Concept of Operations

Department of Health and Human Services as a Control Agency and as a Support Agency in emergencies

Document owners:
Dr Brett Sutton (Chief Health Officer)
Andrea Spiteri (Director Emergency Management)

Version:
Version 1.0 Endorsed (25 November 2019)

1. Contents

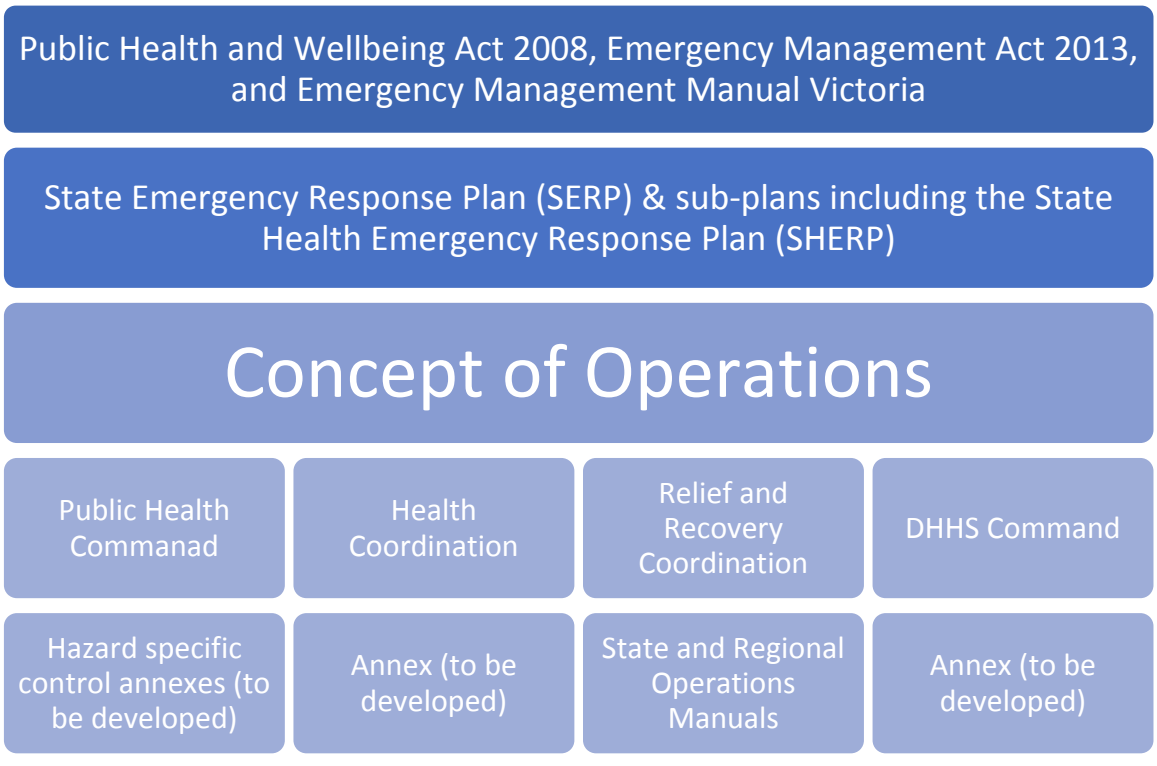
2. Purpose

This Concept of Operations provides guidance to staff working for the Department of Health and Human Services (the department) in emergency-related roles. It explains the department's incident management structure and arrangements used to effectively exercise its emergency-related responsibilities as a **control** and **support** agency, across its key functions:

- Public Health Command
- Departmental Command
- Health Coordination
- Relief and Recovery Coordination and services.

It recognises the department's responsibilities in the Public Health and Wellbeing Act 2008, the Emergency Management Act 2013, the Emergency Management Manual Victoria, and the health specific incident management and escalation arrangements founded in the State Health Emergency Response Plan (SHERP).

This Concept of Operations also provides the foundation arrangements for hazard-specific response plans for which the department is the control agency, which are detailed in annexes.



