3. serum, where possible (to be stored for later analysis).

Label each specimen container with the patient's ID number (for example, medical record number), specimen type (for example, serum) and the date the sample was collected.

Respiratory specimens

Collection of upper respiratory (nasopharyngeal AND/OR oropharyngeal swabs), and lower respiratory (sputum, if possible) is recommended for patients with a productive cough.

1. Upper respiratory tract
    a) Nasopharyngeal swab: Insert a swab into nostril parallel to the palate. Leave the swab in place for a few seconds to absorb secretions. Swab both nostrils (nasopharyngeal areas) with the same swab.

    AND/OR

    b) Oropharyngeal swab (that is, a throat swab): Swab the tonsillar beds, avoiding the tongue.

    c) **To conserve swabs** the same swab that has been used to sample the oropharynx should be utilised for nasopharynx sampling

    d) If testing for other respiratory viruses is indicated, contact your testing laboratory to find out if testing (for example, multiplex PCR) can be undertaken on the same specimen, or if an additional specimen needs to be collected.

    Note. Swab specimens should be collected only on swabs with a synthetic tip (such as polyester, Dacron® or Rayon, flocked preferred) with aluminium or plastic shafts. Do not use calcium alginate swabs or swabs with wooden shafts, as they may contain substances that inactivate some viruses and inhibit PCR testing. For transporting samples, recommended options include viral transport medium (VTM) containing antifungal and antibiotic supplements, or Liquid Amies medium which is commonly available. Avoid repeated freezing and thawing of specimens.

2. Lower Respiratory tract (if possible)

a) Sputum: Have the patient rinse the mouth with water and then expectorate deep cough sputum directly into a sterile, leak-proof, screw-cap sputum collection cup or sterile dry container. Refrigerate specimen at 2-8°C. If sending to Victorian Infectious Diseases Reference Laboratory (VIDRL), send on an ice pack.

b) Bronchoalveolar lavage, tracheal aspirate: Collect 2-3 mL into a sterile, leak-proof, screw-cap sputum collection cup or sterile dry container. Refrigerate specimen at 2-8°C - if sending to VIDRL, use ice pack.

Lower respiratory tract specimens are likely to contain the highest virus loads based on experience with SARS and MERS coronaviruses.

Other specimens:

3. Blood (serum) for storage for serology at a later date:

    a) Children and adults: Collect 1 tube (5-10mL) of whole blood in a serum separator tube.

    b) Infant: A minimum of 1ml of whole blood is needed for testing paediatric patients. If possible, collect 1mL in a serum separator tube.

At the current time there is no serological test for COVID-19 and blood when received at VIDRL will be stored for future testing, when testing is available and if the case is confirmed as COVID-19 infection.

The department is continuously reviewing whether there is a requirement for other specimens such as stool or urine to be sent to VIDRL. At the current time this is not routinely recommended in cases of respiratory illness. A stool specimen may be recommended by the department to provide additional reassurance before a confirmed case is released from isolation.

Specimen collection and transport

See also Undertaking diagnostic testing for PPE recommendations.

Specimen collection process

For most patients with mild illness in the community, collection of upper respiratory specimens (that is, nasopharyngeal or oropharyngeal swabs) is a low risk procedure and can be performed using **droplet and contact** precautions.

- Perform hand hygiene before donning gown, gloves, eye protection and single-use surgical mask. See How to put on your PPE poster on the department's website <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>.
- When collecting throat or nasopharyngeal swabs stand slightly to one side of the patient to avoid exposure to respiratory secretions should the patient cough or sneeze.
- At the completion of the specimen collection process, remove all PPE and perform hand hygiene after removing gloves and when all PPE has been removed. See How to take off your PPE poster on the department's website <https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>.

Note that, for droplet and contact precautions, the room does not need to be left empty after sample collection. Droplet and contact precautions PPE must be worn when cleaning the room. See Environmental cleaning and disinfection for further information.

If the patient has severe symptoms suggestive of pneumonia, for example, fever and breathing difficulty, or frequent, severe or productive coughing episodes then **airborne and contact precautions** should be observed. This means that a P2 respirator must be used instead of a single-use surgical mask.

Patients with symptoms suggestive of pneumonia should be managed in hospital, and sample collection conducted in a negative pressure room, if available. If referral to hospital for specimen collection is not possible, specimens should be collected in a single room. The door should be closed during specimen collection and the room left vacant for at least 30 minutes afterwards (cleaning can be performed during this time by a person wearing PPE for airborne and contact precautions).

There are no special requirements for transport of samples. They can be transported as routine diagnostic samples for testing (that is, Biological substance, Category B).

Handling of specimens within diagnostic laboratories

All diagnostic laboratories should follow appropriate biosafety practices, and testing on clinical specimens, including for other respiratory viruses, should only be performed by adequately trained scientific staff.

Current advice from the WHO is that respiratory samples for molecular testing should be handled at Biosafety Level 2 (BSL2), with the USCDC recommending that the following procedures involving manipulation of potentially infected specimens are performed at BSL2 within a class II biosafety cabinet:

- aliquoting and/or diluting specimens
- inoculating bacterial or mycological culture media
- performing diagnostic tests that do not involve propagation of viral agents in vitro or in vivo
- nucleic acid extraction procedures involving potentially infected specimens
- preparation and chemical- or heat-fixing of smears for microscopic analysis.

Information on testing for coronavirus at VIDRL

VIDRL has moved to utilising Real-Time specific COVID-19 PCR assays as the primary diagnostic tool for COVID-19 detection.

Real-time COVID-19 PCR assay

- The test takes approximately 2–3 hours to perform.
- Results reported as positive or negative for COVID-19, for example, *COVID-19 not detected*.

The current VIDRL testing algorithm is as follows:

- All suspected cases will be tested by a real-time assay as above.
  - This test will be performed twice a day at the current time (morning and afternoon), with results released through routine pathways.
- All negative results will be reported and finalised.
- Any positive results will be confirmed by a second specific Real-Time COVID-19 PCR assay targeting a different RNA sequence.
  - This second Real-Time assay will be run for any presumptive positive results, immediately following completion of the first Real-Time assay.
  - Samples positive in both Real-Time assays will thus be reported on the same day as initial testing and will be telephoned through to the referring pathology service as well as the department.
  - Discordant results between the two different Real-Time assays are not anticipated and will be managed on a case by case basis with further molecular testing (for example, Pan-coronavirus PCR assay).
- Urgent specimens can be tested outside of these periods in consultation with the department.
- Viral culture will be attempted from any positive sample under high containment, but such testing is not a diagnostic modality.
- Serum samples will be stored.

As experience with testing develops this algorithm may change further. VIDRL has the intention to register the Real-Time assays with NATA in the near future once sufficient data is available.

Indeterminate test results

Indeterminate test results have been reported from a number of Victorian laboratories. These are usually samples that have had one gene detected in the assay but not both genes.

Indeterminate results may be referred to VIDRL for further testing, although **these samples should be considered as positive**. Confirmatory testing may not be possible as the sample may already be low titre and degradation due to processing may mean that VIDRL's PCR may not be sufficiently sensitive to offset loss of titre in the sample.

Cases with indeterminant results should be managed as confirmed cases. If the treating clinician feels that the pre-test probability for COVID-19 is low, another sample may be collected for further testing. If the second sample tests negative, the department will discuss the case with the treating doctor and the testing laboratory to determine whether the case should continue to be managed as a confirmed case.

Governance

International response

The WHO declared COVID-19 a Public Health Emergency of International Concern (PHEIC) under the *International Health Regulations 2005* and on 30 January 2020. A pandemic has now been declared.

A State of Emergency was declared in Victoria on 16 March 2020.

Public Health Incident Management Team

The Department of Health and Human Services (the department, DHHS) has formed a Public Health Incident Management Team, chaired by a Public Health Commander, to coordinate the public health and sector response. A Class 2 Emergency, or public health emergency, was declared on 1 February 2020.

The Infection Clinical Network of Safer Care Victoria will be a network that is requested to provide comment and advice to the department, alongside national committees including the Communicable Diseases Network Australia (CDNA).

Communications and media

The department will coordinate communications and media in relation to suspected and confirmed cases of COVID-19. In some instances, the department may – in collaboration with a Victorian health service – request a service to provide media responses in relation to one of more cases associated with that service. A health service should contact the department's Media Unit with any queries.

Role of Ambulance Victoria

Where clinically appropriate, Ambulance Victoria can be used to transport any suspected cases of COVID-19 from a port of entry or unwell suspected cases from general practice or other settings to an emergency department. Triple 000 should be called in the normal manner but advise that the patient may have suspected COVID-19 infection.

Prevention

- From midnight, 28 March 2020, all travellers arriving into Melbourne from overseas will be quarantined for two weeks in hotel rooms and other accommodation facilities
- Follow physical distancing advice
- Follow advice on influenza vaccination.
- Ensure adherence to good hand and respiratory hygiene practices.
- Adhere to good food safety practices.
- Consider avoiding live animal markets.
- At the present time, travel within Australia is not recommended, and a ban on overseas travel is currently in place. Check for overseas travel advice or restrictions at Smartraveller <https://www.smartraveller.gov.au>.
- Advice on physical distancing and other transmission reduction measures is available on the department's website <https://www.dhhs.vic.gov.au/coronavirus-covid-19-transmission-reduction-measures>.

Risk management at ports of entry

Infection with COVID-19 was designated a Listed Human Disease (LHD) under the *Biosecurity Act 2015* on 21 January 2020.

As of 18th March, the Australian Government advises all Australians not to travel overseas to any country at this time.

Currently all passengers from every arriving international aircraft are health screened. The department's healthcare workers are also conducting health checks on passengers from any international flight if required by the biosecurity officer. Single-use facemasks are provided to arriving passengers who have been identified as unwell. As of midnight, 28 March 2020, all travellers arriving into Melbourne from overseas will be quarantined for two weeks in hotel rooms and other accommodation facilities after submitting an Isolation Declaration Card. Interstate travellers can return to their home states after fulfilling the mandatory quarantine requirements.

The disease

Infectious agent

Severe Acute Respiratory Syndrome coronavirus 2 (SARS-CoV-2) has been confirmed as the causative agent. Coronaviruses are a large and diverse family of viruses that include viruses that are known to cause illness of variable severity in humans, including the common cold, severe acute respiratory syndrome (SARS-CoV), and Middle East Respiratory Syndrome (MERS-CoV). They are also found in animals such as camels and bats.

First termed 2019 novel coronavirus (2019-nCoV), the virus was officially named Severe Acute Respiratory Syndrome coronavirus 2 (SARS-CoV-2) 11 February 2020. The disease it causes is now called coronavirus disease 2019 (COVID-19).

Reservoir

The reservoir is essentially unknown, but probably zoonotic, meaning they are likely transmitted between animals and people; however, an animal reservoir has not yet been identified for COVID-19.

Initial cases were business operators at the Hua Nan Seafood Wholesale Market, which sold live animals such as poultry, bats, marmots, and wildlife parts. The source of the outbreak is still under investigation in Wuhan. Preliminary investigations have identified environmental samples positive for COVID-19 in Hua Nan Seafood Wholesale Market in Wuhan City, however some laboratory-confirmed patients did not report visiting this market.

Mode of transmission

The mode or modes of transmission of COVID-19 are not yet fully understood, although based on the nature of other coronavirus infections, transmission is likely through droplet and contact. There were cases with a strong history of exposure to the Hua Nan Seafood Wholesale Market in Wuhan City, China where live animals are sold. However, the mechanism by which transmission occurred in these cases, whether through respiratory secretions after coughing or sneezing, or direct physical contact with the patient or via fomites after contamination of the environment by the patient, is unknown.

Person to person transmission has now occurred worldwide and the WHO declared a pandemic on 11 March 2020. As a result, droplet and contact precautions are recommended.

Incubation period

The incubation period is not yet known. However, the interim view on the incubation period is that it is 4 to 14 days, based on the nature of previous coronavirus infections.

Infectious period

Evidence on the duration of infectivity for COVID-19 infection is evolving. Epidemiological data suggests that the majority of transmission occurs from symptomatic cases, however there is some evidence to support the occurrence of pre-symptomatic transmission. As a precautionary approach, cases are considered to be infectious from 48 hours prior to onset of symptoms until they meet the criteria for release from isolation.. Infection control precautions should be applied throughout any admission and until the department has declared the confirmed case to be released from isolation.

Given that little information is currently available on viral shedding and the potential for transmission of COVID-19, testing to detect the virus may be necessary to inform decision-making on infectiousness. Patient information (for example age, immune status and medication) should also be considered. Criteria for release from isolation are described in this guideline.

Clinical presentation

Common signs of infection include respiratory symptoms, fever, cough, shortness of breath and breathing difficulties. Sore throat, coryzal symptoms, headache and fatigue have been reported.

In more severe cases, it appears that infection can cause pneumonia, severe acute respiratory syndrome and multi-organ failure (including renal failure). In summary the clinical spectrum varies from mild cases, through to severe acute respiratory infection (SARI) cases.

Illness is more likely in the middle-aged and elderly.

The case fatality rate is unknown but appears to be lower than for SARS and higher than the common cold. The case fatality rate may be higher in elderly, people with immune compromise or who have co-morbidities. The case fatality rate also appears to be higher in countries where the rate of infection has overwhelmed the ability of the relevant health system to care for unwell patients. Current estimates are that the case fatality rate may be as high as two to four per cent.

Information resources

The department will place resources for health professionals on the department's Coronavirus website <https://www.dhhs.vic.gov.au/novelcoronavirus>.

It is important that health professionals consult this website regularly, as case definitions and content of this guideline change regularly during the response to this outbreak.

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

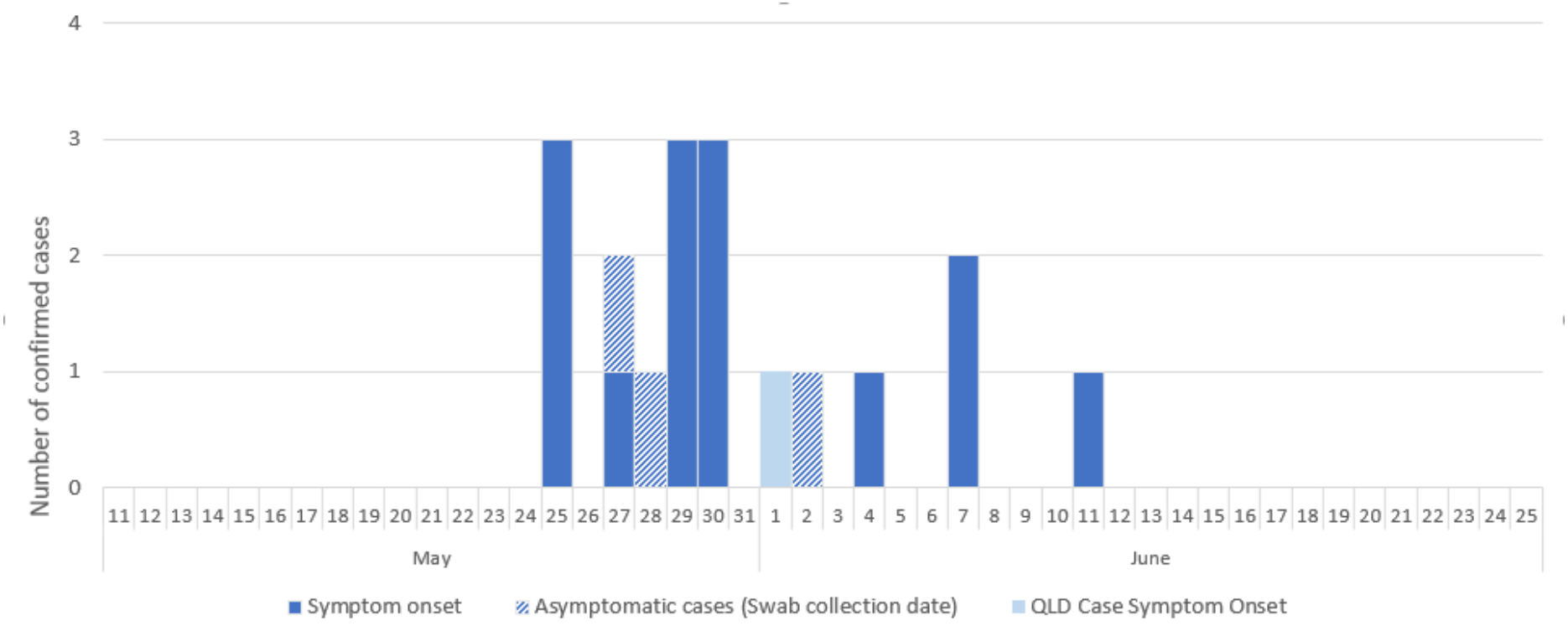


Figure 1: Epidemic curve for Rydges on Swanston Outbreak, by date of calculated symptom onset, including QLD case

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

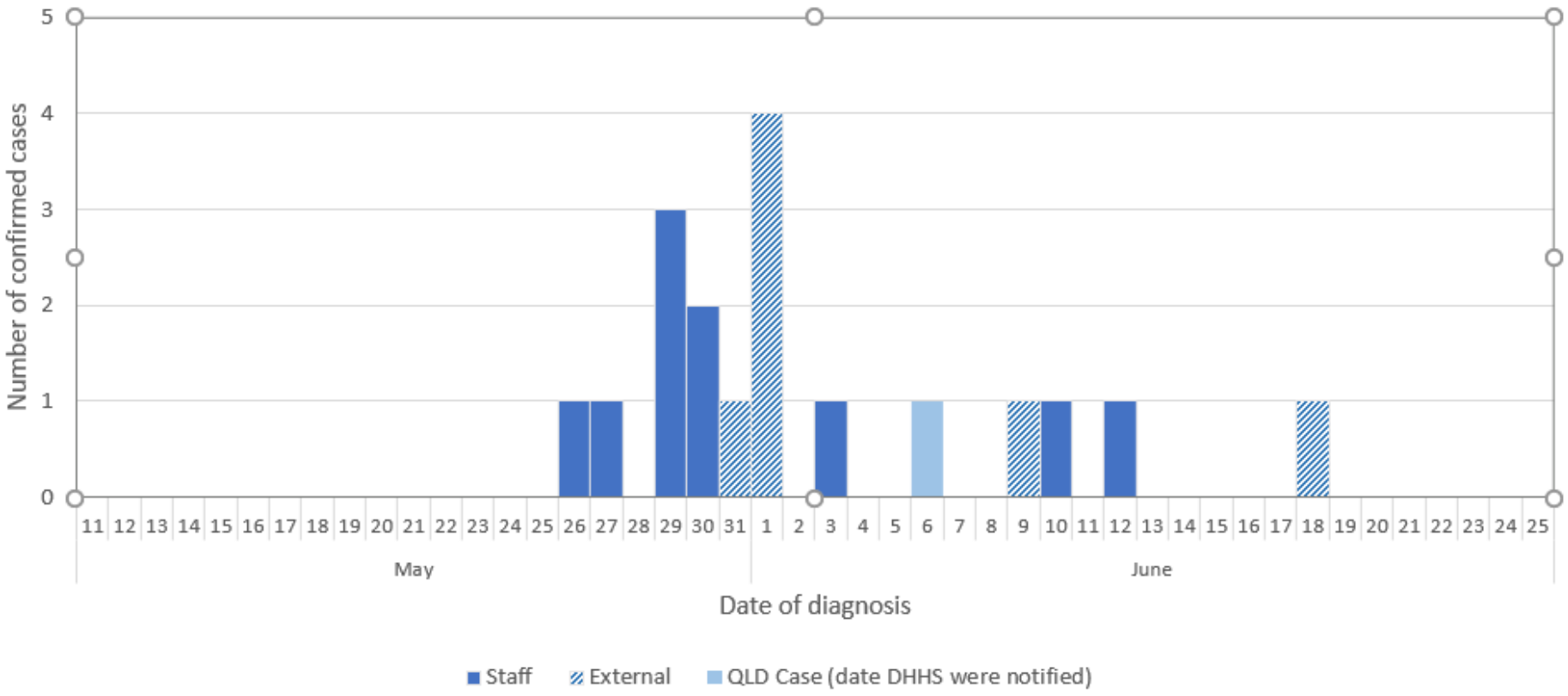


Figure 2: Epidemic curve for Rydges on Swanston Outbreak, by date of diagnosis, including QLD case