3. Scope

This Concept of Operations document:

- Outlines the department's operational functions, roles, key activities and deliverables at the state and regional tiers across all types of emergencies. Similar elements at the incident level will be detailed in annexes, where relevant.
- Describes the Concept of Operations for public health emergencies (class two emergencies where the department is the designated control agency) and for emergencies where the department is a support and/or coordination agency.
- Provides guidance on governance and other arrangements to inform further operational plans and annexes to this document, for health coordination, relief and recovery coordination and services, and managing public health emergencies due to:*
  - communicable disease;

  - foodborne illness;
  - drinking water contamination;
  - radiation; and
  - other causes of human disease.
- Inform other agencies involved in making operational decisions and supporting the department in relation to emergencies, by clearly describing the Concept of Operations in place within the department.

**Note the Emergency Management Manual of Victoria Part 7 indicates that the department is the control agency when the major effect of an emergency is due to:*

- *Accidents involving biological materials (including leaks or spills);*
- *Accidents involving radioactive materials (including leaks or spills);*
- *Retail food contamination;*
- *Food / drinking water contamination; and*
- *Human disease.*

These obligations are translated into two types of plans: hazard-specific plans such communicable disease plans, and plans related to vehicles of transmission of hazards, such as foodborne illness plans.

4. Principles

Principles for the Department acting as a control agency

A public health emergency can start abruptly, such as a radiation emergency or an epidemic thunderstorm asthma event, or it can build over days, weeks or months such as a communicable disease outbreak that is eventually recognised as a pandemic. In both situations, as soon as it is determined to be an emergency and the department is determined to be the control agency, the department's response will be guided by the following principles and critical actions:

- Manage the response in line with the State Emergency Management Priorities (noting these are currently subject to consultation):
  - Safety of department and emergency services personnel.
  - Safety of community members including vulnerable community members and visitors/tourists located within the incident area.
  - Issuing of community information and community warnings detailing incident information that is timely, relevant and tailored to assist community members make informed decisions about their safety.
  - Protection of critical infrastructure and community assets that supports community resilience.
  - Protection of residential property as a place of primary residence.
  - Protection of assets supporting individual livelihoods and economic production that supports individual and community financial sustainability.
  - Protection of environmental and conservation assets that considers the cultural, biodiversity and social values of the environment.
- Identify a Controller (Class 2) with the ability to coordinate a whole-of-government response to the consequences from the emergency, beyond the scope of human health, as determined by the State Health Emergency Management Coordinator (SHEMC) as per the State Health Emergency Response Plan.
- The responsibilities or ability of the Chief Health Officer (and staff) or ability to fulfil their obligations under relevant legislation, are not compromised through the appointment and subsequent decisions of the Controller (Class 2), if that person is not also the Chief Health Officer.
- Establish or modify its incident management structure to accommodate a greater emphasis on managing the hazard directly.
- Continue to perform all support and coordination agency responsibilities while it also takes on responsibility as the nominated control agency.

Principles for the Department acting as a support and coordination agency

The principles to guide the department's response as a support and coordination agency include:

- Maintain clarity about when the department is advising other agencies or authorities, and when the department is responsible for delivering a specific function. For example, in an emergency for which the department is a support agency, the public health command function is coordinated through a Public Health Advice Cell, chaired by the public health commander.
- Maintain vigilance for when there is a hazard requiring controls, that may require consideration of proposing the department as a control agency.

Concepts of command, control and coordination

Control refers to the overall direction of response activities in an emergency and operates horizontally across agencies.

Coordination is the bringing together of agencies and resources to ensure an effective response to, and recovery from, an emergency.

Command refers to the concept of an individual leading a hierarchy within an organisation and directing people and resources**.**

5. Functions, roles and key activities

Overview of functions, leadership roles and key activities

In an emergency, the department undertakes a number of key activities at the state and regional levels to meet its emergency management and public health responsibilities. ***Key activities*** of like kind are grouped together under a descriptive umbrella referred to as a ***function***. Each *function* is led by a ***leadership role***, who is the person allocated to this role responsible for ensuring each of the key activities within their function are effectively carried out, as part of the department's broader response to the emergency. These are summarised in Table 1 (state) and Table 2 (region). State and Regional Health Command is the responsibility of Ambulance Victoria and has been included to acknowledge the interdependencies between the agencies under SHERP.

Table 1. The department's state-level functions, leadership roles and key activities.

Function	Public Health Command	Departmental Command	Health Coordination	Relief & Recovery Coordination and Services	Control (Class 2)	State Health Command (Ambulance Victoria)
Leadership role	**Public Health Commander**	**State Departmental Commander**	**State Health Coordinator**	**State Departmental Commander**	**Controller**	**State Health Commander**
Key activities	Command the public health activities of an emergency response (including the investigation, management of public health risk, and communication of risk) Undertake actions to reduce pressure on the health system through control measures and advice Monitor the impacts of an emergency on public health Authorise public health communication to the public	Monitor the impacts of an emergency on the department's clients and funded services Undertake activities that support the safe deployment of DHHS personnel to acquit responsibilities of the department Coordinate activities to manage the consequence of these impacts on clients, funded services and DHHS staff Authorise public communications about impacts to departmental services	Monitor state-level impacts of an emergency across the health system Coordinate health sector emergency response activities to support the health system (including hospitals and primary health) Authorise health system impact communication to the public	Coordinate the provision of financial assistance to affected communities Coordinate the provision of emergency accommodation to affected communities Coordinate the provision of psychosocial support to affected communities Authorise relief and recovery public communications	Ensure implementation of control measures for the identified hazard(s) Manage the emergency consequences across government Authorise public information and warnings to the public Support the Emergency Management Commissioner, and the sector	Command the pre-hospital and field response to an emergency at the state tier (including ambulance services, first responder assistance, and spontaneous volunteers)

Decision-making	Chief Health Officer/Public Health Commander	Department Incident Management Team (D-IMT)* leadership group Department Executive Board (BC/surge)	State Health Incident Management Team	D-IMT leadership group	State Control Team	State Health Incident Management Team
State EM Committees	State Control Team State Coordination Team	N/A	State Control Team State Coordination Team State Emergency Management Team	State Relief & Recovery Team State Control Team State Coordination Team State Emergency Management Team	State Coordination Team State Emergency Management Team	State Control Team State Coordination Team State Emergency Management Team

Note: The Public Health Commander and Health Coordinator are detailed in SHERP, along with State Health Commander (Ambulance Victoria), which has not been included as it sits outside the department

*See page 8 for details

Table 2. The department's regional level functions, leadership roles and key activities

Function	Public Health Command	Departmental Command	Health Coordination	Relief & Recovery Coordination and Services	Control (Class 2)	Regional Health Command
Leadership role	**Regional DHHS Commander**	**Regional DHHS Commander**	**Regional Health Coordinator**	**Regional DHHS Commander**	**N/A**	**Regional Health Commander**
Key activities	Working with local government authorities and public health commander, monitor and report on the impacts of an emergency on public health. Act as a liaison to all regional tiers and agencies to assist implementation of controls and to facilitate information exchange.	Monitor the impacts of an emergency on the department's clients and funded services within the relevant Operations Division Undertake activities that support the safe deployment of DHHS Operations Division personnel to acquit responsibilities of the department Coordinate activities to manage the	Monitor regional-level impacts of an emergency across the health system Coordinate regional health sector emergency response activities to support the health system (including hospitals and primary health)	Coordinate regional relief and recovery activities Coordinate the provision of financial assistance to affected communities Coordinate the provision of emergency accommodation to affected communities Coordinate the provision of		Command the pre-hospital and field response to an emergency at the regional tier (including ambulance services, first responder assistance, and spontaneous volunteers)

		consequence of these impacts on clients, funded services and DHHS staff within the relevant Operations Division Authorise public communication about impacts to departmental services		psychosocial support to affected communities Provide input into relief and recovery public communications		
Decision-making	Chief Health Officer/Public Health Commander	Department Incident Management Team (D-IMT)* leadership group Operations Division Executive (BC/surge)	State Health Incident Management Team Regional Health Incident Management Team (where required)	Post Incident Regional Relief and Recovery Committee	N/A	Regional Health Incident Management Team
Regional EM committees	Regional Emergency Management Team		Regional Control Team Regional Emergency Management Team	Regional Emergency Management Team	Regional Control Team Regional Emergency Management Team	Regional Emergency Management Team

6. Further description of activities and deliverables

Below is a description that breaks up the key activities from Table 1 into discrete deliverables, activities or sectors, under an incident management system at the incident, regional and/or/state level/s).

When an emergency is identified, it is likely that there will be a need for rapid establishment of operational units led by functional lead officers. There is value in mapping a possible set of activities in supporting each departmental function in advance, that a leadership role is responsible for.