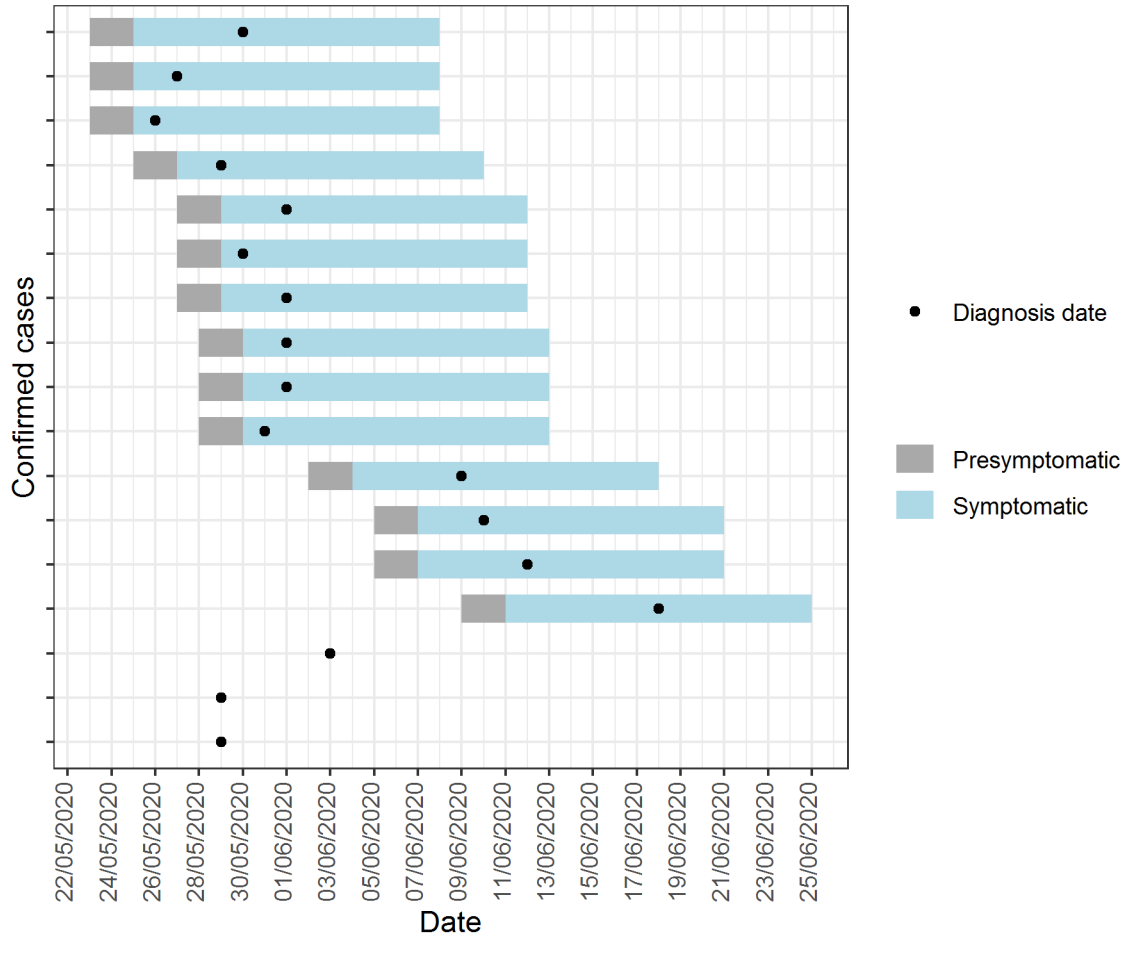


Figure 3: Onset date and incubation period for confirmed cases, Rydges on Swanston

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

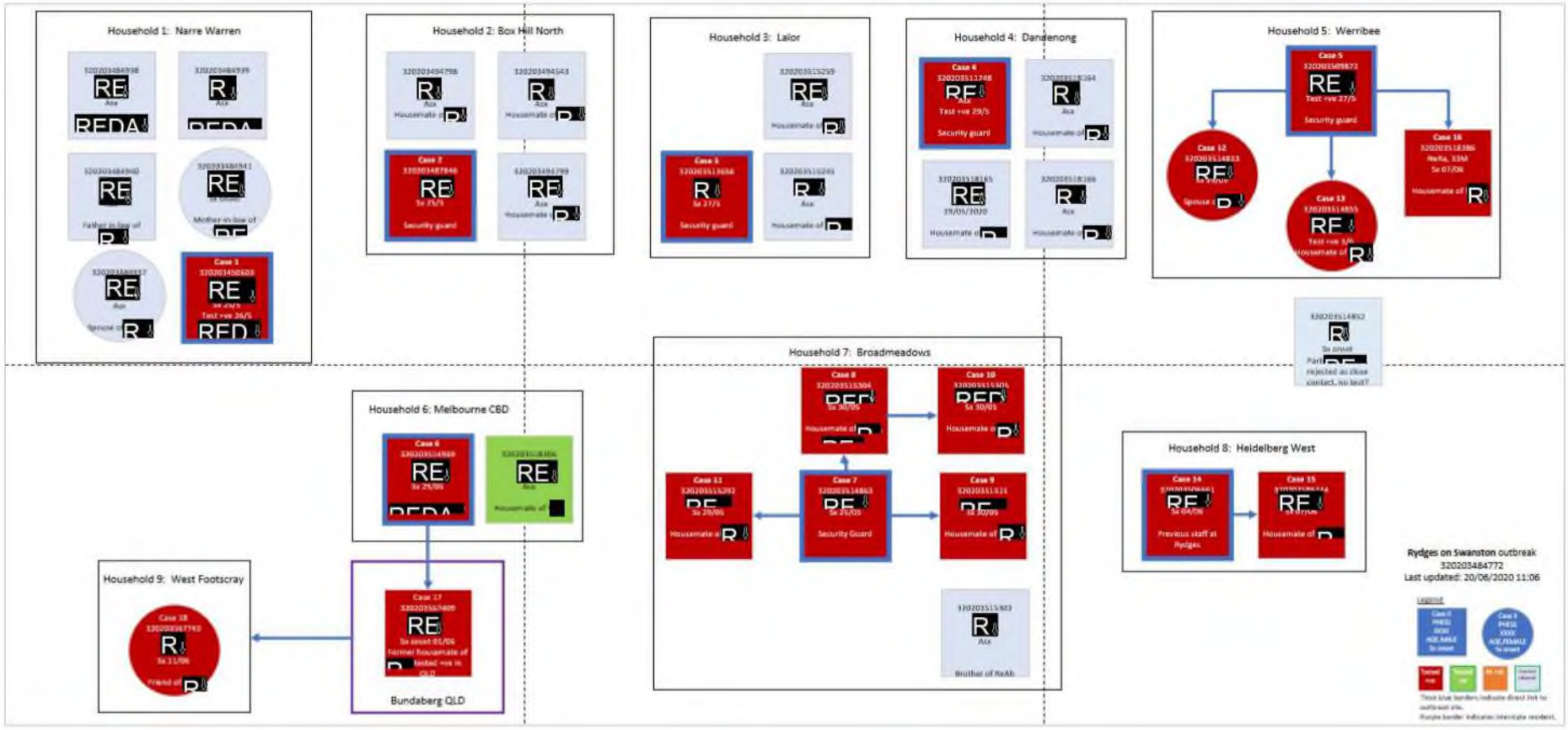


Figure 4: Visio transmission diagram, Rydges Swanston, Updated 21 June 2020, 15:00

RE: Rydges on Swanston - messaging for staff

From: REDACTED (DJPR) <REDACTED REDACTED
To: "Sarah McGuinness (DHHS)" <REDACTED "Pam Williams (DHHS)" REDACTED REDACTED "Meena Naidu (DHHS)" REDACTED REDACTED (DHHS)" <REDACTED REDACTED "REDACTED (DHHS)" <REDACTED
Cc: REDACTED (DHHS)" <REDACTED REDACTED REDACTED (DHHS)" <REDACTED REDACTED
Date: Wed, 27 May 2020 22:47:58 +1000

Hi Sarah,

Thank you for your email and letter. I can confirm that I have sent a cover email with the attached letter to:

- Rydges Hotel – they will confirm tomorrow if any further staff require testing
- Unified Security – will confirm tomorrow if any further staff require testing
- DJPR Logistics staff (5 people) – I believe no staff fit the criteria of "30minutes or more", even though they attended the site in the date period. I am awaiting confirmation from 3 staff (one of whom is in REDACTED

Regards
REDACTED

REDACTED
Operations Soteria (COVID-19)
DJPR Hotel Quarantine Agency Commander
djprcovidaccom-lead@ecodev.vic.gov.au

REDACTED
Department of Jobs, Precincts and Regions
402 Mair Street Ballarat, Victoria Australia 3350
REDACTED
REDACTED

djpr.vic.gov.au

From: Sarah McGuinness (DHHS) <REDACTED REDACTED
Sent: Wednesday, 27 May 2020 9:22 PM
To: Pam Williams (DHHS) REDACTED REDACTED (DHHS) <REDACTED REDACTED Meena Naidu (DHHS) REDACTED REDACTED REDACTED (DJPR) <REDACTED REDACTED REDACTED (DHHS) <REDACTED REDACTED REDACTED (DHHS) REDACTED
Cc: REDACTED (DHHS) <REDACTED REDACTED (DHHS) <REDACTED REDACTED
Subject: Rydges on Swanston - messaging for staff

Dear All,

Please find attached an updated letter for staff who work at the Rydges on Swanston.

I understand that REDACT has been liaising with security/hotel staff and REDACTED / REDACT REDAC with medical & nursing staff (as well as DHHS staff). Can REDACTE and REDAC REDACT please ensure that the attached letter gets sent out to all staff who attended the site for 30 minutes or more on or after the 11th of May?

REDA advised tonight that up to 45 staff have already been tested. It would be great if the public health team (via myself/RED) could get an update tomorrow morning regarding the number of people you expect to attend for testing & when so that we can provide support if necessary.

Key messages to staff include:

- Two cases of coronavirus disease (COVID-19) in staff members of the Rydges on Swanston have been notified to the Department of Health and Human Services today.
- We are asking that all staff who attended the site for 30 minutes or more on or after the 11th of May be tested for COVID-19. Staff who have not already been tested should present to Rydges on 28th May to be tested for COVID-19.
- If staff have not been contacted directly by the department, then they have not been identified as close contacts and do not need to quarantine.
- Staff who do not have symptoms do not need to isolate whilst awaiting results
- Staff with symptoms should not attend work and should be advised to seek testing and isolate whilst awaiting results.
- Symptoms of COVID-19 include fever, chills, cough, sore throat, shortness of breath, runny nose and new loss of smell.

Thanks and kind regards,

Sarah

Dr Sarah McGuinness
Infectious Diseases Physician
Senior Medical Advisor
Case, Contact and Outbreak Management | COVID-19 Surge Workforce
Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
REDACTED

FW: New public health advice for staff at Rydges on Swanston

From: "Merrin Bamert (DHHS)" <"/o=exchangelabs/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=638a479568194a798229202add0cc910-mbam1802">
To: "DJPR COVID Accom-Lead (DJPR)" <djprcovidaccom-lead@ecodev.vic.gov.au>
Date: Sat, 30 May 2020 14:15:55 +1000

FYI

Merrin Bamert
Commander, Operation Soteria, Covid - 19
Director, Emergency Management, Population Health and Health Protection
South Division
Department of Health and Human Services
Level 5 / 165-169 Thomas Street, Dandenong, 3175
REDACTED
REDACTED

From: Sarah McGuinness (DHHS) REDACTED
Sent: Saturday, 30 May 2020 2:13 PM
To: REDACTED REDACTED
Cc: REDACTED (DHHS) REDACTED; REDACTED (DHHS) REDACTED; Merrin Bamert (DHHS) REDACTED
Subject: New public health advice for staff at Rydges on Swanston

Dear RE

I am part of the public health team investigating the outbreak of COVID-19 at Rydges on Swanston. I am writing to provide you with some new public health advice.

In the past 24 hours, four new cases of COVID-19 have been detected in staff who work at the hotel, bringing the total for this outbreak to six. As you are aware, four of these cases are in security guards. The new cases were all identified as part of testing initiated after identification of the first case in a staff member of the hotel.

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.

The following advice applies from today (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 **quarantine for 14 days** since their last visit to the hotel. The Department of Health and Human Service'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 Rydges on Swanston from midday on 28 May should not work elsewhere for now while the investigation is underway.

As mentioned above, we will make contact with each of these staff on an individual basis, but you can use the criteria above to help you determine who can be rostered on for the hotel for this evening. We will be in touch with you later today to confirm the list of security staff who meet the criteria for quarantine.

As you know, we have previously asked that all staff who attended the hotel between 11 to 28 May to seek testing for COVID-19. Thank you for providing us with a spreadsheet yesterday of all of the staff who have been tested and who have received results. Based on the information I currently have to hand, there are 5 outstanding staff (for whom we are yet to receive test results for) – are you aware of whether these staff have been tested, and if so – where they sought this testing?

FIRST NAME	SURNAME	DOB	CONTACT	Test date
REDACTED		REDACTED	REDACTED	

Please let us know if you have any questions or concerns,

Thanks and 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

Cleaning and disinfection

From: "Sarah McGuinness (DHHS)" REDACTED

To: REDACTED REDACTED

Cc: "Merrin Bamert (DHHS)" REDACTED "Pam Williams (DHHS)" REDACTED

Date: Fri, 29 May 2020 15:38:26 +1000

Attachments: Cleaning and disinfecting to reduce COVID-19 transmission Building and construction sites- 4 April (1).docx (64.65 kB)

Hi REDA

As discussed, we are concerned that **environmental transmission** may be happening at the Rydges hotel.

In consultation with our IPC team, I am recommending that we implement **at least once daily** cleaning + disinfection (using a disinfectant for which the manufacturer claims **antiviral activity**) of all common areas at the Rydges hotel frequently by staff including all high touch surfaces AND lifts.

Attached are the current DHHS guidelines for cleaning and disinfection. A commercial cleaning company should be able to provide this level of cleaning.

Thanks and 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

Cleaning and disinfecting to reduce COVID-19 transmission

Building and construction sites

4 April 2020

Purpose

The current outbreak of coronavirus (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 coronavirus (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 coronavirus (COVID-19) transmission in building and construction sites. Note that this advice applies to 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 coronavirus (COVID-19) is transmitted

- Coronavirus (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 coronavirus (COVID-19) may remain viable on surfaces for many hours and potentially for some days. The length of time that coronavirus (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 coronavirus (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.

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- 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

Workplaces should routinely (at least daily) clean frequently touched surfaces (for example, tabletops, door handles, light switches, desks, toilets, taps, TV remotes, kitchen surfaces, cupboard handles and other equipment and materials relevant to construction and building sites). 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 coronavirus (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.

The department will notify employers when a worker has been diagnosed with coronavirus (COVID-19) and has been infectious while on a building and construction site. The department will advise if cleaning and disinfection is required. It is the responsibility of employers to apply the principles in this document to conduct relevant cleaning and disinfection.

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 coronavirus (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 coronavirus (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 ☒  ☑ 

RE: Public Health investigation - assistance required

From: REDACTED
To: "Sarah McGuinness (DHHS)" REDACTED (DHHS)" REDACTED
Cc: "Merrin Bamert (DHHS)" REDACTED "Pam Williams (DHHS)" REDACTED REDACTE (DHHS)" REDACTED , "REDACTED (DHHS)" REDACTED
Date: Wed, 10 Jun 2020 17:04:56 +1000

Hi Sarah,
Always glad to assist.

- Guests are not allowed in the lobby
- I will review CCTV on Fri and see movement of this guests.

- Did the family move in and out of the hotel at any point or have fresh air breaks, gardens, smoke breaks, balconies? (The notes we received from the Authorised Officers indicate that the family went for a fresh air break/walk on the RED of May accompanied by 2 nurses and 4 security guards, but it is unclear what time this occurred and who the people were that accompanied the family)
  - The AO have records of guests who leave their rooms for any reason in including walks. I can view CCTV for time and individuals who escorted them for the break.
  - The rooms do not have balconies
- Did the family have any direct contact with the environment? (e.g. when they were out of their room, where did they go and what surfaces were they observed to touch [if any])
  - 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.
- What were the processes regarding changes of sheets / removal of rubbish from the room? (E.g. were people doing these jobs wearing protective equipment, how were sheets/rubbish transported?)
  - As a hotel, we provided linen and ask guests to change their own linen
  - Soiled linen is to be placed in double bags and placed outside rooms
  - The soiled linen is then collected wearing full PPE including gown.
  - For these guests REDAC the nurses assisted since the REDACTED was very flustered managing RE REDACT and went over and above to clean the room. I am told that they wore full PPE but I feel would be good for them to answer this question.
- What do staff movements look like on hotel floors and the lobby area, particularly during the night shift? (e.g. how often do security guards move from their stations, are there any places where staff congregate e.g. at break times or start or end of shift times)
  - Certainly not my area and will ask RE at REDAC security to provide some information.

Thanks a lot,
RED

From: Sarah McGuinness (DHHS) REDACTED
Sent: Wednesday, 10 June 2020 4:50 PM
To: REDACTED REDACTED (DHHS) REDACTED
Cc: Merrin Bamert (DHHS) REDACTED Pam Williams (DHHS) REDACTED REDACTED REDACTED EDACTED (DHHS) REDACTED REDACTED
Subject: RE: Public Health investigation - assistance required

Dear REDACT,

My name is Sarah and I have been working with RED ACTE on the Rydges outbreak investigation.

Thank you for providing this information about the guests – it is consistent with the information collected by the public health team & documented by the Authorised Officers working at the hotel.

We would really appreciate it if you could go through the CCTV footage when you return back to work. We are particularly interested in any footage of the hotel corridors and common areas (e.g. lobby, lifts) which might shed light on the following questions:

- Did the family move in and out of the hotel at any point or have fresh air breaks, gardens, smoke breaks, balconies? (The notes we received from the Authorised Officers indicate that the family went for a fresh air break/walk on the RED of May accompanied by 2 nurses and 4 security guards, but it is unclear what time this occurred and who the people were that accompanied the family)
- Did the family have any direct contact with the environment? (e.g. when they were out of their room, where did they go and what surfaces were they observed to touch [if any])
- What were the processes regarding changes of sheets / removal of rubbish from the room? (E.g. were

people doing these jobs wearing protective equipment, how were sheets/rubbish transported?)
- What do staff movements look like on hotel floors and the lobby area, particularly during the night shift? (e.g. how often do security guards move from their stations, are there any places where staff congregate e.g. at break times or start or end of shift times)

Feel free to contact me directly on my work phone (REDACTED if you'd like to discuss any of the above – I'll be in the office on Friday

Thanks and kind regards,
Sarah

From: REDACTED
Sent: Tuesday, 9 June 2020 11:28 AM
To: REDACTED (DHHS) REDACTED
Cc: Merrin Bamert (DHH Pam Williams (DHHS)
REDACTED ACTED ; Sarah McGuinness (DHHS)
Simon Crouch (DHHS) REDACTED REDACTED
REDACTED
Subject: RE: Public Health investigation - assistance required

Hi REDACTE
Just got a further update
- REDACTED
- Guest arrived RE May and Departed RE May
- Room was very messy
- RED drew on the walls
- Nurses changed linen on R th May (Nurses advised us on RE th May) as guests were unhappy that they had to do it themselves and REDACTE was struggling to keep up REDACTED
- Nurses vacuumed the floor too since it was very dirty

Thanks,
REDA

From: REDACTED
Sent: Tuesday, 9 June 2020 11:20 AM
To: REDACTED
Cc: Merrin Bamert (DHHS) REDACTED Pam Williams (DHHS)
REDACTED Sarah McGuinness (DHHS)
REDACTED
Simon Crouch (DHHS) REDACTED
REDACTED
Subject: RE: Public Health investigation - assistance required

Hi REDACT
Apologies for the delay in responding.
Thank you for reaching out and I will certainly assist in any investigation.
At the moment I do not have access to the CCTV footage as I am working from home and the CCTV is only on a fixed computer onsite. When I return back to work on Fri I will go through the footage and advise if I notice any contact.

With regards to room REDAC we do not have any footage as we do not have CCTV coverage on the floors. Some information about the guests below:
REDACTED
- Guest arrived RE May and Departed RE May
- Room was very messy
- RED drew on the walls
- Nurses changed linen (don't have date & time) as guests were unhappy that they had to do it themselves and REDACTE was struggling to keep up REDACTED
- Nurses vacuumed the floor too since it was very dirty

I don't have a contact for YNA to get details on when the room was serviced and if they followed the normal protocol with the linen and rubbish. Would appreciate if you could point me to a contact person so I can investigate further.

I'll certainly get back to you once I go through the footage.

Thank you very much and apologies once again for the delay in responding.

Best regards,

REDACTED REDACTED | Rydges on Swanston Melbourne

701 Swanston Street, Carlton, VIC, 3053

REDACTED **Mobile:** REDACTED

Email REDACTED **Web:** www.rydges.com/swanston | www.skylineevents.com.au

From: REDACTED
Sent: Saturday, 6 June 2020 6:41 PM
To: REDACTED
Cc: Merrin Bamert (DHHS) <Merrin.Bamert@dhhs.vic.gov.au>; Pam Williams (DHHS) REDACTED Sarah McGuinness (DHHS) REDACTED Simon Crouch (DHHS) REDACTED REDACTED (DHHS) <REDACTED REDACTED
Subject: Public Health investigation - assistance required

Dear REDAC

As you are no doubt aware, the department is currently investigating an COVID-19 outbreak associated with Rydges on Swanston. I am the Deputy Public Health Commander of our outbreak management section. Thank you to the hotel for your assistance with the investigation to date.