Key activities under each function are shown below, noting this is an indication only, is not exhaustive, and may vary. Appendix 2 provides one possible initial grouping of activities under functional lead officers, established in the incident management system for a complex public health emergency. Not all activities will be required, depending on the hazard, and the grouping of activities can flex and change to meet the needs of the emergency and other considerations, such as span of control.

Health Coordination activities are:

- Monitoring capacity of hospitals to receive patients, including those requiring specialised care
- Prioritising and coordinating patient distribution
- Activation of health coordination protocols and arrangements, including Field Emergency Medical Officers, Victorian Medical Assistance Teams, Field Care Clinics and activation of casualty data collection and monitoring
- Activation of protocols and liaison with hospitals including Code Brown and Private Hospitals Protocol
- Public information on health system impacts and treatment options.

Relief and Recovery Coordination and Services activities are:

- Financial assistance coordination and delivery
- Social recovery planning and coordination
- Emergency accommodation coordination
- Psychosocial support coordination
- Regional relief and recovery coordination
- Advice to State Recovery Coordinator
- Public information on support services.

Departmental Command activities are:

- Client and funded service impact monitoring
- Coordinate client and funded services
- Oversight of deployed DHHS staff
- Supporting coordination of business continuity across the department
- Public information on clients and services impacted.

Public Health Command activities are:

- Relating to incident control:
  - Discharge of statutory powers under Acts
  - Determination of required public health control measures
  - Representing the department on national response committees.
- Relating to planning and intelligence:
  - Rapid literature review and options analysis
  - Human health risk assessment (hazard, exposure, hypothesis)
  - Health impact assessment (morbidity and mortality)

  - Specialist functions (toxicology, infection control, infectious diseases, radiation protection, others)
  - Epidemiological analysis (environmental, descriptive human epidemiology, analytical human epidemiology)
  - Situational analysis and communication (briefings, PPQs)
  - Public health advice to councils, agencies and health services.
- Relating to operations:
  - Case management
  - Contact management
  - Clinical investigation
  - Laboratory and testing arrangements
  - Infection prevention and control
  - Field investigation and control
  - Local government advice and liaison
  - Agency liaison.
- Relating to public information:
  - Public information and advice to the community on health risks and mitigations
  - Coordinate public information with local, state and national government, and other responding agencies
  - Represent the department on the Victorian Emergency Management Joint Public Information Committee and the National health emergency media response network (Commonwealth Department of Health).
- Relating to logistics:
  - Providing a call centre and supporting field investigation teams
  - Providing countermeasures (medicines, vaccines, personal protective equipment)
  - Supporting the D-IMT, and any Public Health Advice Cell (PHAC), for meetings and through minutes and agendas
  - Rosters, accommodation, catering, on-boarding protocols, off-boarding protocols
  - Incident debriefing and health protection practice improvement.

Note: State Health Command is an Ambulance Victoria (AV) function, which undertakes a number of roles under SHERP. This function is represented by a Senior AV Officer who provides pre-hospital intelligence to the incident management team. While not a direct departmental activity, state health command is strongly connected under SHERP to departmental decision making. Key activities are:

- Community Health Assessment Centres
- Field clinics of any description
- Field Emergency Medical Officer response
- Victorian Medical Assistance Team response (in association with State Health Coordinator)
- First aid response
- Ambulance services response
- Public information on impacts to ambulance services.

7. Decision-making– Departmental Incident Management Team

Role of the Departmental Incident Management Team (D-IMT)

During an emergency, whether in control, support or coordinating, the department will convene a single body to inform decision-making by leadership roles irrespective of the type of hazard that has precipitated the emergency. For the purpose of the SHERP, the departmental incident management team fulfils the function, and will operate as the State Health Incident Management Team under SHERP when required.

The D-IMT determines the strategic priorities for the department, and in some cases the health and human services and emergency management sectors, in responding to emergencies across all functions. The D-IMT provides guidance on required decision-making, across the span of strategic, tactical and operational decisions. The D-IMT provides direction for functional lead officers in the discharge of all key activities and activities for which the department is accountable.

For example, a D-IMT that is managing a public health emergency, which is two confirmed Ebola cases with 30 dispersed close contacts across Victoria, may need to set priorities, guide critical individual decisions on how to quarantine contacts and give advice to the Public Health Commander through to the Controller (Class 2) on social distancing and closure interventions, and appropriate public information and relief activities to support the overall objectives and the affected communities.

Activation of the D-IMT

A D-IMT may be called by any of the leadership roles, following a risk assessment. For example, the SHERP outlines many of the factors that are relevant for identifying whether a public health emergency may be present. A request for a D-IMT by a leadership role may occur at the outset of an emergency, or at some point after its occurrence where it is deemed that the scale, complexity and impact on the community has grown such that there is benefit in the D-IMT being established to inform collective decision making where required for the relevant emergency management function (health, relief and/or recovery).

Membership of the D-IMT

All leadership roles are members of the D-IMT as are functional lead officers and a representative DHHS Regional Commander (if regions are active). Inclusion of functional lead officers ensures leadership roles have access to intelligence, key issues and problems to be solved, and is efficient by avoiding parallel briefings and meetings for functional lead officers.

However, it may be necessary to act quickly in a rapid onset emergency, and it would be appropriate for the Chair of the D-IMT to hold a meeting of the leadership roles and functional lead officers already on roster (such as the Public Information Officer) as required.

All leadership roles are also represented on Emergency Management committees, as noted in Tables 1 and 2.

Chairing the D-IMT

The principle is that the chair of the D-IMT is the leadership role responsible for the most significant or complex consequences of the emergency that need to be managed. Where the department is the control agency it will be the Public Health Commander, and where the department is the support agency, or the predominant Emergency Management function is to address relief and recovery, this will be the State Departmental Commander.

The priorities of the D-IMT will be actioned through the DHHS State Operations incident management structure which operates according to AIIMS principles and incorporates the relevant functions for a particular emergency. Consistent with the principle of unity of command, there will be one role leading this structure. This will be the chair of the D-IMT. For example, in an emergency where the most significant consequence relates to significant strain on Victoria's public health services, the State Health Coordinator may be the chair of the D-IMT and will perform the leadership role for DHHS State Operations. However, all other leaderships roles remain accountable for their functions.

Representation of regional responsibilities on the D-IMT

The lead departmental officer in each region during an emergency is the DHHS Regional Commander, and this role is usually undertaken by the relevant Operating Division Director Emergency Management and Health Protection.

Irrespective of whether the department is the control, support or coordination agency in an emergency, the regional response has four overall components:

- To act as a point of liaison and connection in relation to the public health command function (which is a centralised function in Victoria);
- To deliver key activities of the DHHS Regional Commander function in that region;
- To deliver key activities of the health coordination function in that region;
- To deliver key activities of relief and recovery in that region.

The D-IMT is structured so that for every key activity or deliverable under the overall functions of the department, there is a functional lead officer with carriage of those functions for the state. For example, the Operations Officer has carriage of emergency accommodation activity and contact tracing activity (see Appendix 2). The functional lead officer at the state level will have a regional functional lead officer they can work with, situated in the relevant Operations Division (likely in the Regional Emergency Operations Centre).

The Regional DHHS Commander and other response agencies will need to be closely supported in any initial period by the public health command function in a public health emergency where a regional field presence is required.

An example is a radiation emergency, where in the initial period, expertise or public health resources will be mobilising and will be *en route* from Melbourne to the location of the emergency. Regional DHHS Commander(s) (if activated) will also be represented on the D-IMT directly.