We believe it is likely that the staff cases identified at the hotel were exposed to a common environmental exposure on the R May 2020. It is obviously important for us to ensure we make every attempt to identify the cause of transmission and ensure appropriate actions are undertaken to mitigate any public health risk.

For this reason, can we please request any CCTV footage you may have of common hotel areas from R May to R May? In addition to common areas, we are particularly interested in any footage you may have relating to room REDACT We understanding there were some challenging circumstances relating to the management of a family in this room and the potential for gross environmental contamination. Furthermore, genomic testing suggests there is a likely relationship between the virus type of this family and of at least two of the cases.

Merrin Bamert has suggested I contact you directly with this request. Please let us know if you need any further information. I am not in the office on Monday or Tuesday, but others on this email are and should be able to assist.

Kind regards

REDACTED

Senior Medical Advisor
Health Protection Branch | Regulation, Health Protection and Emergency Management Division
Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
t. REDACTED | e. REDACTED
w. www.dhhs.vic.gov.au

Follow the Chief Health Officer on Twitter @VictorianCHO

FW: AO notes 16-27 May Rydges Hotel

From: "Sarah McGuinness (DHHS)" <"/o=exchangelabs/ou=exchange administrative group [redacted]

To: [redacted]

Cc: [redacted]

Date: Fri, 05 Jun 2020 19:47:30 +1000

Attachments: AO notes Rydges 16-27 May.pdf (4.31 MB)

Hi [redacted]

I've just received the attached notes from [redacted] and filed them in the Rydges TRIM folder – [redacted]. The attached are scanned pages of a handwritten notebook.

I've reviewed the written entries looking for reference to any of the family members' names ([redacted] room number [redacted] PHESS notes state that the family were moved to Rydges room [redacted] on [redacted] May. The written entries seem to reference room [redacted] as a unit, so I've assumed that these are the rooms the family are in ([redacted] The documentation is not amazing but includes the following entries:

17/05/2020:

- * Entry @ 2100h re: [redacted] – "Called requesting slippers and a vacuum. The nurses who just came on shift went up to the room to find a "bomb" scene. Rubbish everywhere and crayon over the wall. They have taken cleaning products up to room."

18/05/2020:

- * Entry @ 0730h referencing "overnight issues" re: [redacted] – "Nurses said spent 1 ½ hours in room – changing sheets, tissues with excrement on floor, crayons on walls. Worried about state of room/welfare – requested maternal nurse from [redacted] – said not qualified"
- * Entry @unknown time re: [redacted] – "Nurse [redacted] family for a walk. MH assessment – see how they're going with child minding / see state of room. Flagged as urgent following last night's findings of room conditions. 2 nurses & 4 security to oversee to assist with access safely to outside – MH request. AO/TL discussion in this circumstance – necessary with this additional supervision."
- * Entry @ 9am morning meeting re: [redacted] "Damage to room, crayons on walls. [redacted] when they go up will look and take photos. Food everywhere/rubbish. [redacted] will take [redacted] out for walk & assess. Want to get fresh air for all including [redacted]. 2 nurses & 4 security. [redacted] confirmed that pool is cordoned off. Went around everyone – approved one-off walk.
- * Entry @9:54am – room [redacted] Walks for today overseen by MH nurse [redacted] Permission – forms completed & loaded on app. [redacted] Data fix in App – [redacted] not in App. Updated Hoetl and room number.
- * Entry @ 10:25am. "Spoke to [redacted] – verbally authorised walk. Paperwork sent up with MH nurse to give to them… MH nurse returned from walks. Showed AO & TL photos of room [redacted] – room damage."
- * Entry on 11pm shift re: [redacted] – '[redacted] The [redacted] screaming, scratching their faces, room carpet had poo, crumbs all over, gloves on the floor, crayon, scribbling on walls and bed linen. Nurses asked [redacted] to vacuum but [redacted] doesn't know how to use it, nurses explained they would do it tonight - [redacted] will need to in the future and they showed [redacted] how to do it. Temperature checks on [redacted] all within normal

range."

22/05/2020:

- * Entry relating to 11pm-7am shift [redacted] – "Exits for tomorrow (as it currently stands) – [redacted]"

23/05/2020:

- * Entry @ unknown time: "Family in rooms [redacted] has been informed that they have been cleared. We need to determine their intent[redacted] they leaving today or are they staying the night and leaving tomorrow and then inform [redacted] [redacted] so current paperwork can be generated"

Note that there is no entry in the notes from the 0700-1500h shift or the 1500-2300 shift to indicate that the family arrived.

Overall, these entries suggest that [redacted] went out for at least one walk (accompanied by security & nurses) on [redacted] and that there was likely gross environmental contamination of their room.

CCTV footage might be really helpful.

Cheers,
Sarah

From: [redacted]
Sent: Friday, 5 June 2020 6:05 PM
To: [redacted]
Subject: AO notes 16-27 May Rydges Hotel

Hi [redacted]
Please find attached the AO notes for Rydges on Swanston for 16-27 May.
Fresh air breaks are documented in this.

Kind regards
[redacted]

[redacted]

COVID 19 Health Coordination
dhhsopsoteriaeoc@dhhs.vic.gov.au

Outbreak handover

From: "Sarah McGuinness (DHHS)" REDACTED

To: "REDACTED (DHHS)" <REDACTED>

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

Date: Sat, 06 Jun 2020 18:04:09 +1000

Dear REDACT ED,

Please find below a summary of current outbreaks & outstanding actions. I've CC'd Simon (who will be here tomorrow), RED (who will be here tomorrow) and also RED (who will be in on Monday). RED attended the Aged Care, Rydges and Newbury OMTs with me today.

Good news is that there were 0 cases yesterday and no cases so far today…. (touch wood, fingers crossed etc.)

Happy for you to call me if you have any questions over the next couple of days

Key Contacts over the next couple of days include:

- DET – REDACTED on for Sunday/Monday (REDACTED also on call)
- Outbreak squads – REDACTED on Sunday, REDACTE D on Monday
- Operation Soteria – Merrin Bamert
- DHHS Commander – R EDACTED
- Ops Lead – REDACTED is on for Sunday

Cheers,
Sarah

Rydges - TRIM folder IIEF/20/1421

- 14 cases have been linked to this outbreak – 7 are staff who work night shifts at Rydges on Swanston (1 REDACTE D, 5 REDACTED and 1 REDACTED e). Seven are household close contacts.
- The most recent case is a former housemate of one of the staff cases, who moved to Queensland early on R June 2020 and subsequently developed symptoms. This case was diagnosed and reported in Queensland. The case was not previously identified as a close contact as their housemate (a Rydges staff member) declined to mention that they previously had two housemates in their case interview. Six close contacts of the case have been identified in Victoria and are being contacted by the department. This case travelled on the Skybus and on a flight from Melbourne to REDACT ED during their infectious period (before onset of symptoms); they were not aware at this time that they were a close contact of a case.
- 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 25 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 isolates from case 1 and case 2 cluster closely with a family of returned travellers who have stayed at the hotel.
- On 4 June, PHU staff arranged for an ambulance to transport one of the staff cases from home to hospital after their symptoms deteriorated. The case remains under close observation at RMH ICU.
- Testing was arranged for a symptomatic household close contact who is symptomatic on 5 June - .
- This outbreak is active and under investigation. There is no projected closure date.
- **Risks/concerns:**
  - QLD case has 6 close contacts in Victoria, some of whom we do not yet have contact numbers for (possibility of further cases)
  - RED remains in ICU at RMH – last update provided by ID registrar on RED June suggested RE was stable on REDACTED ; CXR changes of bilateral pneumonia c/w COVID-19. RMH will contact us if any major changes (e.g. intubation or step down to ward).
  - Op Soteria are have indicated that they would like to relocate back to the Rydges at some point. REDACT from the outbreak squads raised some concerns about needing to address IPC issues including shared toilet/handwashing facilities and baggage area for storing belongings before this occurs
- **Outstanding actions:**
  - Case interview for QLD case still pending (awaiting contact number from QLD health). Given that the apartment he was staying in is a 2 bedroom, 1 bathroom unit, there is speculation that RE may have been couch surfing rather than living at the apartment as an official housemate.
  - Need to confirm with Op Soteria timing of relocation to Rydges so that outbreak squad visit can occur prior to this (to address IPC concerns)
  - Awaiting CCTV footage from the Rydges from period 16/5 – 22/5 to better pinpoint the likely exposure – REDA has directly requested this from Pam Williams today (as there has been no success in getting access following earlier requests)
  - Further genomic findings to be discussed at next MDU meeting (4pm Wednesday) – I've asked REDACTED to add the additional PHESS numbers from new cases to the list
  - NB1: As case 14 has been reported in QLD, RE is not part of our official Victorian numbers and therefore doesn't appear in the summary table in the Outbreak Management Report. However, RED has included RED in the Epi curve (in a different colour), and RE is referred to in our report.
  - NB2: Transcribed notes from AO handover paints a picture potential environmental contamination of the room(s) the genomically linked 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
- **Next OMT meeting:** scheduled for Monday 8 June at 2pm (invitation in your calendar)

Newbury Primary School (single case) – TRIM folder IIEF/20/1666

- Single case in a RED child who is a REDACTE pupil of the schoo REDACTED Symptom onset 31 May, tested 3 June, notified to DHHS 4 June 2020. Attended school for one day during infectious period (29 May 2020) while asymptomatic.
- Close contacts identified include 20 students, 5 staff and 2 household contacts. All have been contacted and are in quarantine. Of the 20 students, four were mildly unwell last week and have been asked to seek testing. Two teachers have reported symptoms and have been asked to seek testing. All close contacts will be asked to undergo end-of-quarantine period testing for COVID-19 on 9 June.
- The parents of the students are now symptomatic and have been asked to seek testing.
- The outbreak response squad visited the school on 5 June.
- The department is working closely with Department of Education and the school to support communications and the implementation of public health actions.

- A deep clean of the school commenced on Friday 5 June and should be completed by the afternoon of Monday 8 June.
- It is anticipated that the school will reopen on Tuesday 9 June.
- **Risks/concerns:**
  - VIDRL unexpectedly received a large batch of tests (~200) from a pop-up clinic in Epping on Sat 6 May, many of which appear to be linked to Newbury school. This is not in keeping with comms sent out by the department, as we had only advised ~8 people to seek testing, preferentially at the Northern. It appears at this stage that the pop-up clinic has gone outside of normal processes and has tested people who are not close contacts, but are in some way associated with the school (potentially including asymptomatic people).
- **Outstanding actions:**
  - Follow up test results for symptomatic close contacts - 2 parents, 2 teachers, 4 children (hopefully most will be tested through Northern Hospital)
  - Confirm day 11 testing arrangements for 20 student & 5 staff close contacts at Northern Hospital on 9 June (letters went out last night)
  - Confirm that cleaning is completed before school re-opens (should be complete by Monday PM)
  - Confirm school re-opening plan (should be OK to reopen Tuesday 9 June provided no further cases identified)
- **Next OMT meeting:** scheduled for Monday 8 June at 1pm (invitation in your calendar)

Keilor Downs Family Cluster - TRIM folder IIEF/20/1419

- A total of 13 cases have been associated with one large family group comprising four households and their contacts. REDACTED REDACTED
- The outbreak response squad has visited all four households associated with this family group on 31 May and reported on adequacy of isolation, infection prevention control 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 [redacted] 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 26 May with comorbidities who was admitted to hospital and ICU. This case is improving and ready for discharge. This case is still considered infectious so cannot go home. Alternate accommodation is being arranged by the department.
- This case attended Sunshine hospital on 11 May, the same day as a case from the Cedar Meats cluster. The Cedar Meats case was already confirmed and managed in full PPE. Initial genomic analysis has suggested a possible relationship between the Keilor Downs family cluster and the Cedar Meats outbreak.
- [redacted] 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 [redacted] further household cases as of 29 May.
- Testing also occurred on 3 June on [redacted] children in house A REDACTED who had previously tested negative – both remain negative.
- Testing occurred for 2 contacts in house C on 3 June - results pending.
- These cases attended or worked in their infectious periods at a number of sensitive settings and a workplace:
  - **Keilor Downs College**, one case attended on 26 May during their infectious period
    - Around 66 students identified as close contacts (including 5 students from Taylors Lakes SC and 1 student St Albans SC). 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 to occur through Sunshine Hospital for 6 June.
    - School/DET aware
      - Advised that school has re-opened 1 June
  - **Holy Eucharist Primary School,** one case attended on 26 May during their infectious period (asymptomatic)
    - School/DET/Catholic Education 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 for 6/6/2020.
        - 2 staff members were symptomatic and have been tested – results both negative
        - Expecting school reopened on Wednesday 3 June
    - **Global Resource Recovery Site, 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 25 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 on site staff were asked to get tested – 24 negative, 7 pending (including some staff who weren't on site).
        - Site closed. Deep clean undertaken. Outbreak response squad have visited. Return to work testing will be undertaken.
        - Worksafe and EPA aware
    - **Sunshine Hospital/Footscray Hospital**
        - Two cases attended Sunshine Hospital and Footscray Hospital 15-18 May. One was a patient, REDACTED
        - Infectious periods from 15 and 16 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 more than 14 days have elapsed since initial exposure).
        - No close contacts identified from Sunshine Hospital (appropriate PPE used). 16 close contacts identified through Footscray Hospital – all in quarantine and have been tested. All results are negative.
- A pop up testing clinic opened briefly 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
- **Potential risks:**
    - Ops team advised on Sat PM that confirmed case REDACTED (from House A) left Quest for a brief period on Sat AM to go to a local convenience store. Risk to others thought to be low, given Day 18 of illness (not yet cleared due to ongoing cough) and only brief interactions with others (spent <15min talking to reception staff and was gone for <30min as per CCTV footage; likely only spent 5-10min in convenience store allowing 10min walking to and from).
- **Outstanding actions:**
    - REDA sent a comprehensive update on Friday evening (REDACT CC'd already, forwarded to Simon)
    - Day 11 testing for Holy Eucharist Primary, St Albans, Taylors Lakes and Global Resource Recovery planned for 6 June (today) – all have been asked to present to Sunshine hospital with tests to be processed through Dorevitch (Contact at Sunshine Hospital: REDACTED – RED will send through results Mon am; RE REDAC is contact at DET & would like to be updated with test results)
- **Next OMT meeting:** scheduled for Monday 8 June at 1:30pm (invitation yet to be created)

Embracia Aged Care - TRIM folder IIEF/20/1613

- 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.
- Seven 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 and 3 June to perform an assessment and provide training and support. The facility is being supported with supplies of PPE.
- Testing for all staff and residents was undertaken on 2-4 June. All 97 residents tested negative. All 142 staff tested negative.
- A second mass re-testing for all staff and residents will occur on the 7 June which will

include the day 11 testing date for residents and staff who are close contacts of case 1.
- Results from this testing will guide outbreak closure planning. If no new cases are identified, it is anticipated that isolation restrictions may be lifted on 11 June 20.
- **Outstanding actions:**
  - Clearance testing for Case – first return to work clearance test planned for 7 June
  - Mass testing of staff/residents planned for 7 June (need to chase results)
- **Next OMT meeting:** scheduled for Sunday 7 June at 11am (standing invite)

Lynden Aged Care - TRIM folder IIEF/20/1297
- 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 and has subsequently met clearance criteria.
- Cases 2 and 3 (both staff members) are currently undergoing return-to-work clearance testing – each has had one negative test, and second tests are pending.
- The facility advised that a resident with symptoms of a respiratory illness died on the 11 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.
- 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 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.
- PPE training was conducted on 21 May by outbreak squads, IPC site visits occurred 26th, 27th and 28th May.
- Repeat testing for all staff and residents was undertaken on 25th - 29th May. All results for residents, permanent staff and contractors are negative.
- Another round of testing for all residents and staff was performed on Friday 5th June. To date, of 85 residents tested – 84 are negative and one result is pending. Of 61 staff tested – 59 are negative and 2 are pending. Final results from this round will guide outbreak closure planning. If no new cases are identified, it is anticipated that isolation restrictions will be lifted on 9 June 20.
- **Outstanding actions:**
  - Clearance testing for Cases 2 & 3 – each has had one negative test, and second tests are pending
  - Chase remaining results from 5 June testing round
  - If no new cases, stand down/soft closure can occur on 9 June
- **Next OMT meeting:** scheduled for Sunday 7 June at 11am (standing invite)

Hammond Aged Care - TRIM folder IIEF/20/1296
- 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 was scheduled to be tested yesterday; two agency nurse close contacts of case 2 (who were subsequently identified) were to be tested yesterday, and the remainder have tested negative.
- All but one of the residents have been tested. The resident who has not been tested has dementia 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. There had been concerns regarding her mental health and wellbeing while isolating in the separate cottage. The department has outlined specific requirements for case 2 to be safely isolated in the cottage.
- Case 1 has received 2 x negative swabs and is now cleared.
- Case 2 has received 1 x negative swab; results for a second swab (performed 5 June).
- Day 11 testing for close contacts of case 2 (including 5 residents) was performed on 4 June. 3

residents (all close contacts with dementia) refused testing on 4 June and subsequently on 5 June. These residents had a negative test earlier in their quarantine period. The remaining 2 residents and 16 staff have tested negative. Results are still pending for 4 agency nurses.

- 1 agency nurse was reclassified as a close contact on 5 June - this staff member was already in quarantine.
- Staffing support is being provided by the Commonwealth
- This outbreak is active and under investigation. Projected release date for the second cottage where case 2 resides is early next week (Monday 8th by dates, but Tuesday 9th easier for facility due to public holiday), if clearance testing for residents and staff is negative and everyone remains asymptomatic.
- **Outstanding actions:**
  - Clearance testing for Case 2 – has had one negative test, results for second test (performed 5 June) pending
  - Chase pending results for remaining agency and permanent staff close contacts (day 11 testing)
  - If no new cases, stand down/soft closure can occur on 9 June
- **Next OMT meeting:** scheduled for Sunday 7 June at 11am (standing invite)

Covid positive case in Rydges on Swanston

From: Public Health Operations <publichealth.operations@dhhs.vic.gov.au>

To: DHHSOpSoteriaEOC <dhhsopsoteriaeoc@dhhs.vic.gov.au>, "Rydges Swanston (DHHS)" <rydgesswanston@dhhs.vic.gov.au>

Cc: REDACTED REDACTED, Public Health Operations <publichealth.operations@dhhs.vic.gov.au>, REDACTED (DHHS)" <REDACTED "Simon Crouch (DHHS)" REDACTED "Pam Williams (DHHS)" REDACTED REDACTED (DHHS)"REDACTED REDACTED, "Clare Looker (DHHS)"REDACTED "Sarah McGuinness (DHHS)"REDACTED

Date: Tue, 26 May 2020 20:40:42 +1000

Hi Team

As discussed, DHHS have been notified of a confirmed positive case in a staff member of Rydges on Swanston. Thank you for the information that has already been provided.

The information we have so far:
The case works at Rydges on Swanston as a REDACTED from REDACTED – each handover is roughly five minutes. The case claims to work alone and does not interact with other staff.
The case has an onset of 25 May 2020 – this means that RE infectious period is from the 23 May.
The case has worked one shift during RE infectious period and 6 shifts during RE acquisition period.

We were hoping to obtain a little more information in order for us to undertake a risk assessment and provide further advice regarding other staff at the hotel. I note that some staff have already been swabbed.

1. Can you please provide us with some background as to what duties/jobs/functions are undertaken by the REDACTED over a shift. This includes which floor RE works on predominately and which floor RE would visit during the course of RE shift.
2. What are RE interactions with other staff (all staff on site) and guests.
3. Can we please have the rosters for the following shifts: this includes all DHHS staff, hotel staff and nurses and contractors that would have worked during these times
   - 13 May 2300 - 0700 (who worked on shift with RED ACT ED in all roles, and who did RED ACT ED handover to and from)
   - 14 May 2300 – 0700 (who worked on shift with ED in all roles, and who did ED handover to and from)
   - 17 May 2300 – 0700 (who worked on shift with in all roles, and who did handover to and from)
   - 20 May 2300 – 0700 (who worked on shift with in all roles, and who did handover to and from)
   - 21 May 2300 – 0700 (who worked on shift with in all roles, and who did handover to and from)
   - 22 May 2300 – 0700 (who worked on shift with in all roles, and who did handover to and from)
   - 23 May 2300 – 0700 (who worked on shift with in all roles, and who did handover to and from)
4. What is the cleaning regime like at the hotel? A clean of all common areas, and the cases' direct work areas will need to occur.
5. A list of all staff that have been swabbed and whether any staff are symptomatic.
6. A floor plan of the hotel
7. Can you please confirm if any staff (hotel, DHHS or nurses) work at any other premises?

Any questions please let me know – I will be handing this over to an officer in the morning.

Kind Regards,

REDACTED REDACTED
Public Health Operations | Novel Coronavirus (COVID-19) Response

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

Urgent: Rydges - Outbreak requests for action

From: REDACTED

To: "DJPR COVID Accom-Lead (DJPR)" <djprcovidaccom-lead@ecodev.vic.gov.au>, "Rydges Swanston (DHHS)" <rydgesswanston@dhhs.vic.gov.au>, "Sarah McGuinness (DHHS)" REDACTED

Cc: DHHSOpSoteriaEOC <dhhsopsoteriaeoc@dhhs.vic.gov.au>, REDACTED (DHHS)" REDACTED Public Health Operations <publichealth.operations@dhhs.vic.gov.au>, "Simon Crouch (DHHS)" REDACTED

Date: Wed, 27 May 2020 17:17:53 +1000

Hi REDACT
I have just spoken with Sarah McGuinness, the Public Health Case Contact lead and she says it is needed tonight.

Now that we know that there were at least two of the security guards 'cleaning' the common areas, we cannot risk exposing the two nurses and MH nurse on the night shift. I have spoken with REDACTED and let him know the urgency to do it tonight.

You may also know that Channel 10 news was at the Rydges outside doing a live reporting.

Regards,
REDAC

REDACTED
REDACTED
Deputy Commander, Hotels
Operation Soteria

From: DJPR COVID Accom-Lead (DJPR) <DJPRcovidaccom-lead@ecodev.vic.gov.au>
Sent: Wednesday, 27 May 2020 5:01 PM
To: REDACTED Rydges Swanston (DHHS) <RydgesSwanston@dhhs.vic.gov.au>
Cc: DJPR COVID Accom-Lead (DJPR) <DJPRcovidaccom-lead@ecodev.vic.gov.au>; DJPR COVID Accom-Support (DJPR) <DJPRcovidaccom-support@ecodev.vic.gov.au>; DHHSOpSoteriaEOC <DHHSOpSoteriaEOC@dhhs.vic.gov.au>; REDACTED (DHHS)REDACTED
Subject: RE: Rydges - Outbreak requests for action

Hi REDA

See below, we have arranged a bioclean for Rydges. IKON cleaning will commence cleaning the Rydges hotel tomorrow morning.

REDACTED said it should take 1 day to clean all the common areas of the hotel after discussing this with REDAC (who knows the site) – 4 floors and the size of the hotel. They will send in a full crew and maybe a couple of additional staff to assist.

The instructions we have given them are cited below.

Regards
REDACTED

REDACTED
Operations Soteria (COVID-19)
DJPR Hotel Quarantine Agency Commander
djprcovidaccom-lead@ecodev.vic.gov.au

A / Executive Director Emergency Coordination and Resilience
Department of Jobs, Precincts and Regions
402 Mair Street Ballarat, Victoria Australia 3350
REDACTED
REDACTED

djpr.vic.gov.au

From: REDACTED (DJPR) REDACTED
Sent: Wednesday, 27 May 2020 4:48 PM
To: REDACTED REDACTED
Cc: REDACTED (DJPR) REDACTED ; REDACTED (DJPR) REDACTED ; REDACTED (DJPR) REDACTED
Subject: Confidential : IKON Clean required at Rydges
Importance: High

Hi REDACTED

Please see the list of areas the require a full 'bioclean' at Rydges on Swanston.

- Kitchen,
- Bathrooms
- Reception area
- Elevators
- Stairwells,
- Bannisters
- Offices
- Coffee machine
- Touch points etc. on all levels of the building
- Door knobs
- Shared chairs and desks
- And anything else that would be commonly used, on all floors.

Can you please provide this list to REDACTED.

Staff will still be on site tomorrow at the Rydges accommodating the needs of quarantine guests. Can REDACTED please ensure the cleaning crew works with staff on site to ensure safety and make staff areas a priority to clean first to enable staff to complete their tasks in a safe environment.

Also, it would be great if IKON could provide a quotation for this work. This will assist with future budgeting and auditing processes.

Thanks for your support and cooperation.

Regards

REDACTED
REDACTED
Project Officer – Accommodation Support
Operation Soteria
Department of Jobs, Precincts and Regions
REDACTED
REDACTED REDACTED
agriculture.vic.gov.au

AGRICULTURE VICTORIA

REDACTED
Operations Soteria (COVID-19)
DJPR Hotel Quarantine Agency Commander
djprcovidaccom-lead@ecodev.vic.gov.au

A / Executive Director Emergency Coordination and Resilience
Department of Jobs, Precincts and Regions
402 Mair Street Ballarat, Victoria Australia 3350
REDACTED
REDACTED

djpr.vic.gov.au

From: REDACTED
Sent: Wednesday, 27 May 2020 4:09 PM
To: Rydges Swanston (DHHS) <RydgesSwanston@dhhs.vic.gov.au>
Cc: DJPR COVID Accom-Lead (DJPR) <DJPRcovidaccom-lead@ecodev.vic.gov.au>; DJPR COVID Accom-Support (DJPR) <DJPRcovidaccom-support@ecodev.vic.gov.au>; DHHSOpSoteriaEOC <DHHSOpSoteriaEOC@dhhs.vic.gov.au>
Subject: FW: Rydges - Outbreak requests for action
Importance: High

Hi REDAC
Please note below. I am trying to contact DJPR who will be coordinating a deep clean in all the common areas as per recommendation below.

Please call me, thanks.

Regards,
REDA

REDACTED
Deputy Commander, Hotels
Operation Soteria

From: REDACTED (DHHS) REDACTED
Sent: Wednesday, 27 May 2020 3:51 PM
To: Sarah McGuinness (DHHS) REDACTED ; DHHSOpSoteriaEOC <DHHSOpSoteriaEOC@dhhs.vic.gov.au>
Cc: REDACTED Pam Williams (DHHS) REDACTED REDACTED (DHHS) REDACTED REDACTED (DHHS) REDACTED ; Simon Crouch (DHHS) REDACTED
Subject: Rydges - Outbreak requests for action
Importance: High

HiREDAC
Can please arrange for an immediate FULL "Bioclean" of Rydges in all common areas across the hotel (excluding quarantine / guest rooms):
This cleaning must include:
Elevators
Stairwells,
Bannisters
Offices

Coffee machine
Touch points etc.on all levels of the building

Can [redacted] please send through copies of rosters.
Please ensure security staff / Rydges staff are not wearing gloves and masks or using sub-optimal hand gel.

The Public Health Unit Case and contact lead is now: Sarah McGuinness[redacted]
The Rydges lead on site can be contacted on: (M) [redacted] (Either [redacted]
[redacted]
The DHHS Outbreak Squad Nurse lead is [redacted] (M) [redacted] – for advice on PPE

Thank you,
[redacted]
Covid Squad Coordination and Operations Director | Office of the Deputy Secretary
Public Health, Emergency Operations and Coordination
[redacted]
Department of Health and Human Services | 50 Lonsdale St, Melbourne VIC 3000

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.

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

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

Briefing for Finn

From: "Sarah McGuinness (DHHS)" REDACTED
To: REDACTED
Cc:
Date: Fri, 29 May 2020 15:58:55 +1000

Hi REDACTED,

Brief summary of the 4 Rydges cases is provided here:

	Case 1	Case 2	Case 3	Case 4
PHESS ID	320203450603	320203487846	320203509872	320203513656
Age/gender	REDACTED			
Symptoms?	Yes	Yes	No	No
Symptom onset date	25/05/2020	25/05/2020	Asymptomatic	Asymptomatic
Current location	Isolating at Rydges hotel	Isolating at home	Hotel accommodation arrangements in process	Isolating at home
Work role	REDACTED	Security	Security	Security
Last worked at Rydges	Night shift starting 23rd May	Night shift starting 23rd May	Night shift starting 26th May	Night shift starting 25th May
Swab date	25th May	26th May	27th May	27th May
Testing location	Monash Dandenong / Southern Cross Pathology	Box Hill Hospital / Eastern Health Pathology	GP / ACL	Epping Drive Through
Notification date	26th May	27th May	29th May	29th May

As discussed, we are in contact with the security company to get rosters for the above workers.
Case 1 works as REDACTED in lobby
Case 2 works on the floors of the hotel
Case 3 works on both the floors and in the lobby
Case 4 works on the floors of the hotel

All deny close contact with other workers during their shifts.

We are concerned that there is potentially environmental transmission based on:

- REDACTED 's involvement in cleaning duties, including the lift used to transport positive patients
- Use of masks and gloves that are non-standard (e.g. porous gloves) and lack of training in hand hygiene and PPE use
- Lack of routine cleaning & disinfection with agents that have antiviral activity in areas of hotel where staff work (cleaning products used in common areas & lifts are household variety products)
- No reported contact with confirmed cases.

Thus far, we have advised that everyone who has been on-site for 30 minutes or more since 11th May undergo testing for COVID. No staff have been identified as close contacts to date. We started providing advice this afternoon that staff who have worked at Rydges on Swanston since the 11th May (14 days before symptom onset in the first case) do not work elsewhere, unless they have not been on site in the past 14 days (i.e. since 15th May) AND have had a negative swab.

As discussed, there are probably four stages of action that we could consider in such a setting:
Stage 1 – active monitoring only
Stage 2 – test everyone but do not enforce restrictions
Stage 3 – testing PLUS cohorting of staff (i.e. say they can't work elsewhere for now) +/- designate certain people (e.g. overlapping shifts with a case during their infectious period) as close contacts
Stage 4 – designate everyone as close contacts and get in an entirely new workforce.

My current feeling is that we should go with Stage 3.

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

OFFICIAL: RE: Actions & Outcomes - Daily Outbreak IMT for 27 May 2020

From: REDACTED

To: REDACTED REDACTED REDACTED (DHHS)"
REDACTED REDACTED REDACTED
REDACTED
REDACTED
"Sarah McGuinness (DHHS)" REDACTED "Simon Crouch (DHHS)"
REDACTED EDACTED
REDACTED

Cc: REDACTED

"Kira Leeb (DHHS)" REDACTED
REDACTED

Date: Wed, 27 May 2020 14:24:07 +1000

Hi all,

Key actions and outcomes from today's Outbreak IMT stand-up below. Please let me know if I've missed or mischaracterised anything.

Outbreak IMT stand-up, 27 May 2020

1. 1. Updates were provided for the following outbreaks:
   Linden
   - Worksafe to be informed for all aged care outbreaks

   Hammond
   - Re-testing for all residents and staff on track for 28 May

   Villa Maria
   - Team to finalise email template for information to be provided to the facility, and incorporate this into our process guidelines
   - Note with facility that no-need to wait for daily check-ins to provide PH-related updates or emerging information on cases

   Kyabrum
   - REDAC finalising details in the report to the Minister
   - CEO putting together re-opening action plan, with DHHS consultation
   - No implications for re-opening for upstream or downstream contact tracing in this particular case

   Sunshine
   - Undertaking a PAG to determine potential case link to this outbreak

2. 2. REDA CTED will determine case counting process and procedure regarding outbreaks and report back

Cheers,

REDACTED
REDACTED
Program Manager, Public Health Command COVID-19
Department of Health and Human Services
Level 5, 2 Lonsdale St, Melbourne VIC 3000
m. REDACTED | **e** REDACTEREDACTED

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

Outbreak Management Team - Rydges on Swanston Outbreak

From: "Finn Romanes (DHHS)" [redacted]
To: "Finn Romanes (DHHS)" [redacted]
Date: Sat, 30 May 2020 11:08:44 +1000

Sarah McGuinness – Outbreak Team Lead

- [redacted]
- [redacted] – JIU, SCC
- [redacted]
- Finn Romanes
- [redacted]
- Merrin Bamert - Commander
- Meena Naidu
- Anthony Kolmus

New cases

- Six cases all exposures from 18 May 2020
  - One genomics result shows on first case: aligns with four cases who have been in [redacted] – suggesting from hotel environment not externally from somewhere into Victoria
- Hypothesis – acquired through workplace

Controls

- All staff tested from working on 11 May – 143 from yesterday
- Full clean required – DJPR / Merrin Bamert organising
- Unclear how it was acquired, and likely there is a common environmental source
- No clear single point source, manage environmental and close contact source
- High attack rate amongst security guards – suggests inappropriate PPE, not practising regular hygiene
- No new admissions and minimise movement outside room
- Clean, PPE, IPC from today
- Quarantine of staff who have entered the hotel on or after 18 May 2020
- Manage Marriott exposures – team; close contact assessment
- Finalise

Summary of actions – Rydges on Swanston

- Assessment
  - Complete interview of case that attended Marriott - CCOM
  - Chase genomics over the coming week
- Management
  - Cleaning – commercial cleaning [Operation Soteria / DJPR]
  - PPE training and discussion with security company management [Squad, CCOM]
  - Embed IPC lead from a health service – very important [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 of staff who attended from 18 May 2020 for 14 days from last exposure – Sarah to define clearly and agree with DPHC [CCOM]
    - Will involve a letter for quarantined persons
- Consequences
  - Emergency accommodation arrangements for cases – case 5 [DHHS Commander]
- Communication
  - Liaise with WorkSafe [CCOM]

Finn

Dr Finn Romanes
Public Health Commander
Novel Coronavirus Public Health Emergency
REDACTED
Department of Health and Human Services
State Government of Victoria

Rydges on Swanston - meeting summary, actions and communication

From: "Sarah McGuinness (DHHS)" <REDACTED

To: "Merrin Bamert (DHHS)" <REDACTED
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REDACTED
"Anthony J Kolmus (DHHS)" <REDACTED
REDACTED
<em.comms@dhhs.vic.gov.au>, "Euan Wallace (DHHS)"
REDACTED
REDACTED
<publichealth.intelligence@dhhs.vic.gov.au>, REDACTED
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

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 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

FW: key points from today's OMT meetings

From: Jason Helps (DHHS) [redacted]
To: Melissa Skilbeck (DHHS) [redacted] Pam Williams (DHHS) [redacted] Andrea Spiteri (DHHS) [redacted]
Date: Tue, 02 Jun 2020 17:04:12 +1000

From OMT today

Jason Helps – State Controller Health

Deputy Director Emergency Operations and Capability | Emergency Management Branch

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

[redacted] | e. [redacted]

www.dhhs.vic.gov.au | www.emergency.vic.gov.au | https://twitter.com/VicGovDHHS

From: [redacted]
Sent: Tuesday, 2 June 2020 4:55 PM
To: Jason Helps (DHHS) [redacted]
Subject: key points from today's OMT meetings

Hi Jason & co.,

Quick update on key points of interest from the OMT meetings today.

Rydges

- * Lots more training indicated for hotel and security staff on use of PPE, understanding of COVID-19 and COVID-19 etiquette etc. at Novotel (new COVID-19 positive hotel). Not ready to lift restrictions – **still considered high risk.**
- * It was flagged that Rydges hotel night shift staff had been using the same sofa and blankets when sleeping there at night.
- * Two positives (initially close contacts) are [redacted] – case contact tracing being completed with intel from [redacted]. Approx 20 known close contacts identified from [redacted]. Engagement with DoT/Commercial Passenger Vehicles discussed – took off-line with JIU [redacted] and supported reaching out to DoT, a) to give them a heads up (and we'll likely see more though won't be engaging them on detail or each case, all in hand with PH) – also b) opportunity to flag that case contact tracing is limited when [redacted] aren't booked via phone/app/on-line – known close contacts aren't necc a concern – it's the ones we don't know about - potential for sector to explore ways through messaging and/or systems to support the COVID-19 response from this angle?

Keilor Downs cluster

- * SEMC has arranged alternate accom for Family A [redacted] current positive members of the family to [redacted]) and Family B [redacted] to [redacted] – all to move today (total [redacted] pax)
- * Two more symptomatic members of Family B have been tested – expected to come back positive
- * Concerns around Family B isolation and potential exposure of others in apartment complex – DPH Commander considering risks of advising others in complex and identification of family involved.

I'm also linked into the daily **Aged Care OMT meetings** from tomorrow.

[redacted]

Department of Health & Human Services | Agency Commander

[redacted]

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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 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

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

Rydges OMT - follow-up with Op Soteria

From: REDACTED

To: REDACTED Public Health Intelligence <publichealth.intelligence@dhhs.vic.gov.au>, "SCC-Vic (State Intel Manager)" <sccvic.stateintelmgr@scc.vic.gov.au>, "DHHS EmergencyCommunications (DHHS)" <em.comms@dhhs.vic.gov.au>, REDACTED

REDACTED

REDACTED, "Sarah McGuinness (DHHS)" REDACTED

Cc: "Braedan Hogan (DHHS)" REDACTED, SCC-Vic (State Controller Health)" <sccvic.sctrl.health@scc.vic.gov.au>, "StateEmergencyManagementCentre SEMC (DHHS)" <semc@health.vic.gov.au>, "Jason Helps (DHHS)" REDACTED

Date: Mon, 08 Jun 2020 13:46:31 +1000

Hi team,

Further to the discussion at today's Rydges OMT, I have spoken to Merrin Bamert (Commander – Operation Soteria) and can confirm:

- There is no plan to move COVID-19 positive cases who are in the Novotel back into Rydges, or to resume using Rydges as a COVID-19 positive hotel
- Hotel Grand Chancellor Melbourne is being engaged and set up as the next (ongoing) COVID-19 positive hotel through Operation Soteria
- DHHS is taking on the contract with Hotel Grand Chancellor Melbourne (rather than DJPR)
- The Novotel and Hotel Grand Chancellor will be run concurrently until the COVID-19 positive cases who are currently in the Novotel have been cleared/finished their stay.
- It is anticipated that COVID-19 positive cases will be able to be placed in the Hotel Grand Chancellor from mid-late this week
- The outbreak squads should connect with Merrin Bamert/Pam Williams regarding the set-up of the Grand Chancellor. Merrin will also reach out to REDACTED

Hope this helps,

Kind regards,

REDACTED

Department of Health & Human Services | Agency Commander

REDACTED

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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

Stamford Hotel - update on actions re: family, contractors and staff

From: "Sarah McGuinness (DHHS)" REDACTED

To: REDACTED

Cc: REDACTED

Date: Wed, 17 Jun 2020 12:27:25 +1000

Attachments: Stamford Plaza advice on testing letter.pdf (255.6 kB); Copy of Staff Details - SPM.xlsx (14.02 kB); AO Master Roster 12 June to 20 June.xlsx (309.38 kB); Stamford Rosters - June 1 to June 16.xlsx (34.13 kB)

Hi REDACTED

I have sorted through the many emails that Simon REDACTED have forwarded to me and consolidated this information with the information provided by Merrin Bamert (Operation Soteria) and others.

Regarding the contractors & staff groups at the Stamford Hotel:

AOs (DHHS):

- The AO roster from 12-20 June is attached, we will need a roster going back to 1st June to identify people who need to be tested. Some staff (e.g. Team Leader) are included in the attached Stamford Roster - June 1 to June 16
- Steve Ballard (mobile REDACTED, email REDACTED appears to be the key contact (Commander, Enforcement and Compliance), Merrin has been communicating with him.

SECURITY:

- Contact person is REDACTED REDACTED at **MSS security** (REDACTED REDACTED, Merrin has been communicating with RED ACT
- The company subcontract to two other companies called "**The Security Hub (TSH)**" (REDA REDACTED or REDACTED and the "**Ultimate Protection Group (URM)**" (REDACTED
- Merrin Bamert (Op Soteria) has already notified REDACT who has in turn notified the other security companies (who has forwarded the above details)
- The case is employed by TSH and they have been in contact with RED ACT to check on REDA CTED wellbeing.

NURSING:

- The Alfred provide nursing support to the hotels – contact person is REDACTED REDACTE REDACTED I have spoken to REDAC this morning and sent RED the attached letter to distribute to the relevant staff. Still awaiting a staff list.
- YNA provide nursing support – no contact person identified to me yet
- SwingShift provide mental health nursing support – no contact person identified to me yet

MEDICAL:

- Medi7 is the GP group that provides medical support to quarantine hotels – contact person is REDACTED (email: REDACTED). I have spoken to REDA this morning and sent RED the attached letter to distribute to the relevant staff. Still awaiting a staff list.

STAMFORD PLAZA

- Contact person appears to be REDACTED REDACTED, at Stamford Plaza REDACTED REDACTED. There is also a REDACTED, Human Resources Business Partner, at Stamford Plaza (email: REDACTED REDACTED, mobile REDA REDACTE
- We have received the attached spreadsheet (Copy of Staff Details – SPM) with staff

members roles and contact phone numbers, but this does not have information on shifts worked.