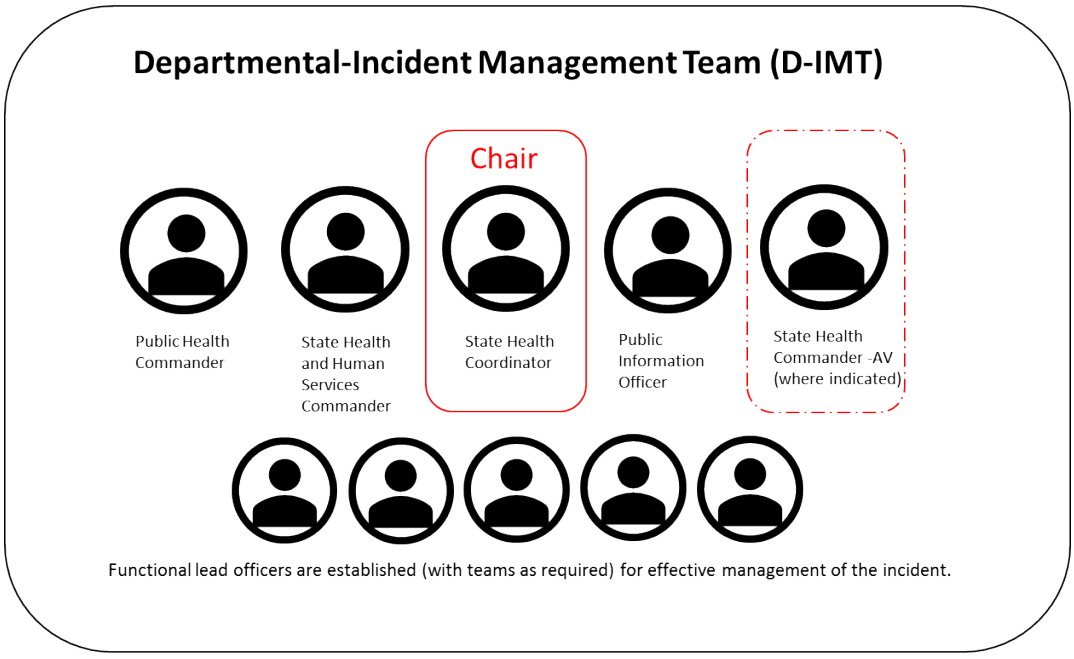
Initial actions for the D-IMT

At its first meeting the D-IMT will:

- Confirm a chair
- Apply the SHERP escalation or relevant process to determine tiers of activation and incident management structure required, including location of functions, for example in the State Emergency Management Centre, the State Control Centre, or Regional Emergency Operations Centre
- Determine the strategic priorities for the department across all functions.

An example agenda for a D-IMT is shown at **Appendix 1**.

Figure 1. An example Health Coordination-led D-IMT acting as a SHIMT under SHERP



8. Functional lead officer roles

Functional lead officers will be responsible for all functions within their unit, as per the DHHS State Operations structure and determined by the nature and consequences of the emergency. Depending on the scale and complexity of the emergency there may be cells (teams) formed under a functional lead officer to address functions. Staff to fulfil all activities will be drawn from the Emergency Management branch, Health Protection branch, subject matter experts within DHHS business areas and departmental emergency management surge workforce. Functional lead officers are likely to be staff from Emergency Management and Health Protection Branches when the department is the control agency, or when there are significant public health impacts of an emergency where the department is a support and coordination agency.

Where the department is the nominated control agency, DHHS State Operations structures are likely to vary for different hazard types. One example is provided at Appendix 2.

9. Departmental - Incident Management Team summary

When	In anticipation of, or in response to, an emergency that threatens to, or has, resulted in significant consequences for communities that are the responsibility of the department of health and human services sectors to manage.
Purpose	• To set the strategic priorities relating to the management of consequences on: – The health system – The community including public health, and relief and recovery services – The department's clients and funded services. • Provide expert advice to the Controller (Class 2) for the establishment of control strategies, where activated. • To provide direction to DHHS State Operations, health and human services sectors and Executive Board.

Membership	Membership will be: • State Health Coordinator • State Health and Human Services (Departmental) Commander • Public Health Commander • State Health Commander (as required) • Regional Commanders (as required) • Functional lead officers

10. Transition to recovery

The State Departmental Commander will take on the role of chair (if not already) within the D-IMT once the response phase nears transition to recovery. During this phase, membership of the D-IMT may begin to source appropriate expertise for decision making for recovery.

Where an emergency has transitioned to recovery, new members may be included in the D-IMT membership from across the department to coordinate services directly to support regions, councils and communities affected by the emergency.

11. De-escalation of the emergency management response

As the emergency de-escalates, the membership of the D-IMT will be continuously reviewed, and transition as agreed by the leadership roles.

During this time, the work will be transitioned to the functional unit's business area to manage and report on through standing business (non-emergency) arrangements.

12. Interface with national arrangements

The governance of an emergency may involve engagement with national governance arrangements, national agencies and other jurisdictions. Usually this will be through Victorian representation on national committees.

Inter-jurisdictional health arrangements are typically described in national plans overseen by the Australian Government Department of Health, and often describe the obligations of jurisdictional public health authorities / health departments alongside the obligations and role of national departments or agencies.