HAIRDRESSING FACILITY
- Located on ground floor of hotel and accessed by public
- IPC nurse report advises that the clients use hotel bathroom facilities on L1 (crossover with staff?)
- Need to clarify movement of clients (e.g. entrance & overlap with hotel staff / facilities)

Regarding the family, I have looked through the PHESS notes and emails and identified the following sites of potential interest:

GP CLINIC
- REDA has contact the GP practice this morning and spoken to the practice manager REDACTE. The practice has a deep clean every 2 days. The GP states RE work PPE and the case was in the consultation room for <15 minutes (approx. 5-6 mins); no close contacts identified (case appropriately socially distanced in waiting room)

ST VINCENT'S HOSPITAL:
- Swabbed on 15 June, presumably at COVID-19 testing clinic
- Admitted to St Vincent's on 16 June (driven by REDA CTED
- REDA has spoken to Richmond from Infection Control team @ St Vincent's who confirms that case was isolated on admission and no public health actions have therefore been identified at St Vincents

EARLY FOUNDATIONS CHILDCARE CLIFTON HILL:
- Childcare drop-off only (2-3 min), unsure which days.

HOUSING ESTATE:
- Family lives in [redacted] ACTED Fitzroy REDACTED
- Listed occupants of apt RED are the REDACTED
- [redacted]
- No public health actions for now, unless case provides info re: contact with other residents
- The contact in the housing area of DHHS (North East Melbourne) is REDA CTED - REDACTED

SUPERMARKETS:
- Attended Coles & Woolworths Collingwood (?during infectious period) – both supermarkets have been contacted

In terms of testing, the attached letter has been approved by REDA and will be distributed to the appropriate contractors today. I've already sent it to the Alfred and Medi7 and will link in with Merrin to see who she has distributed it to REDACTED (Health & Wellbeing) has sent the letter and some information to COVID-19 testing sites (health services, community health, GP clinics and retail sites).

TRIM Folder = IIEF/20/2003
Index case = 320203630268

I'm still awaiting a call-back from Merrin Bamert to find out which of the above agencies she has contacted and provided the new letter to today.

I'm in the process of booking an OMT meeting for 2pm.

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 Plan – Stamford Plaza

PHESS ID: 320203632182

OMT Lead updated 25 June 23:20

Epi updated 19 July 10:30

Purpose

The purpose of this document is to provide an update on the current status and public health actions relating to the Stamford Plaza Outbreak.

Governance

Outbreak Management team

Functional role	Name:	Mobile No:	Email:
Outbreak Lead	Sarah McGuinness/REDACTED	REDACTED	REDACTED
Case and Contact Lead	REDACTED		
Epidemiology Lead			publichealth.intelligence@dhhs.vic.gov.au
Joint Intelligence Lead			
Communications and Media Lead			
Outbreak Squad Coordinator	REDACTED		
Administrative Support Officer	REDACTED		

Outbreak Management Team meeting dates

Tuesday 16 June (OMT Lead: Simon Crouch)

Wednesday 17 June at 2pm (OMT Lead: Sarah McGuinness)

Thursday 18 June at 2pm (OMT Lead: Sarah McGuinness)

Friday 19 June at 2pm (OMT Lead: Sarah McGuinness)

Saturday 20 June at 2pm (OMT Lead: Sarah McGuinness)

Sunday 21 June at 2:30pm (OMT Lead: REDACTED)

Monday 22 June at 2:30pm (OMT Lead: REDACTED)

Wednesday 24 June at 1:00pm (OMT Lead: REDACTED)

Thursday 25 June at 3:00pm (OMT Lead: REDACTED)

Friday 26 June at 3:00 pm (OMT Lead: Sarah McGuinness)

Sunday 28 June at 2:30pm (OMT Lead)

Wednesday 1 July at 1:00pm (OMT Lead REDACTED

Outbreak summary (Epi)

A total of **48** cases of COVID-19 have been notified to the department, 26 are in security guards at the hotel, one is a REDACT worker that works in the hotel, one is in a workplace close contact (interview pending, 19 are household contacts, one is an individual who completed their hotel quarantine and subsequently tested positive, and one is REDACTED who was exposed to this person. One case is linked to the REDAC Family Outbreak REDACTED and one case is likely household transmission (housemate of staff members). The first case notified to the department had a symptom onset of 15 June and this was identified by the department as a complex case on 16 June; this was upgraded to an outbreak on 18 June. A case notified to the department prior to Case 1, as part of the REDA Family Outbreak, was retrospectively linked to this outbreak following investigation REDACTED – and this is the only case included in both outbreaks as per discussions with OMT 16/7/2020. One case was admitted to ICU in REDACTE Hospital RE June but has since been discharged. The index case and RE family spent the night at the REDACTED and were discharged on 21 June (index case required rehydration). The cases related to the outbreak are currently isolating in hotel accommodation. There have been five cases admitted to hospital.

A total of 21 households are included in the outbreak. One case initiated a further outbreak at REDACT Aged Care REDACTED Two cases in Household 1 had links to the REDA Family Outbreak, one was linked to Stamford on July 4.

Variable	Value
Total Confirmed cases	48
Total active cases	6
Relationship to exposure site	Staff: 26
	Household: 18
	Other: 2
	Resident: 1
	Unknown: 1
Sex distribution	Female: 12; Male: 36
Age (median (range))	26.5 RED
Indigenous	Indigenous: 1; Non-Indigenous: 46; Unknown: 1
Date of first diagnosis	14 June 2020
Date of first symptom onset	10 June 2020
Date of most recent symptom onset	04 July 2020
Total hospitalisations	4
Current hospitalisations	0
Total ICU admissions	1
Current ICU admissions	0
Deaths	0
Presumptive first case	-
Close contacts (active)	572 (49)
Casual contacts (active)	90 (79)
Actions (high level)	-

Situation

The Stamford Plaza was operating as a mandatory quarantine hotel and is closed to the public. The index case[redacted] was notified to the department on 16 June in a contracted staff member (security guard) who worked at the Stamford Plaza hotel on Little Collins Street. The case did not attend work whilst symptomatic and was tested when they developed symptoms on 15 June. However, the case worked two shifts at the hotel during their infectious period on[redacted] June [redacted] The source of acquisition for this case is unknown.

The case lives with[redacted]. Their home situation is[redacted] children are [redacted] – they are well known to the DHHS child protection team. The primary carer is [redacted] and t[redacted] to have supervised contact. The[redacted] [redacted] attend childcare full time. They have no other family support available. The [redacted]. The parents are [redacted] require an interpreter.

Department outbreak control squad nurses visited the hotel site to assess the situation. They have advised that the hotel and security staff are not adequately educated in hand hygiene and PPE and their work is not visibly zoned for safe containment of COVID19 cases, suspected cases and quarantined close contacts. There is therefore a risk of fomite and person-to-person cross contamination. Face-to-face education to staff was provided.

Further cases were notified between 13 June and 18 July. The hotel remains closed.

Epidemiological and clinical investigation

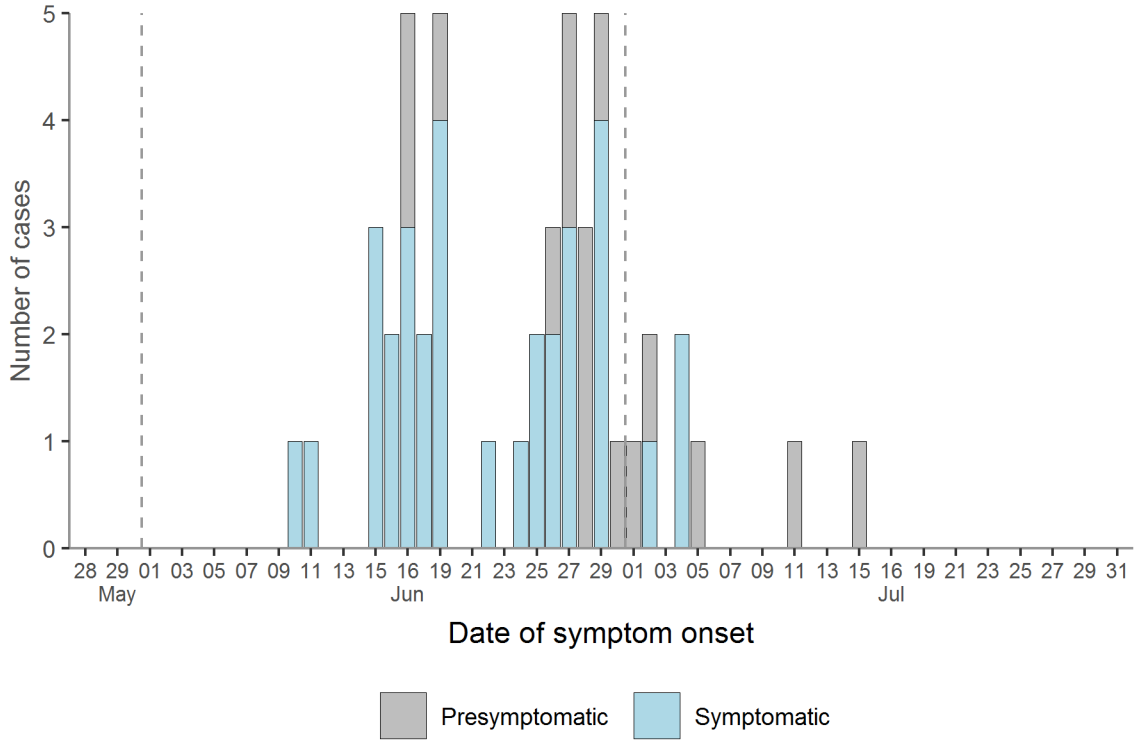


Figure 1: Epidemic curve for Stamford Plaza Outbreak by date of symptom onset* as of 17 July 2020

*for asymptomatic cases, calculated symptom onset date is used

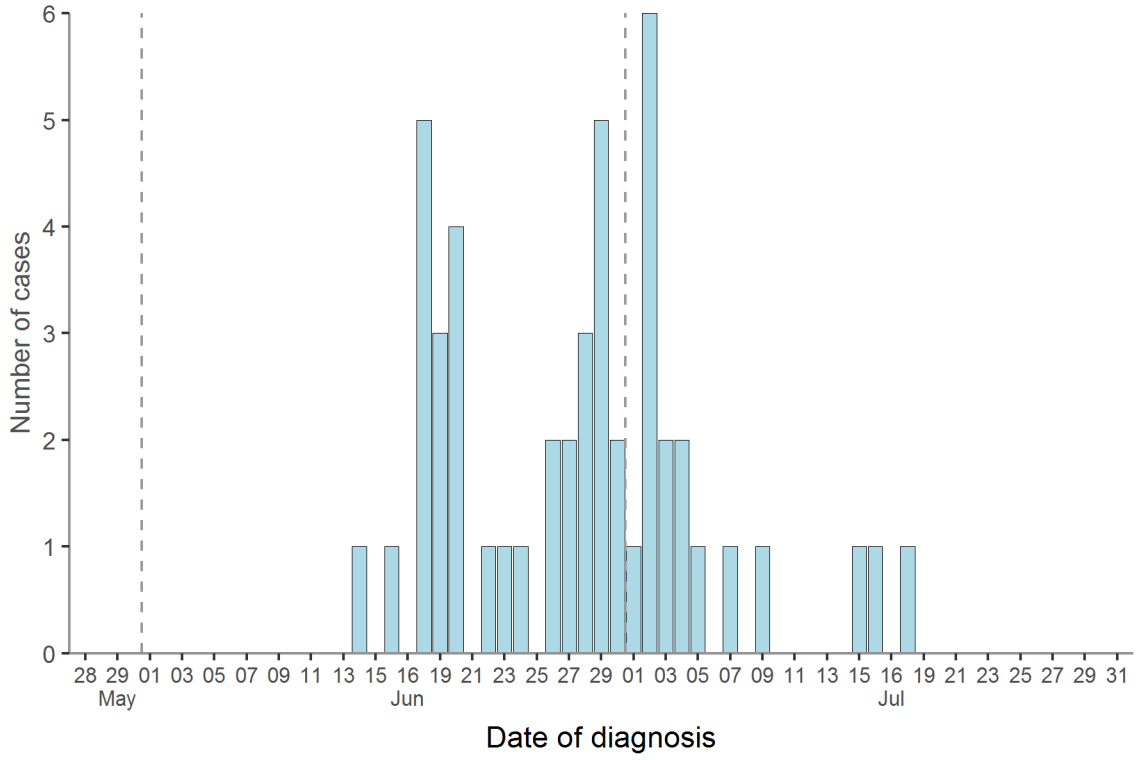


Figure 2: Epidemic curve for Stamford Plaza Outbreak by date of diagnosis as of 17 July

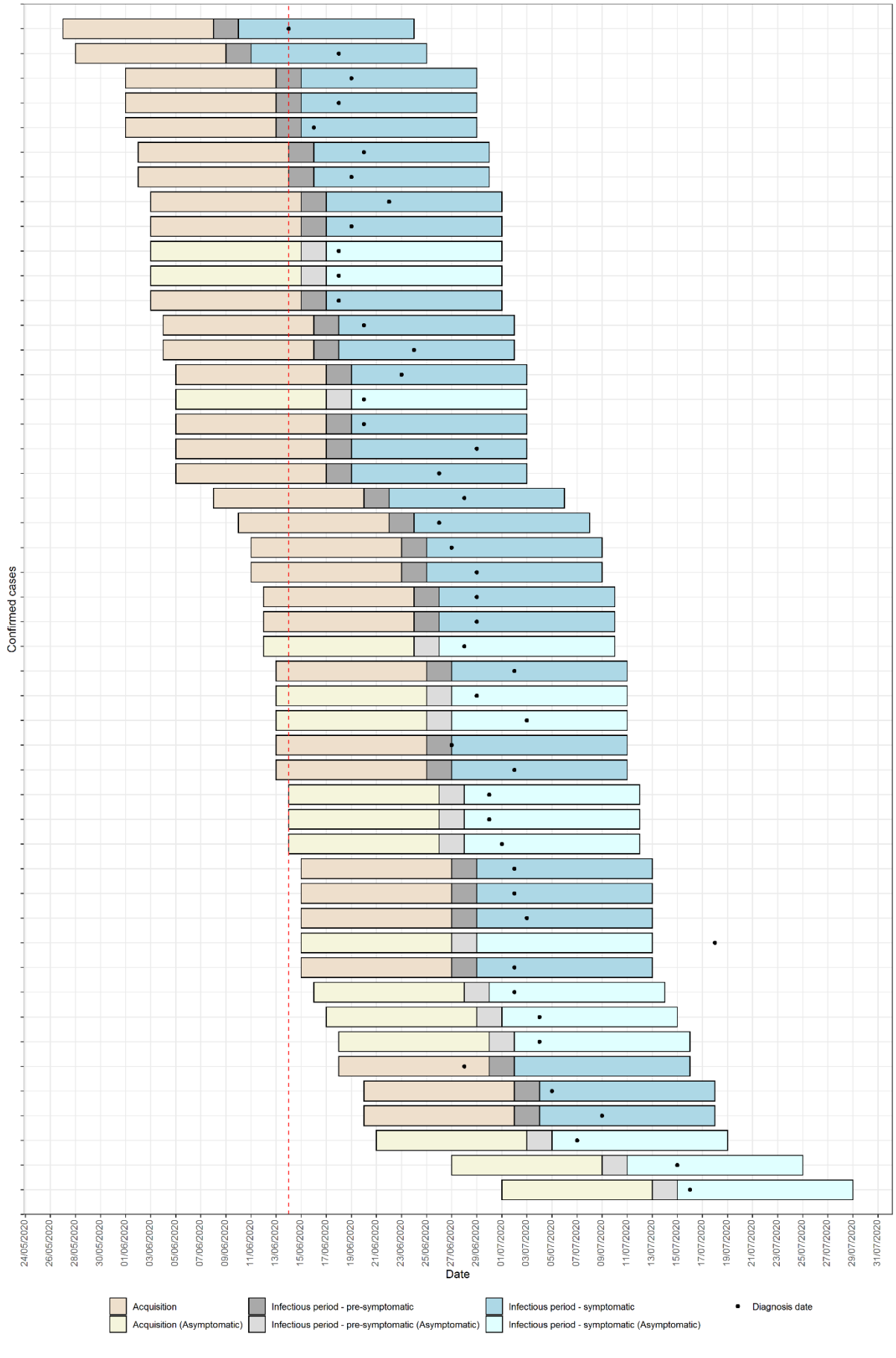

Confirmed cases
24/05/2020
26/05/2020
28/05/2020
30/05/2020
01/06/2020
03/06/2020
05/06/2020
07/06/2020
09/06/2020
11/06/2020
13/06/2020
15/06/2020
17/06/2020
19/06/2020
21/06/2020
23/06/2020
25/06/2020
27/06/2020
29/06/2020
01/07/2020
03/07/2020
05/07/2020
07/07/2020
09/07/2020
11/07/2020
13/07/2020
15/07/2020
17/07/2020
19/07/2020
21/07/2020
23/07/2020
25/07/2020
27/07/2020
29/07/2020
31/07/2020
Date
Acquisition
Acquisition (Asymptomatic)
Infectious period - pre-symptomatic
Infectious period - pre-symptomatic (Asymptomatic)
Infectious period - symptomatic
Infectious period - symptomatic (Asymptomatic)
Diagnosis date

Figure 3: Onset date and incubation period for confirmed cases, Stamford Plaza Outbreak

Case definitions

Current COVID-19 case definition

A confirmed case who has attended the Stamford Hotel on or after 1 June 2020 or is linked to this site through known exposure to a confirmed case who has attended this site.

Outbreak case definitions

Confirmed case: A person tested positive for COVID-19 with an epidemiological link to Stamford Plaza or a confirmed case of this outbreak, with symptom onset (or infectious period) on or after 1 June 2020 (14 days prior to symptom onset of earliest confirmed case).

Close Contact: A person with 15 minutes (cumulative) face-to-face contact, or two hours in an enclosed area with a confirmed case of the Stamford Plaza outbreak on or after 13 June 2020 (two days before symptom onset in the primary case).

In this setting close contacts at risk of infection include

- All staff members and contractors who spent 30 minutes or more at the Stamford Plaza Hotel from Monday 8 June to Wednesday 17 June inclusive are considered close contacts and are being advised to quarantine for a period of 14 days.
- External (non-work, e.g. household, family) close contacts of confirmed cases.

Casual Contact: A person who does not meet the close contact definition but for whom actions are being undertaken.

In this setting casual contacts include

- Staff who were not on those shifts or only worked prior to 11 June with a negative test
- If they have worked on later shifts, are not close contacts (not at risk) and returned a negative test

Epidemiological Link: any person who attended the Stamford Plaza (not as a resident detainee) for longer than 30 minutes on or after 1 June OR a contact of a confirmed case that is part of the Stamford Plaza outbreak.

Close contacts

All staff members and contractors who spent 30 minutes or more at the Stamford Plaza Hotel from Monday 8 June to Wednesday 17 June inclusive are considered close contacts and are being advised to quarantine for a period of 14 days. The total number of exposure site contacts at Stamford Plaza is ~440 including:

- RED security guards
- R DJPR staff
- R Swingshift staff
- RE DHHS staff
- RE hotel staff
- RE YNA nurses
- R Dnata staff
- R Medi7 staff

- [redacted] AOs
- [redacted] Alfred Health nurses (NB: Alfred Health managing these staff)

For the Park Royal, there are ~ 77 identified close contacts:

- MSS Security [redacted]
- YNA nurses - [redacted]
- Swingshift nurses - [redacted]
- DHHS AOs- [redacted]
- DHHS TL – [redacted]
- Alfred- no close contacts identified
- Medi 7- no close contacts identified
- DNATA [redacted]
- Park Royal Hotel staff- no close contacts
- DJPR- still awaiting contact list

Environmental investigation

Department outbreak control squad nurses have visited the Stamford Plaza Hotel site to assess the situation on 16 June and 17 June.

Observations include:

- Alcohol based hand rub scattered over floors in hotel, readily available and visible
- Hand-rub signage posted on floors, not laminated
- Separate team access to bathrooms (Nursing, Security Staff)
- Some security staff wearing masks on floors
- Clinical waste bins were not available on every floor
- Some general waste observed outside hotel rooms
- Independent Hairdressing facility located on ground floor of hotel which is accessed by the public. Proprietor reports [redacted] clients use hotel bathroom facilities on level 1
- Appropriate physical distancing of security staff in staff area
- Nursing staff feeling unsupported with several issues (including supply of masks, increased workload due to COVID-19 testing, insufficient phone points for screening calls)
- Security staff reporting some gaps in knowledge for hand hygiene and PPE, and are unsure what to do when staff report symptoms consistent with COVID-19
- Nurses and PCAs are reportedly wearing full PPE whenever they go to a room of a guest in quarantine or isolation.

Assessment indicates that there is a risk of fomite and person-to-person cross contamination.

Education of staff was conducted at the site.

A site visit by the Outbreak Squad occurred for the Park Royal Hotel. Cleaning at this site was completed on 22 June.