The Australian Government acts as the World Health Organisation Focal Point for the purposes of obligations and reporting under the *International Health Regulations 2005*, which outline how member states work together to manage risk from specified international hazards, particularly communicable diseases like pandemic influenza or Ebola virus disease.

Inter-jurisdictional social recovery arrangements are in place under the Social Recovery Reference Group, of which Victoria is the chair. This may see additional DHHS State Operations functions to coordinate inter-jurisdictional deployment to or from other states or the Commonwealth government.

A list of critical national plans that are relevant to the department is shown below in Table 3:

Table 3: National arrangements relevant to emergencies

National Arrangement	Functional focus	Key committee	Victorian representative

National Arrangement	Functional focus	Key committee	Victorian representative
AUSTRAUMAPLAN	Health coordination	National Health Emergency Management Standing Committee	Deputy Director Strategy and Policy Emergency Management branch
HEALTH CBRN Plan	Health coordination	National Crisis Committee	DHHS NHEMS rep
CDPLAN	Public health command	Australian Health Protection Principal Committee	Chief Health Officer
SRRG – Interjurisdictional Assistance Guidelines	Relief and Recovery Command	Social Recovery Reference Group	Director, Emergency Management

In a public health emergency with national response arrangements activated, the department will be actively represented on the following national response structures depending on the hazard causing the emergency:

- Australian Health Protection Principal Committee – by the Chief Health Officer
- Communicable Diseases Network Australia – by the Public Health Commander
- enHealth – by the Public Health Commander
- National Health Emergency Media Response Network – by the Public Information Officer.

13. Interface with state arrangements

Roles for the department at the State Control Centre when acting as a control agency

For all emergencies, the department is represented through its leadership roles on State Emergency Management committees (see Table 1).

When the department is a control agency and the emergency is a public health emergency, an appropriate Class 2 controller will be recommended by the State Health Emergency Management Coordinator (Deputy Secretary Regulation Health Protection and Emergency Management) to the department's Secretary for appointment. In keeping with SHERP, the Chief Health Officer will normally be appointed the Class 2 Controller for identified public health emergencies, and when that occurs the Chief Health Officer will delegate the Public Health Commander role to the Deputy Chief Health Officer relevant to the main hazard or consequence. The Public Health Commander will then be the chair of the D-IMT.

For all other emergencies, including in the event of a rapid onset health emergency where the causation is unclear, The State Health Coordinator will be appointed Class 2 Controller. In this case, the State Health Coordinator function will be delegated.

The Class 2 controller and the State Departmental Commander (as the State Health Coordinator and the Senior Liaison Officer, unless the roles are separated) will be on the State Control Team, State Coordination Team and the State Emergency Management Team. The State Departmental Commander will also be a member of State Relief and Recovery Team. The Chief Health Officer will also be on the State Coordination Team and the State Emergency Management Team.

The State Health Emergency Management Coordinator and the Chief Health Officer will attend with the Minister for Health on the Security and Emergencies Management Committee (SEMC) of Cabinet.

The Public Information Officer will attend the Emergency Management Joint Public Information Committee (EMJPIC). The Class 2 controller can request activation of the State Control Centre Public Information Section to support the department's response. A departmental deputy public information officer or a public information liaison officer can work from the SCC public information section.

Table 3: State Arrangements relevant to emergencies

State Arrangement	Functional focus	Key committee	Representative/s
Cabinet	WoVG coordination	Security and Emergencies Management Committee (SEMC) of Cabinet.	Minister for Health and Ambulance Services
Emergency Management Sector	State Emergency Management Coordination	State Control Team, State Coordination Team, State Emergency Management Team State Relief and Recovery Team (SRRT)	See Table 1.
Public Communication and Warnings	Public Communications	Emergency Management Joint Public Information Committee	Public Information Officer

Roles for the department at the SCC when acting as a support agency

When the department is a support agency, the department is represented as above with the exception that the Chief Health Officer is not currently a member of the State Control Team.

Relocation of other functions to the SCC

When the department is the control agency for an emergency, key staff may relocate to the SCC. The timing of any relocation will be determined by the rapidity of onset of the emergency and the need to access the SCC resources or location to support the department to fulfil its emergency management responsibilities. The D-IMT is likely to meet initially at the level 1 State Emergency Management Centre at 50 Lonsdale Street, and to put an incident management structure in place at that location in the first instance.