Genomic Investigation

Request:

On 22 June, the department requested genomic analysis of isolates from cases associated with this outbreak. At this point there were 12 cases associated with the outbreak. A list of 13 COVID-19 positive cases identified in the hotel was also provided to MDU for comparison, their details are below in the table.

Analysis was requested to identify if isolates from cases epidemiologically linked to the outbreak cluster genomically together; and also if these sequences cluster with any sequences from positive detainees at the hotel or those reporting recent overseas travel. If the latter were true, it would support the hypothesis of transmission occurring within the hotel from returned travellers in isolation to staff.

Additionally, a case was identified that was epidemiologically associated with both the Stamford Plaza Outbreak and the Hallam Family Outbreak. Genomic analysis was requested to identify if this case had genomic links to both outbreaks and if they cluster with sequences from cases reporting recent overseas travel. Analysis could support the theory of the source of infection being the case associated with the Hallam Family Outbreak and not from overseas returnees.

Diagnosis Date	PHESS	Age group	Sex	Country of origin
13/05/2020	320203272619	REDACTED		REDACTED
15/05/2020	320203159072			
27/05/2020	320203488762			
04/06/2020	320203543220			
04/06/2020	320203543316			
11/06/2020	320203597559			
12/06/2020	320203603442			
14/06/2020	320203619528			
15/06/2020	320203624264			
15/06/2020	320203624265			
16/06/2020	320203625844			
16/06/2020	320203626373			
16/06/2020	320203626374			

Table showing details for positive cases identified in overseas returnees at the Stamford Plaza Hotel

Results:

As of 13 July, MDU has provided information on the genomic links to the Stamford Plaza Hotel Outbreak. There are sequences from 44 cases that link to form two distinct but closely related genomic clusters that include sequences from cases associated with the Stamford Plaza Hotel.

The first genomic cluster includes sequences from 18 cases. This includes 11 cases associated with Stamford Plaza, seven from the Hallam Family Outbreak (one case is associated with both Stamford Plaza and Hallam Family 320203619599) and one case that reports recent overseas travel to

REDACTED The case reporting recent travel was in hotel detention as of 11 June at Stamford Plaza after travelling with REDACTE who reports an earlier symptom onset, but we are yet to have sequence data available for her. This cluster is distinct from but closely related to a sequence in a returned traveller from REDACTED who was in hotel isolation commencing 1 June.

The other genomic cluster contains sequences from 26 cases. This includes 16 from cases associated with Stamford Plaza (including the case that had completed their hotel detention and subsequently tested positive and th REDACTED at drove this case home), six associated with the Hugo Boss Outbreak, two associated with the REDACTE (one case is associated with both Hugo Boss and M REDACT ED) and three cases that reported recent overseas travel and were completing their isolation in the hotel. Of the three cases reporting recent travel, two were from REDACTED and one was from REDACT ED The two cases from REDACTED were travelling REDAC and commenced hotel isolation at the Stamford Plaza Hotel on 11 June. The case from REDACT was in hotel isolation commencing 26 June at a different hotel (The Brady Hotel) and reports a symptom onset of 29 June. It is unclear what epidemiological link this case has to the outbreak.

Genomic analysis suggests that cases associated with the Stamford Plaza Outbreak were introduced to the hotel via returned travellers from overseas. There is genomic evidence of transmission within the hotel.

Hypothesis

Control measures

- 16 June: All staff members and contractors who spent 30 minutes or more at the Stamford Plaza Hotel between Monday June 1 (14 days prior to symptom onset in the case) and Wednesday 17 June have been asked to undergo testing for COVID-19 as soon as possible
- 17 June: A deep clean of the Stamford Hotel commenced at 1pm
- 17 June: Staff members and contractors who spent 30 minutes or more at the Stamford Plaza Hotel on Saturday 13 June and/or Sunday 14 June are now considered close contacts and are being advised to quarantine for a period of 14 days. This includes all staff and contractors who worked day, afternoon or night shifts on Saturday 13 June and all staff and contractors who worked day or afternoon shifts on Sunday 14 June. It also includes security staff who worked the night shift on Sunday 14 June.
- 17 June: Staff members and contractors who spent 30 minutes or more at the Stamford Plaza Hotel between Monday June 1 and Wednesday 17 June but did not work on Saturday 13 June OR Sunday 14 June are considered exposure site contacts. These staff may return to work if they can provide evidence of a negative test result on or after 17 June 2020. Staff should be advised to be aware of COVID-19 symptoms. If they develop any symptoms, they should be advised not to attend work and to seek further testing.
- 18 June: All staff members and contractors who spent 30 minutes or more at the Stamford Plaza Hotel from Monday 8 June to Wednesday 17 June inclusive are considered close contacts and are being advised to quarantine for a period of 14 days.
- 22 June: All staff and contractors who spent 30 minutes or more at the Park Royal Hotel between 18:35 on 16 June and 07:00 on 17 June are considered close contacts. Additionally, all staff who attended the level 5 staff room used by security personnel on 17 June are considered close contacts.
- 22 June: A deep clean of the Park Royal Hotel was completed.

Stakeholder mapping

Authorised officers (DHHS):

- Key contact: Steve Ballard - Commander, Enforcement and Compliance; [redacted]
  [redacted]

Security:

- Key contact: [redacted]
  [redacted]
- [redacted]
-

Stamford Plaza Hotel:

- [redacted]

Your Nursing Agency (YNA)

- [redacted]

SwingShift (mental health nurses)

- [redacted]

Alfred Hospital (nursing staff)

- [redacted]

Medi7 GPs:

- [redacted]

DJPR:

- [redacted]

Operation Soteria

- Key contact: Merrin Bamert, Pam Williams

Hairdressing facility:

- Key contact: REDACTED

Child Protection Services (Relevant for Case 1)

- REDACTED

Issues/risks:

Relating to populations and transmission

Relating to control measures and contact tracing

Relating to communication about the outbreak

Concerns have been raised about potential transmission risk to guests who have been staying in hotel quarantine, as 'fresh air breaks' have been allowed with individuals accompanied by security guards:

- Guests who require fresh air breaks are recorded in CWMS database – data can be accessed by REDACTED from COVID-19 Enforcement and Compliance and his team
- There are no records of which security guards accompany the guests on their breaks/walks
- According to hotel guest register data:
    - 61 guests arrived on 21 May and departed on 4 June
    - 46 guests arrived on 22 May and departed on 5 June
    - 55 guests arrived on 23 May and departed on 6 June
    - 88 guests arrived on 25 May and departed on 8 June
    - 40 guests arrived on 31 May and departed on 14 June
    - 60 guests arrived on 7 June and due to depart on 21 June
    - 208 guests arrived on 11 June and due to depart on 25 June
- On 20 June, plan discussed to send SMS 'pushes' out to guests following departure to hotel prompting them to seek testing in the event of symptoms

Risk communication

Key messages – general public

Media lines for release on 19 June:

“Four new cases have been detected in security contractors at the Stamford Plaza Hotel, which hosts returned overseas travellers in quarantine. This takes the number of cases in this outbreak to six.

As a result of the exhaustive and detailed contact tracing efforts of the department, a link has been discovered between the Stamford Plaza cases and a case in what is now known as the Hallam family outbreak. An adult associated with the Hallam outbreak had previously worked as a security contractor at the hotel, which was revealed to the department only yesterday.

The investigation into these cases is ongoing and all public health actions are being taken, including further contact tracing and deep cleaning.

The department has reinforced the need for infection control procedures to be followed at all times to protect contractors, staff and guests at the hotel.

This was done yesterday when the outbreak control team made another site inspection at the hotel.”

Timeline of outbreak

Date	Action
16 June	Case 1 notified to DHHS
16 June	PAG held and OMT stood up • Decision made to ask all staff who spent 30 min or more on site between 1 June and 16 June to seek COVID-19 testing
17 June	OMT meeting #2 • Decision made to quarantine all staff who worked overlapping shifts with the case during RE infectious period (all staff on day and night shift 13 June; all staff on day shift 14 June, security staff on night shift 14 June)
17 June	Deep clean of Stamford Hotel conducted
18 June	OMT meeting #3
20 June	Case 11 and 12 notified to the department, first household contact external to the facility notified.
21 June	OMT meeting #4
21 June	Case 14 notified to the department
22 June	OMT meeting #5
22 June	Deep clean of Park Royal Hotel conducted
24 June	Case 15 and 16 notified to the department
25 June	Case 17 linked to the outbreak (this case was notified on 22 June)
26 June	Case 18 and 19 notified to the department OMT meeting #6
27 June	Cases 20, 21 and 22 notified to department
28 June	Cases 23 and 24 notified to department OMT meeting #7
29 June	Cases, 25, 26, 27, 28 and 29 notified to department
30 June	Cases 30 and 31 notified to department
1 July	Case 32 notified to department. OMT meeting #8
2 July	Case 33, 34 and 35 notified to department
4 July	Additional 7 cases notified
15 July	Case 47 notified
18 July	Case 48 notified

OMT meeting actions list

Line list

Exposure PHESS ID: 320203632182

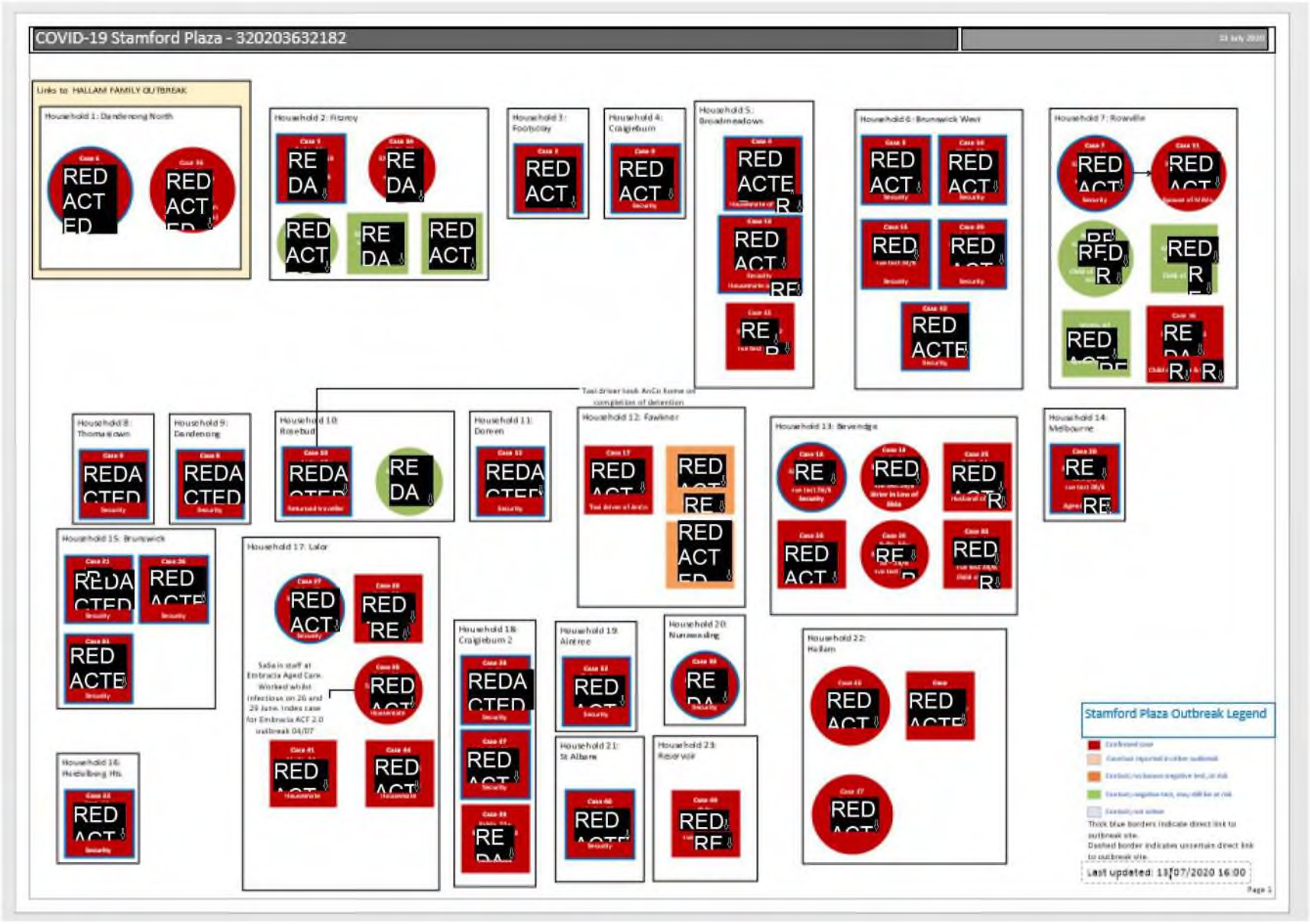
This outbreak is linked to the Halam family though the REDACTED case (320203619599). RE is therefore included in both outbreak s RED contacts are not included here but are in the Hallam Family Outbreak (320203632182). Please check PHESS before entering new IDs as several Hallam Family IDs are marked to note not to link to this Stamford outbreak to avoid double counting.

Case	PHESS ID	Age Group	Sex	Onset Date	Diagnosis Date	Clinical Status	Cluster Link
48	320203821036	REDACTED	REDACTED	NA	2020-07-18	Under investigation	Other
47	320203643137			NA	2020-07-15	Under investigation	Unknown
46	320203847248			NA	2020-07-16	Under investigation	Household
45	320203659232			2020-07-04	2020-07-09	Well, isolation complete	Household
44	320203847222			NA	2020-07-07	Well, isolation complete	Household
43	320203967543			2020-07-04	2020-07-05	Well, isolation complete	Household
42	320203650594			NA	2020-07-04	Well, isolation complete	Staff
41	320203847199			NA	2020-07-04	Well, isolation complete	Household
40	320203650558			NA	2020-07-03	Well, isolation complete	Staff
39	320203847200			2020-06-29	2020-07-03	Well, isolation complete	Household
38	320203544104			2020-06-27	2020-07-02	Under investigation	Household
37	320203556318			2020-06-29	2020-07-02	Well, isolation complete	Household
36	320203676037			NA	2020-07-02	Well, isolation complete	Staff
35	320203847614			2020-06-27	2020-07-02	Well, isolation complete	Household
34	320203847624			2020-06-29	2020-07-02	Well, isolation complete	Household
33	320203872729			2020-06-29	2020-07-02	Home isolation	Household
32	320203650549			NA	2020-07-01	Well, isolation complete	Staff
31	320203659366			NA	2020-06-30	Home isolation	Staff
30	320203797824			NA	2020-06-30	Well, isolation complete	Household
29	320203650560			2020-06-25	2020-06-29	Well, isolation complete	Staff
28	320203650586			NA	2020-06-29	Well, isolation complete	Staff
27	320203650600			2020-06-19	2020-06-29	Well, isolation complete	Staff
26	320203797679			2020-06-26	2020-06-29	Well, isolation complete	Household
25	320203797716			2020-06-26	2020-06-29	Well, isolation complete	Household
24	320203650567			2020-07-02	2020-06-28	Well, isolation complete	Staff
23	320203650569			2020-06-22	2020-06-28	Well, isolation complete	Staff
22	320203659363			NA	2020-06-28	Well, isolation complete	Staff
21	320203650548			2020-06-27	2020-06-27	Well, isolation complete	Staff
20	320203757700			2020-06-25	2020-06-27	Well, isolation complete	Household
19	320203650568			2020-06-19	2020-06-26	Well, isolation complete	Staff

Case	PHESS ID	Age Group	Sex	Onset Date	Diagnosis Date	Clinical Status	Cluster Link
18	320203775646	REDACTED	REDACTED	2020-06-24	2020-06-26	Well, isolation complete	Household
17	320203650539			2020-06-18	2020-06-24	Well, isolation complete	Staff
16	320203687634			2020-06-19	2020-06-23	Well, isolation complete	Household
15	320203695610			2020-06-17	2020-06-22	Well, isolation complete	Other
14	320203659159			2020-06-18	2020-06-20	Well, isolation complete	Staff
13	320203669993			2020-06-16	2020-06-20	Well, isolation complete	Household
12	320203672507			2020-06-19	2020-06-20	Well, isolation complete	Staff
11	320203682536			NA	2020-06-20	Well, isolation complete	Staff
10	320203532956			2020-06-16	2020-06-19	Well, isolation complete	Resident
9	320203661419			2020-06-17	2020-06-19	Well, isolation complete	Staff
8	320203669007			2020-06-15	2020-06-19	Well, isolation complete	Staff
7	320203635486			2020-06-11	2020-06-18	Well, isolation complete	Staff
6	320203655225			2020-06-17	2020-06-18	Well, isolation complete	Staff
5	320203655226			2020-06-15	2020-06-18	Well, isolation complete	Staff
4	320203655227			NA	2020-06-18	Well, isolation complete	Staff
3	320203655972			NA	2020-06-18	Well, isolation complete	Staff
2	320203630268			2020-06-15	2020-06-16	Well, isolation complete	Staff
1	320203619599			2020-06-10	2020-06-14	Well, isolation complete	Staff

Case demographics summary

		N	Perc %
Total		**48**	**100**
Sex	Female	12	25
	Male	36	75
	Unknown	0	0
Age group	0-9	3	6.2
	10-19	2	4.2
	20-29	25	52.1
	30-39	10	20.8
	40-49	2	4.2
	50-59	6	12.5
	60-69	0	0
	70-79	0	0
	80-89	0	0
	90+	0	0
Indigenous status	Indigenous	1	2.1
	Non-Indigenous	46	95.8
	Unknown	1	2.1
Clinical status	Admitted, not known to be in ICU	0	0
	Admitted to ICU	0	0
	Home isolation	2	4.2
	Hospital in the home	0	0
	Deceased	0	0
	Well, isolation complete	42	87.5
	Not recorded	4	8.3


COVID-19 Stamford Plaza - 320203632182
Links to HALLAM FAMILY OUTBREAK
Household 1: Dandenong North
Household 2: Fitzroy
Household 3: Footscray
Household 4: Craigieburn
Household 5: Broadmeadows
Household 6: Brunswick West
Household 7: Rowville
Household 8: Thomastown
Household 9: Dandenong
Household 10: Rosebud
Household 11: Doreen
Household 12: Fawkner
Household 13: Bevendale
Household 14: Melbourne
Household 15: Brunswick
Household 16: Healesville Hts
Household 17: Lalor
Household 18: Craigieburn 2
Household 19: Aintree
Household 20: Nunawading
Household 21: St Albans
Household 22: Hallam
Household 23: Reservoir
Stamford Plaza Outbreak Legend
Last updated: 18/07/2020 16:00

Add additional information below

Shifts worked by staff cases at Stamford Plaza *discrepancies between shifts reported for NaKa between PHESS notes (day shift) and roster (night shift)

Date	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6	Case 7	Case 8	Case 9	Case 12	Case 13
Details	REDACTED										
	320203630268	320203655972	3202036552	320203655226	320203655225	320203635486	320203619599	320203669007	320203661419	320203672507	
	REDACTED										
Role	Security	Security	Security	Security	Security	Security	Security	Security	Security	Security	
Sx onset	15/06/2020	Asymp: test 17/06/2020	Asymp: test 17/06/2020	15/06/2020	17/06/2020	15/06/2020	10/06/2020	17/06/2020	17/06/2020	19/06/2020	
1 June	REDACTED										
2 June											
3 June											
4 June											
5 June											
6 June											
7 June											
8 June											
9 June											

10 June	REDACTED									
11 June										
12 June										
13 June										
14 June										
15 June										
16 June										
17 June										
18 June										

*text in red denotes shifts worked during infectious period (i.e. from 48 hours prior to symptom onset or test date for asymptomatic cases)

FW: Interim report on Stamford from outbreak squad nurses

From: REDACTED REDACTED
To: "Merrin Bamert (DHHS)" REDACTED, "Pam Williams (DHHS)" REDACTED "Sarah McGuinness (DHHS)" RED
Cc: REDACTED (DHHS)" REDACTED REDACTED
Date: Wed, 17 Jun 2020 13:59:27 +1000

Hi all, REDACTED is our Outbreak Squad Lead for Stamford.
REDA

From: REDACTED <REDACTE REDACTED
Sent: Wednesday, 17 June 2020 1:52 PM
To: REDACTED
Cc: A
Subject: Interim report on Stamford

Stamford Hotel on Little Collins St_ Key concerns from IPC visit 17/06/20_ REDACTED

1. The staff of this hotel and MSS security staff are not adequately educated in hand hygiene and PPE.
2. Their work is not visibly readily zoned for safe containment of COVID19 cases, suspected cases and quarantined close contacts.

Problem: Complex case/Outbreak
An REDACTED who last worked on REDACTED tested positive (result 16/6/20)

Security Guards who all attended a gathering on 70 people including now confirmed cases need to be assessed for possible exposure and quarantined and all be instructed in PPE and hand hygiene

Apart from R MSS security guards sent home R /5/20; at time of visit nobody knew their exposure status because letter for staff from DHHS had not been distributed.

Recommendation: Contain case(s) by containing security staff

Individuals
- Case & Contact will find close contacts asap.Advise case and contact to look broadly within hotel staff
- Educate new staff in hand hygiene and PPE and recognition clean and dirty zones.

Contain security guard room
- IPCON IPC advised General Manager to distribute the letter asap.
- Teach security appropriate handwashing and PPE use
- Coffee machine should be removed from Security Guard room until further notice
- Food service to security guard room needs to be all disposable nothing should go back to the kitchen

Problem: Risk of fomite and person to person cross contamination: Security Guard room to room housing Nursing PCA & DHHS staff.

Today I saw REDACTED DHHS officer- inside security guard room handling paperwork with REDACTED before returning to room with Nursing PCA and DHHS staff.

Recommendation: Keep DHHS PCA Nurses area clean

- If the Green room with Nursing PCA and DHHS staff is to stay clean no security guards including head of security should enter it

- Elevators need to be divided into clean a dirty or chlorine wiped after every use
- Nothing should go from any room back to the kitchen

Nurses and PCAs
Reportedly are wearing full PPE whenever they go to a room of a guest in quarantine or isolation but that needs to be checked.

Recommendation: Keep Stanford contained
- Do not send staff from one hotel to another.
- For example AO from DHHS was AO at Novotell yesterday.

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
M: REDACTED
E: REDACTED

Outbreak Management team meeting

Date & Time: 2:00pm Wednesday 17 June 2020

Outbreak Name / Setting: Stamford Plaza

Purpose of Meeting: Daily update

Attendees: Braedan Hogan, REDACTED Merrin Bamert, REDACTED Sarah McGuinness, Simon Crouch, REDACTED Jason Helps, REDACTED REDACTED

Action list

Date allocated	Action	Responsible person	Due date	Date Completed
17/06/2020	Contact head of microbiology at the testing lab – find out specifics of the test result for the case	REDAC Sarah / REDACTED	17/06/2020	
17/06/2020	Conduct an offline discussion to confirm arrangements for the case's [redacted] children	Braedon / REDACTED	17/06/2020	
17/06/2020	Support communication with the family regarding accommodation based on outcome of above discussion	REDACTED	17/06/2020	
17/06/2020	Follow up DET for translated hygiene training / communications which can be shared with security staff and affected families	REDACTED	17/06/2020	
17/06/2020	Prepare comms for DHHS staff who attended Stamford Plaza and send to Merrin	Sarah / Simon	17/06/2020	
17/06/2020	Review Rydges comms for guests, modify as required, and start distribution / translation	REDACTED Sarah	17/06/2020	
17/06/2020	Schedule next OMT meeting for 18/06/2020	Sarah	17/06/2020	
17/06/2020	Schedule outbreak squad visit to Stamford	REDACTED	17/06/2020	
17/06/2020	E-mail Simon and Sarah with proposal for Stamford staff attendance this afternoon	Merrin	17/06/2020	

Notes

Situation:

- Single case – security guard working at the Stamford Plaza
  - 15/06/2020 symptom onset
  - Worked 13/06/2020 and 14/06/2020 REDACTED at Stamford Plaza
    - Floor by floor movements are not known by the employer – the hotel may have this information
  - CCOM have not been able to contact the case today
  - Case's RE has not been answering the phone
  - The case is still at St Vincent's, as are immediate family members (REDACTED all of whom are household contacts)
  - Family members have been swabbed today at St Vincent's
    - All [redacted] returned negative results
    - REDACTE have runny noses
  - R other close contact has been identifies so far through work: contacted and quarantining
- The security roster has not been received yet – this will determine many of the other contacts
  - First names only have been given for potential contacts at this point in time – the CCOM team are unable to start to contact these persons with this information only

Risks:

- Early morning security team meetings take place daily with overlapping shifts (day and night) in a 6x6m room
- Case definition: the following definitions are in place until further investigation of contacts has been completed
  - Anyone who worked an overlapping shift will need to be considered as a close contact in the short term; this includes:
    - All staff on day shift 13/06/2020
    - All staff on night shift 13/06/2020
    - All staff on day shift 14/06/2020
    - Security staff on night shift 14/06/2020
    - Night shift on 12/06/2020 is NOT included as this was prior to the infectious period for the case, which was conservatively designated as 13/06/2020
- Areas of concern at Stamford:
  - Guards have a room that they sit in which was allegedly not used by DHHS staff, however DHHS staff have been observed in hat room to process paperwork
  - Elevators are shared
  - Some bathrooms are shared
  - Security members also go into DHHS room
- If we can confirm that security aren't going into shared service areas (i.e. the kitchen) then we can exclude people working in those areas from close contacts
  - Breakfast services are delivered to the rooms; it is unclear if trays and their contents are then returned directly to the kitchen
  - Staff delivering meals will be designated close contacts until proven otherwise
- Staff who attended work outside of infectious period and return negative test results can return to work
  - This includes staff who worked prior to 13/06/202, and people who worked on 15, 16, or 17/06/2020
  - Testing for these people is for acquisition for the case, rather than transmission from the case
- Getting the case's REDACTED to understand needs of quarantine will be challenge (low medical literacy)

Control Measures:

- Commercial cleaning started 1pm today; this will take a long time to complete
- Testing for staff: all who worked since 1/06/2020 are recommended for testing
    - This can be done at any COVID testing centre
    - Letters have been sent out to all contractors (security, YNA Wingsihft, Alfred, DJPR, DHHS, hotel)
- Outbreak squad feedback:
    - Understanding of clean/dirty areas and hygiene practices are low among security staff
    - "Creative" use of masks has been noted; glove use is OK
    - Alcohol based hand sanitiser has been made available but is not seen to be used often
    - Further PPE and hygiene education needs to be provided for security staff, but also hotel staff
        - Outbreak squads have developed training packages
        - DET have developed messages in many languages which can be shared
        - REDA language is spoken by the family – resources have previously been developed and translated by DPC – these should be used

Comms:

- The hotel was named earlier today
- Comms for commission housing have been contacted to spread hygiene messaging
- Strong community groups exist in the REDACTED
- No comms have gone out to guests at the Stamford Plaza yet
    - There are about 240 guests
    - Language requirements are not yet clear
    - Fact sheets should be prepared as a priority and slid under all doors – in English first, then translated as appropriate
- Comms need to go out to DHHS staff who have been on site

Other Issues:

- This afternoon and this evening's shifts are severely impacted as testing is still progressing
    - A duty manager is required; one duty manager has not worked since Thursday 11/06/2020
        - Provided that this person is asymptomatic, we can permit that individual to return to work this afternoon
    - An REDAC has been living in hotel in a room as RE is concerned about spreading the virus to RE family; this REDACT can provide support this afternoon / this evening if required
    - Stamford's GM is negotiating with the CEO in Sydney to potentially fly down staff to keep hotel working (with DHHS support)
- REDACTED


REDACTED

Outbreak Management team meeting

Date & Time: 2:00pm Friday 19 June 2020

Outbreak Name / Setting: Stamford Plaza Outbreak

TRIM reference: IIEF/20/2003

Purpose of Meeting: Daily update

Attendees: REDACTED Merrin Bamert, REDACTED Pam Williams, REDACTED Sarah McGuinness, REDACTED

Action list

Date allocated	Action	Responsible person	Due date	Date Completed
17/06/2020	Contact head of microbiology at the testing lab – find out specifics of the test result for the case	REDACTED Sarah / REDACTED	17/06/2020	
17/06/2020	Follow up DET for translated hygiene training / communications which can be shared with security staff and affected families	REDACTED	17/06/2020	
17/06/2020	Prepare comms for DHHS staff who attended Stamford Plaza and send to Merrin	Sarah / Simon	17/06/2020	
~~**18/06/2020**~~	~~Schedule next OMT for tomorrow~~	~~Sarah~~	~~18/06/2020~~	17/06/2020
~~**18/06/2020**~~	~~Investigate REDACTED – is this person linked to another outbreak setting?~~	~~Sarah~~	~~18/06/2020~~	17/06/2020
18/06/2020	Follow up the existing case for details of movements in/around his home building	CCOM	20/06/2020	
~~**18/06/2020**~~	~~Organise SCC relief cell / City of Melbourne to provide toys / etc for the case's family (there is nothing in the Quest townhouse and this will make caring for the children difficult for the case)~~	REDACTED	~~18/06/2020~~	17/06/2020
19/06/2020	Provide an update on alternative accommodation arrangements for close contacts and cases	REDACTED	19/06/2020	
19/06/2020	Provide an update on cleaning		19/06/2020	
19/06/2020	Contact Child Protection to determine a contingency plan for children of RED		19/06/2020	
19/06/2020	Schedule next OMT for the same time 20/06/2020	Sarah	19/06/2020	

Notes

Situation:

- 2 additional cases
  - Both are [redacted]
  - Both carpool with the [redacted] known [redacted] cases
  - Interviews are still going – no further info at present
  - 1 had symptom onset 17/06/2020
  - The other was en route to hospital
- Alternative accommodation arrangements are in train for many of the new cases and close contacts
- In total there are 7 cases associated with the [redacted] family and 8 associated with the Stamford Plaza outbreak – both figures include the security guard linked to both settings (see "Risks" section)
  - At this stage they need to be treated as separate outbreaks due to great distance between them and single link
  - Discussion will take place later on regarding merging of outbreaks if the link between settings will be confirmed

Risks:

- The link between the security guard case and the [redacted] outbreak setting has been confirmed – [redacted] (contacted through the other outbreak setting) confirmed that [redacted] works as a [redacted] and has worked at Stamford Plaza, but didn't give full details
  - At the initial interviews with this family through the other outbreak setting, everybody said that nobody in the family was employed
  - This [redacted] had symptom onset on 10/06/2020, worked 2 days prior to onset, and worked 4 days with symptoms
  - The period of risk at the hotel is now to be considered as 8/06/2020 to 17/06/2020; this has been communicated to Operation Soteria and all relevant contractors

Hypothesis:

- The [redacted] linked with another outbreak setting (with symptom onset [redacted]/06/2020, which was earliest of all cases in this outbreak setting) may have acquired COVID from the hotel setting
- The virus may have been brought into the family setting by this case and infected family members including the [redacted]
  - Last contact with the [redacted] was 8/06/2020
  - Genomics are to be used to support this hypothesis by comparing virus in the security guard against the virus from cases in guests within the Stamford Hotel

Control Measures:

- Significant issues relating to cleaning
  - Deep clean still not done
  - Proper disinfectants have not been used
  - The outbreak squad are now are talking to the team leader
  - The understanding of clean vs dirty is very very poor
  - Fresh air breaks were taking place for guests – these have been put on hold again
  - The team of cleaners onsite are the same ones that have been there the whole time
  - Spotless are cleaning the positive hotel – we can ask them to clean Stamford Plaza as well
  - There is a general lack of understanding of the process and the products that are suitable for completion of a deep clean. [redacted] team are working to rectify this. The endorsed cleaning guide has been sent back out to [redacted] for implementation.

Comms:

- Media lines that went out today made the link between the Hallam outbreak and this outbreak
- Annaliese Van Diemen will speak directly to Monash CEO and IPC lead to convey this information, and that a link will be made in media today

Other Issues:

- REDA complex family situation (REDACTED with supervision requirements)
  - Symptoms have progressed and will likely need hospitalisation
  - St Vincent's Hospital in the Home visited to review RE DA condition
  - It has been determined that RE DA needs hospitalisation
  - Child Protection need to be contacted to determine a contingency plan for the children
- New staff have been located to run the hotel
  - The only person suitable as a trainer is someone identified as close contact
    - This person is asymptomatic and has had a negative test
    - Arrangements have been made for training to take place with physical distancing, PPE, and IPC support
    - DJPR have supported this proposal
- Media are parked up outside the hotel; unfortunately we can't tell them to move as it's public space but this impacts the fresh air policy and breaches privacy if guests are let out

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Other Hotel Issues

- There has been a new case identified linked to Rydges
  - This is a close contact of the REDACTED RED ACTE who recently went to QLD (who was a close contact of a case)
  - This person is now in quarantine
- Next meeting this time tomorrow

Outbreak Management team meeting

Date & Time: 2:30pm Monday 22 June 2020

Outbreak Name / Setting: Stamford Plaza Outbreak

TRIM reference: IIEF/20/2003

Purpose of Meeting: Daily update

Attendees: REDACTED Merrin Bamert, REDACTED REDACTED Braedan Hogan, REDACTED Pam Williams, REDACTED

Action list

Date allocated	Action	Responsible person	Due date	Date Completed
17/06/2020	Contact head of microbiology at the testing lab – find out specifics of the test result for the case	REDACTED Sarah REDA	17/06/2020	
17/06/2020	Follow up DET for translated hygiene training / communications which can be shared with security staff and affected families	DHHS Comms	17/06/2020	
~~**17/06/2020**~~	~~Prepare comms for DHHS staff who attended Stamford Plaza and send to Merrin~~	~~Sarah / Simon~~	~~17/06/2020~~	22/06/2020
18/06/2020	Follow up the existing case for details of movements in/around his home building	CCOM	20/06/2020	
19/06/2020	Provide an update on alternative accommodation arrangements for close contacts and cases	REDACTED	19/06/2020	
19/06/2020	Provide an update on cleaning		19/06/2020	
~~**19/06/2020**~~	~~Contact Child Protection to determine a contingency plan for children of~~ REDACTED		~~19/06/2020~~	22/06/2020
~~**19/06/2020**~~	~~Schedule next OMT for the same time 20/06/2020~~	~~Sarah~~	~~19/06/2020~~	20/06/2020
22/06/2020	Contact Park Royal for details of the common areas that security staff use	REDACTED	22/06/2020	
22/06/2020	draft e-mail to DJPR accommodation lead requesting CCTV footage (including what is required and in what spaces)		22/06/2020	
22/06/2020	Investigate potential crossover of security staff and other staff, and current cleaning practices		22/06/2020	

Notes

Situation:

- There are now 14 confirmed cases linked to this setting

    - The most recent case was notified last night: a security guard who worked during their acquisition (but not infectious) period
    - This case is a housemate of another Stamford security guard who is a case
    - The case also worked 1 night during their infectious period at the Park Royal Hotel
- Park Royal Hotel:
    - About 15 people identified as close contacts – mainly security staff
        - Still waiting for some contacts' info to come through from the hotel
    - A letter should have gone out to all staff at the Park Royal last night
    - Affected security staff asked to self isolate
    - The case allegedly had no interactions with staff from other areas of the hotel
    - A brief handover conversation takes place with 6-8 other security employees
    - The outbreak squad observed security at Park Royal as being well separated from other staff (especially on night shift)
    - Consensus: close contacts are all security staff who worked on 16 and 17/06/2020
    - We can broaden the definition of close contacts to include anyone who worked the same shift or was part of a handover on the preceding / following shifts
- A large number of staff members have not received test results from 17/06/2020
    - It is unclear whether YNA or other nurses completed testing
    - DHHS are working with VDRL to get results
    - Some people went to their own providers; the letter for contacts that would have enabled expedited testing went out too late and were not available at the time many went to respiratory clinics
- REDACTED
    - RED REDACTED
        - Friday – just RED due to deterioration in presentation
        - Saturday – deterioration in RED and RE spouse – both hospitalised
    - All were transported to Northern on Saturday for overnight admission
    - RED was tested again and returned another negative result, and was discharged back to Quest
    - The family are in better health today and are back at REDA CTED

Control Measures:

- An additional clean will take place at Park Royal at 1pm today

Other Issues:

- YNA staff have been available 24/7 (until Sunday) to support REDACTED
    - This included coordinating with ambulances for the Saturday hospitalisation
    - There were significant delays and stress throughout the process for the family and the YNA staff
- REDACTED

CONFIDENTIAL DHHS employee case - linked to Stamford Plaza

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 "Melissa Skilbeck (DHHS)" REDACTED Sarah McGuinness (DHHS)"

Date: Wed, 01 Jul 2020 23:50:59 +1000

Dear Annaliese and Brett

We have been notified today of a case who is a DHHS employee and has worked as an REDACTED at the Stamford Plaza

The case has been in home quarantine since 17 June 2020 due to exposure to the Stamford Plaza on 13 June 2020. The case also worked at the Park Royal on 16 June 2020.
RED tested positive on day 11 swab – RE is asymptomatic.
ACT has two household contacts and is moving to hotel accommodation to isolate.

The team will link in with the AO leadership team tomorrow to support comms and management of the case.

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 | REDACTED
w. www.dhhs.vic.gov.au | he/him

Outbreak Management team meeting

Date & Time: 2:00pm Thursday 18 June 2020

Outbreak Name / Setting: Stamford Plaza Outbreak

Purpose of Meeting: Daily update

Attendees: REDACTED, Breadan Hogan, Sarah McGuinness, REDACTED REDACTED Naomi Bromley, REDACTED Merrin Bamert, REDACTED REDACTED

Action list

Date allocated	Action	Responsible person	Due date	Date Completed
17/06/2020	Contact head of microbiology at the testing lab – find out specifics of the test result for the case	REDAC Sarah / REDA	17/06/2020	
~~**17/06/2020**~~	~~Conduct an offline discussion to confirm arrangements for the case's~~REDACTED	~~Braedon /~~ REDACTED	~~17/06/2020~~	17/06/2020
~~**17/06/2020**~~	~~Support communication with the family regarding accommodation based on outcome of above discussion~~	REDA CTED	~~17/06/2020~~	17/06/2020
17/06/2020	Follow up DET for translated hygiene training / communications which can be shared with security staff and affected families	REDA CTED	17/06/2020	
17/06/2020	Prepare comms for DHHS staff who attended Stamford Plaza and send to Merrin	Sarah / Simon	17/06/2020	
~~**17/06/2020**~~	~~Review Rydges comms for guests, modify as required, and start distribution / translation~~	REDACTE D ~~Sarah~~	~~17/06/2020~~	17/06/2020
~~**17/06/2020**~~	~~Schedule next OMT meeting for 18/06/2020~~	~~Sarah~~	~~17/06/2020~~	17/06/2020
~~**17/06/2020**~~	~~Schedule outbreak squad visit to Stamford~~	REDACT	~~17/06/2020~~	17/06/2020
~~**17/06/2020**~~	~~E-mail Simon and Sarah with proposal for Stamford staff attendance this afternoon~~	~~Merrin~~	~~17/06/2020~~	17/06/2020
18/06/2020	Schedule next OMT for tomorrow	Sarah	18/06/2020	
18/06/2020	Investigate REDACTED – is this person linked to another outbreak setting?	Sarah	18/06/2020	
18/06/2020	Follow up the existing case for details of movements in/around his home building	CCOM	18/06/2020	
18/06/2020	Organise SCC relief cell / City of Melbourne to provide toys / etc for the case's family (there is nothing in the REDA townhouse and this will make	REDACT ED	18/06/2020	

	REDACTED			

Notes

Situation:

- Info received from VDRL 7 mins ago: there are 3 positives from this morning's run
  - All are security guard contractors
  - More info to come – formal notification to the department has not been received yet
- There are 242 names on the security contractor's list but not clear who worked what dates
- RE guards carpool – one of these persons is a positive case REDACTED (positive). Others are REDACTED (awaiting result) and REDACTED (awaiting result) – all live in REDACTED is not on the list from VDRL.
- Existing case:
  - Family have been relocated to a REDACTED
  - The case is still symptomatic
  - The family are still asymptomatic
  - All are doing OK
  - Case's visit to the childcare centre: dropped kids off, on site 1-2mins only, no contact with staff members
  - The existing case worked on every floor during shifts when he was infectious
  - The existing case also attended 2 meetings – 12/06/2020 evening (approx. 20mins), and 13/06/2020 morning (approx. 20mins) – there awere reported to be up to 130 people attended
- Close contacts identified so far:
  - Approximately 40 nursing staff
  - Approximately 8 AOs
  - Hotel staff still being confirmed
- Going forward it will be best for the contact team to deal directly with contractor groups
  - A template or guidance about exactly what they need is usually provided but was not given to Merrin
- Samples have been requested to be couriered to VDRL
  - Some people got tested before getting letters and therefore are going to take a while to find in the system
- Each of the contractors will need to keep track of their own staff; text message can be used to show that they're clear to return to work. We won't contact individuals who are not close contacts with results but we can share with contractors.

Risks:

- No action is required at the childcare centre where the existing case dropped off RE DA children duye to only being on site for 1-2 minutes and having no interactions with staff
- CCOM need to follow up the case for details of his movements around his home building
-

Control Measures:

- Outbreak squad visit: arrived 4:30 yesterday
  - Cleaning not done as expected – poor PPE practices – rectified by outbreak nurses
  - New cleaners organised today
  - Originally directed only to complete high touch services
  - Cleaning was grossly insufficient
  - Bathrooms were not done
  - Elevators were not done
  - IPC nurses had to complete cleaning for elevators and bathrooms

    - The company has been decontracted
- Testing is planned to take place at the case's public housing residence:
    - Directive from [redacted]: organise onsite testing at [redacted] public housing (symptomatic testing only)
    - The team are currently on site and will stay for a few days
    - Posters etc being put in place to reinforce key messaging

Comms:

- Comms did not go to Stamford guests yesterday due to the requirement for the DPC bunker to review comms
    - EM comms approved the document this morning; it has been sent to the hotel, they should have placed copies under everyone's doors
    - Only the English version has been passed on so far - translation is taking place and is hoped to be completed tomorrow
- There is no need to communicate to tenants of the case's building that a case has been found in in a resident

Other Issues:

- Operations of hotel are compromised by staffing issues – close contacts being contacted to ensure that people can return asap
    - If people did not work on 13-14/06/2020 and a negative result is available, they can return to work. This includes persons who worked on or after 15/06/2020 but this may change based on further test results.
- Request made for other services to help the family (toys, colouring books for kids etc); SCC relief cell / City of Melb council can provide this

Outbreak Management team meeting

Date & Time: 1:00pm Wednesday 24 June 2020

Outbreak Name / Setting: Stamford Plaza Outbreak

TRIM reference: IIEF/20/2003

Purpose of Meeting: Daily update

Attendees: REDACTED Merrin Bamert, Pam Williams, REDACTED

Action list

Date allocated	Action	Responsible person	Due date	Date Completed
17/06/2020	Contact head of microbiology at the testing lab – find out specifics of the test result for the case	REDACTED Sarah RED[illegible]n	17/06/2020	
~~**17/06/2020**~~	~~Follow up DET for translated hygiene training / communications which can be shared with security staff and affected families~~	~~DHHS Comms~~	~~17/06/2020~~	
~~**18/06/2020**~~	~~Follow up the existing case for details of movements in/around his home building~~	~~CCOM~~	~~20/06/2020~~	
~~**19/06/2020**~~	~~Provide an update on alternative accommodation arrangements for close contacts and cases~~	REDACTED	~~19/06/2020~~	
~~**19/06/2020**~~	~~Provide an update on cleaning~~		~~19/06/2020~~	
~~**22/06/2020**~~	~~Contact Park Royal for details of the common areas that security staff use~~		~~22/06/2020~~	
~~**22/06/2020**~~	~~draft e-mail to DJPR accommodation lead requesting CCTV footage (including what is required and in what spaces)~~		~~22/06/2020~~	
~~**22/06/2020**~~	~~Investigate potential crossover of security staff and other staff, and current cleaning practices~~		~~22/06/2020~~	
24/06/2020	Follow up the hotel for CCTV footage	REDACTED	24/06/2020	
24/06/2020	Organise offline discussion regarding cleaning contracts and establishment of performance monitoring.	Merrin	25/06/2020	
24/06/2020	Deliver IPC training at Park Royal	REDACTED	25/06/2020	
24/06/2020	Next meeting to take place 25/06/2020 – send invite		24/06/2020	

Notes

Situation:

- 1 new case notified this morning
    - We have not been able to contact this person yet – this is hoped to take place this afternoon
    - RE[redacted] was a close contact of a known case
    - Worked for MSS (security) at Stamford Plaza REDACTED
    - Has not worked at Park Royal
    - Currently checking whether RE[redacted] has worked elsewhere
    - Has previously reported symptoms and was tested negative (fever and dry throat since 16/06/2020, tested negative 17/06/2020)
    - In isolation since 19/06/2020
- The new case has no major impact on current outbreak management plans
- Contact tracing – 14 outstanding from Stamford Plaza
- Majority of test results have been provided to Stamford staff
    - Phone calls should be provided to staff (not just a text message) to manage the relationship, which has been damaged by delays in test results
- Park royal close contacts:
    - Day 11 testing only
    - Park Royal is not being treated as a separate outbreak site to Stamford Plaza
    - Acquisition is believed to be through household contacts who work at Stamford / Park Royal

Other Issues:

- Park Royal is still operating
    - A deep clean has been completed
    - Staffing is not an issue
    - A large number of new guests are due to arrive today – it needs to be confirmed whether these guests should enter Park Royal, or if other accommodation arrangements are required
        - Agreement has been reached in this meeting: new guests are OK to continue being accepted at Park Royal
    - Staff areas don't have someone designated to cleaning and/or are "difficult to clean" on a regular basis due to large number of staff present
        - Concerns about confidential information being visible to cleaning staff have also been raised

Outbreak Management team meeting

Date & Time: 3:00pm Thursday 25 June 2020

Outbreak Name / Setting: Stamford Plaza Outbreak

TRIM reference: IIEF/20/2003

Purpose of Meeting: Daily update

Attendees: REDACTED Merrin Bamert, Pam Williams, REDAC REDACTED

Action list

Date allocated	Action	Responsible person	Due date	Date Completed
17/06/2020	Follow up genomics of the REDACTED d who links with the Hallam family cluster	REDA / Sarah / REDA	17/06/2020	
~~**24/06/2020**~~	~~Follow up the hotel for CCTV footage~~	REDACTED	~~24/06/2020~~	25/06/2020
24/06/2020	Organise offline discussion regarding cleaning contracts and establishment of performance monitoring.		25/06/2020	
24/06/2020	Deliver IPC training at Park Royal		26/06/2020	
~~**24/06/2020**~~	~~Next meeting to take place 25/06/2020 – send invite~~		~~24/06/2020~~	25/06/2020
25/06/2020	Confirm whether REDACTED REDACTED is reported in this outbreak setting as well as the Hallam family cluster		25/06/2020	
25/06/2020	Coordinate / follow up engagement with Health and Wellbeing to identify a suitable health service (perhaps linking with community care or GPs) that can support the family (emergency, paediatric, and maternity care)		26/06/2020	
25/06/2020	Review th REDACTE case for potential links to this setting		26/06/2020	

Notes

Situation:

- 1 or 2 new cases since last meeting
- Now up to 16 cases in total – the only overlap with the REDA case reported in these numbers is the s REDACTED who is a family member of the REDA family (RED RED
    - There is still an open question about the direction of transmission between Hallam and Stamford

    - Genomics have been delayed due to a machine failure
- Case 15 had worked at Stamford only for 14 days in a row (during the acquisition period)
    - This case has been in isolation in provided accommodation since 17/06/2020
    - This person went out for a cigarette break during isolation with another close contact; the other close contac has had their isolation start date reset
- Case 16 is a child and household contact
    - Exposed to REDA and REDA REDACTE RED)
    - Asymptomatic positive
    - Has not attended childcare since 15/06/2020 – no exposure at that site
    - No new close contacts from this case
    - R other household members were tested yesterday – results are pending
    - We are satisfied with their isolation activities – there are 4 bathrooms and 5 bedrooms R E REDACTED
- Contact tracing:
    - Total close contacts at Stamford: 421; all should have been e-mailed and received a letter
        - 11 still require a phone call
    - Total close contacts at Park Royal: 77; the majority have been contacted
    - CCOM are following up DJPR to check whether anyone was onsite at Park Royal in the period of concern
- 1 REDACTE is symptomatic and test results are pending
    - Accommodation has been provided
- Park Royal reviewed CCTV footage from the night of 16-17/06/2020
    - It has been established that no Park Royal staff from front of house or level 5 interacted with the case or went up to the levels that were exposed; they are therefore not considered close contacts
- Park Royal have started accepting new transit guests
- A REDACT case who went to Stamford has unknown acquisition
    - He also picked up a passenger from Pan Pac hotel
    - He has a number of contacts from Stamford and other quarantine hotels
- NZ case – no apparent links to known cases in Victoria

Other Issues:

- REDACTED

Outbreak Management team meeting

Date & Time: 3:00pm Friday 26 June 2020

Outbreak Name / Setting: Stamford Plaza Outbreak

TRIM reference: IIEF/20/2003

Purpose of Meeting: Daily update

Attendees: REDACTED Pam Williams, Sarah McGuinness, REDACTED

Action list

Date allocated	Action	Responsible person	Due date	Date Completed
17/06/2020	Follow up genomics of the REDACTED who links with the Hallam family cluster	REDACTED	17/06/2020	
24/06/2020	Organise offline discussion regarding cleaning contracts and establishment of performance monitoring.		25/06/2020	
24/06/2020	Deliver IPC training at Park Royal		26/06/2020	
~~**25/06/2020**~~	~~Confirm whether REDACTED security guard working at REDACTED is reported in this outbreak setting as well as the Hallam family cluster~~		~~25/06/2020~~	26/06/2020
~~**25/06/2020**~~	~~Coordinate / follow up engagement with Health and Wellbeing to identify a suitable health service (perhaps linking with community care or GPs) that can support the family (emergency, paediatric, and maternity care)~~		~~26/06/2020~~	26/06/2020
~~**25/06/2020**~~	~~Review the taxi driver case for potential links to this setting~~		~~26/06/2020~~	26/06/2020
26/06/2020	Prepare messaging for agencies regarding staff return to work conditions		26/06/2020	

Notes

Situation:

- There are 17 cases in total including 1 hotel quarantine, 1 taxi driver, 2 household contacts, and 13 security guards
- The newest case was identified in the last 24 hours
  - A REDACTED who took a previously linked case (a quarantine guest) from the Stamford on 14/06/2020 for a 1 hour 20 minute journey to Rosebud
  - The traveller had negative day 3 and day 11 tests
  - The traveller developed symptoms 2 days after leaving the hotel (16/06/2020)

    - The[redacted] developed symptoms 17/06/2020
    - Close contact tracing: need to review the questionnaire to confirm whether this case worked while infectious
    - There is no intention to make the occupation of this case public
- Contact tracing is largely complete for both Stamford and Park Royal
    - About 4 or 5 outstanding
    - All are people who have not been answering phones
- Day 11 testing: the last of the people in infectious periods will end over the weekend

Comms:

- Close contacts on the site: the existing contacts team will be following these people up to ask whether they've been for testing, if they have their result, and to issue the end of quarantine letter
- Messaging for affected agencies will go out:
    - If your staff are close contacts, if they have a letter from DHHS and have a negative test they can return to work
    - Cases will receive letters but do not require end of isolation tests

Other Issues:

- Risks around use of [redacted] for hotel quarantine exit are to be discussed, however the view of PH representatives is that this is a unique situation:
    - The traveller who was in quarantine has somehow been infectious at exit
    - The [redacted] ride was exceptionally long

Outbreak Management Team meeting

Date & Time:	2:30pm Sunday 28 June 2020
Outbreak Name / Setting:	Stamford Plaza Outbreak
TRIM reference:	IIEF/20/2003
Purpose of Meeting:	Daily update

Attendees: REDACTED Braedan Hogan, REDACTED REDACTED

Action list

Date allocated	Action	Responsible person	Due date	Date Completed
17/06/2020	Follow up genomics of the REDACTED who links with the Hallam family cluster	REDACTED	17/06/2020	
24/06/2020	Organise offline discussion regarding cleaning contracts and establishment of performance monitoring.		25/06/2020	
24/06/2020	Deliver IPC training at Park Royal		26/06/2020	
26/06/2020	Prepare messaging for agencies regarding staff return to work conditions		26/06/2020	
28/06/2020	Follow up quarantining status of the 3 new cases		28/06/2020	
28/06/2020	URGENT: confirm to RED and REDAC whether the DHHS nurse case was quarantined from 17/06/2020 or 19/06/2020 – if not immediate action required		28/06/2020	
28/06/2020	Confirm status of day 11 letters and testing for close contacts from this setting		29/06/2020	

Notes

Situation:

- Total: 20 cases
- 3 new cases in the last 24 hours
  - 1 new case is a security guard
  - 1 new case is a household contact REDACTED
  - 1 is a REDA nurse
- Status of quarantine of the 3 new cases is unclear at present – were they put in quarantine as close contacts on 17/06/2020 or 19/06/2020?
  - Security guard believed to already be in quarantine
  - Nurse and household contact unclear – RE to confirm by end of today to REDACTED
    - Decanting will be required urgently if it's a nurse from a new cohort

- Day 11 has passed for many close contacts (even those with later last exposure dates)
    - Status of letters and testing needs to be confirmed

Other Issues:

- If new cases are from existing close contacts, we need to confirm what this means for isolation requirements for other close contacts

Outbreak Management Team meeting

Date & Time:	1:00pm Wednesday 1 July 2020
Outbreak Name / Setting:	Stamford Plaza Outbreak
TRIM reference:	IIEF/20/2003
Purpose of Meeting:	Daily update

Attendees: REDACTED
RED, Braedan Hogan, REDACTE, Braedan Hogan

Action list

Date allocated	Action	Responsible person	Due date	Date Completed
~~**17/06/2020**~~	~~Follow up genomics of the REDACTED who links with the Hallam family cluster~~	REDACTED ~~Sarah / RED ACTE~~	~~17/06/2020~~	1/07/2020
~~**24/06/2020**~~	~~Organise offline discussion regarding cleaning contracts and establishment of performance monitoring.~~	~~Merrin~~	~~25/06/2020~~	1/07/2020
~~**24/06/2020**~~	~~Deliver IPC training at Park Royal~~	REDACTED	~~26/06/2020~~	1/07/2020
~~**26/06/2020**~~	~~Prepare messaging for agencies regarding staff return to work conditions~~	~~Sarah~~	~~26/06/2020~~	1/07/2020
~~**28/06/2020**~~	~~Follow up quarantining status of the 3 new cases~~	REDACTED	~~28/06/2020~~	1/07/2020
~~**28/06/2020**~~	~~URGENT: confirm to REDACTED whether the DHHS nurse case was quarantined from 17/06/2020 or 19/06/2020 – if not immediate action required~~		~~28/06/2020~~	1/07/2020
~~**28/06/2020**~~	~~Confirm status of day 11 letters and testing for close contacts from this setting~~		~~29/06/2020~~	1/07/2020
1/07/2020	Discuss with Simon – how can translation activities be built into OMT plans?		1/07/2020	
1/07/2020	Forward PHESS details of the case admitted to hospital to REDACTE		1/07/2020	
1/07/2020	Discuss with VicPol – can check-ins be made to close contacts as part of Operation Sentinel?	Braedan	1/07/2020	

Notes

Situation:

- 31 cases confirmed in total
    - Many identified through day 11 testing and through household contacts therefore most new cases are not expected to require significant contact tracing

    - One case is a healthcare worker who worked at a REDACTED Clinic
        - This is linked to the North Melbourne outbreak
- Many staff have already gone for day 11 testing but this is a large cohort (approx. 500 people)
    - We have asked employers to insist on provision of return-to-work test results before permitting staff to take on shifts
- A case has been admitted to ICU today

Risks:

- There are reports of security guards who have been told to go into quarantine applying to work at other security companies
    - 104 indiviuduals related to the Stamford outbreak have applied for hardship payments; these payments require that they do not perform any work during the period
    - Use of Soprano / Whispr messaging to reiterate quarantine requirements to be considered
    - Approximately 40% of the security staff have English as their second language
    - All security companies involved in Operation Soteria are to be contacted to request vigilance in reviewing employees' testing and quarantine status before permitting them to work
    - VicPol may be able to do check-ins with close contacts as part of Operation Sentinel to ensure quarantine orders are being followed

Other Issues:

- Alfred Hospital are taking over cleaning contracts including green areas; by 13 July all hotels will be covered
- Translation turnaround time is a huge barrier to getting information out to people rapidly enough
- Genomics information suggest Stamford is linked to 2 distinct groups, one of which originated from REDACTED and was clearly separate from Rydges

RE: New COVID-19 case in Queensland - link to Rydges hotel

From: REDACTED (DHHS)" REDACTED

To: REDACTED <REDACTED REDACTED, "press (DHHS)" <press@dhhs.vic.gov.au>

Cc: "Brett Sutton (DHHS)" REDACTED, "Finn Romanes (DHHS)" REDACTED "REDACTE (DHHS)" <REDACT REDACTED "Sarah McGuinness (DHHS)REDACTED 'REDACTED (DHHS)" <REDACTED RE EDACTED REDACTED (DHHS)" <REDACTED REDACTE (VICMIN)" <REDACTE REDACTED REDACTED REDACTED

Date: Sat, 06 Jun 2020 12:59:56 +1000

Hi REDACTE,

We are attempting to contact the new case (in Queensland) now.

- Our current understanding is that this individual was moving permanently to Queensland, which is permitted if you remain (home) quarantined for 14 days. (https://www.covid19.qld.gov.au/government-actions/border-closing#exempt-person)
- RE had previously been living in Victoria.
- The original Rydges case did not identify that RE had previously had two housemates in RE case interview on 30/5/20.
  A single household contact was identified who has been followed up with our usual processes.
  On 1/6/20, after repeated difficultly contacted the original case, the department requested police attend the apartment and confirm the case's whereabouts, welfare and living arrangements. Police reported that the Rydges case was at home and a single other housemate lived there also. This aligned with what we had been told in the case interview. It has subsequently transpired that the new (Qld) case left the house very early on REDACT to fly to Brisbane.

(Interactions with both the Rydges case and previously identified housemate have been via interpreters. The original Rydges case remains in RE at RMH.)

Kind regards

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

Follow the Chief Health Officer on Twitter @VictorianCHO

From: REDACTED (VICMIN) <REDACTED REDACTED
Sent: Saturday, 6 June 2020 12:05 PM
To: press (DHHS) <press@dhhs.vic.gov.au>

Cc: [redacted] (DHHS) [redacted]; Brett Sutton (DHHS) [redacted], Finn Romanes (DHHS) [redacted] Sarah McGuinness (DHHS) [redacted] (DHHS) [redacted] (VICMIN) [redacted]
Subject: Re: New COVID-19 case in [redacted] - link to Rydges hotel

Hi team

Do we have any info on the following :

- How was [redacted] able to travel to Qld if they have closed borders?
- Is [redacted] a Qld resident?
- did we identify them as a close contact ? - - if not do we have idea Why [redacted] wasn't disclosed as a close contact?

Sent from my iPhone

> On 6 Jun 2020, at 11:41 am, press (DHHS) <press@dhhs.vic.gov.au> wrote:
>
> All,
>
> Queensland Health is holding a media conference now and has announced this as a Queensland case in a traveller who recently arrived from Melbourne.
>
> [redacted]
> Victorian Department of Health and Human Services
> (03) 9096 8041
> [redacted]
>
> **From:** [redacted] (DHHS) [redacted]
> **Sent:** Saturday, 6 June 2020 11:30 AM
> **To:** Brett Sutton (DHHS) [redacted] Finn Romanes (DHHS) [redacted]
> **Cc:** [redacted] press (DHHS) <press@dhhs.vic.gov.au>; Sarah McGuinness (DHHS) [redacted] (DHHS) [redacted] (DHHS) <[redacted]>; Nikki Mott (VICMIN) [redacted]
> **Subject:** New COVID-19 case in Queensland - link to Rydges hotel
>
> Dear Brett and Finn,
>
> This morning Queensland Health have confirmed that they have identified a **new case of COVID-19** is a recent housemate (close contact) of a known Victorian case.

The new case is a former housemate of one of the Rydges staff (REDACTED currently in RMH RE RE moved out of the house on 31st May, during the case's infectious period but was not identified as a close contact by the case when the case was asked about household contacts.

29/5/20 – **symptom onset** of Rydges staff member (isolated)
30/5/20 – Rydges staff member identified as confirmed case and interviewed – new case was not identified as housemate or close contact
31/5/20 – new case (housemate) moved out of the apartment
REDACTE – new case travelled from Victoria to Queensland (details below). New case **symptom onset**.
05/06/20 – new case tested in Queensland for COVID-19
06/06/20 – Positive test result – new case.

Exposure sites during infectious period (new case)
30/06/20 – Spent day with friends. 3 close contacts identified.
31/5/20 – Spent day with different friends. 3 close contacts identified.
REDAC – Skybus from Southern Cross station to Melbourne Airport (reportedly wore mask)
REDAC-REDAC depart REDA Melbourne to Brisbane. (Queensland Health seeking plane manifest from National Incident Room)

Actions
- Continue to work closely with Queensland Health in management of this case and contacts.
- Case to be re-interviewed by Victoria (information above from Queensland Health). Interview underway.
- Victoria social close contacts being contacted by DHHS.
- Skybus to be contacted by DHHS.
- Flight manifest will go to Queensland as they were the destination for the flight. Queensland Health to manage contact tracing of flight contacts. DHHS to be alerted to any close contacts who may have returned to Victoria.
- Draft media lines being prepared.
  Skybus to be informed that Skybus trip will be included as possible public exposure site. Recommendation that flight details and Skybus are included in media release (with an awareness that many passengers are likely to be in Queensland).

Kind regards

REDACTED
Senior Medical Advisor
Health Protection Branch | Regulation, Health Protection and Emergency Management Division
Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
REDACTED m. REDACTED | e. REDACTED
w. www.dhhs.vic.gov.au

Follow the Chief Health Officer on Twitter @VictorianCHO

<image001.jpg>

notify Postmaster@dhhs.vic.gov.au

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