Relocation of roles to the SCC may be required when:

- The scale of the consequences is large, and the coordination of the emergency response is complex, for example when multiple sectors are affected, and multiple agencies or departments are responding
- When the Class 2 controller or Emergency Management Commissioner request such a relocation
- When the department determines it is necessary e.g. for the public information function

There may be circumstances when the department chooses to relocate roles to the SCC when the department is acting as a support agency. For example, in a class 3 deliberate-release emergency when there is a substantial amount of health risk assessment, management and public information required to support the control agency to manage the hazard or consequences.

Options for location

At a minimum, the relevant leadership roles will attend the SCC for meetings of State Emergency Management committees, as per the committee membership.

Once DHHS becomes a control agency, the Class 2 controller and the Senior Liaison Officer will be based at the SCC.

A further escalation may involve the movement of other roles to the SCC, noting for SCC tier 3, a departmental Emergency Management Liaison officer is always required.

14. Appendix 1 – Example Agenda for D-IMT

1. Welcome, apologies, confirmation of chair (first meeting and as required)
2. Situation
3. Strategic priorities for the department.
4. SHIMT - Public health command decisions (if required)
5. SHIMT - State health command decisions (if required)
6. SHIMT - State health coordination decisions (if required)
7. DHHS command decisions (if required)
8. State relief and recovery decisions (if required).
9. Recap of critical actions from the D-IMT, and any outstanding actions from previous meeting
10. Recap of internal and external communication / liaison of external communication / liaison required
11. Date and time of next meeting

15. Appendix 2 - Potential functions for functional lead officers when department is the control agency

In an emergency for which the department is the control agency, the following functions / activities / deliverables could be overseen by each functional lead officer, in additional to the roles in the State Operations Manual. The type and span of functions will be different depending on the hazard.

The likely source of each functional lead officer in an emergency for which the department is the control agency is:

- Planning Officer: Emergency Management Branch
- Intelligence Officer: Health Protection Branch
- Operations Officer: Health Protection Branch
- Logistics Officer: Emergency Management Branch
- Public Information Officer: Communications Branch

Note: many of these functions will be required when the department is a support agency or to support relief and recovery coordination and services. When the department is a support agency, the Emergency Management branch will source an Operations Officer.

Relevant leadership roles could oversee:

- Discharge of statutory powers under Acts
- Determination of required public health control measures
- Representing the department on national response committees.

Planning Officer could oversee:

- Develop plans
- Client and funded service impact monitoring
- Situational analysis and communication (briefings, PPQs).

Intelligence Officer could oversee:

- Sector impact monitoring including casualty data collection
- Rapid literature review and options analysis
- Human health risk assessment (hazard, exposure, hypothesis)
- Health impact assessment (morbidity and mortality)
- Specialist functions (toxicology, infection control, infectious diseases, radiation protection, others)
- Epidemiological analysis (environmental, descriptive human, analytical human).

Operations Officer could oversee a range of functions including:

- Health coordination-related operations functions:
  - Service coordination including Code Brown, Private Hospitals Activation
  - Health service alert coordination
- Relief and recovery-related operations functions:
  - Emergency accommodation coordination
  - Psychosocial support coordination
  - Financial assistance coordination.
- DHHS Command-related operations functions:
  - Coordinate changes to client and funded services
  - Business continuity
  - surge staff.
- Public health command-related functions:

  - Case management
  - Contact management
  - Laboratory and testing arrangements
  - Clinical investigation
  - Infection prevention and control
  - Field investigation and control
  - Local government advice and liaison
  - Public health advice to councils, agencies and the community.

Logistics Officer could oversee:

- Oversight of deployed DHHS staff including transport and accommodation
- Response team safety (D-IMT)
- Providing a call centre and supporting field investigation teams
- Providing countermeasures (medicines, vaccines, personal protective equipment)
- Supporting the D-IMT, any Public Health Advice Cell (meetings and minutes and agendas)
- Rosters, accommodation, catering, onboarding protocols, off-boarding protocols
- Scheduling of incident debriefing

Public Information Officer could oversee:

- The department's public information response covering public health advice; health coordination and health system impacts; relief and recovery support services and impacts to the department's clients and services
- Issue public information and warnings through the Victorian warning system and via the department's communication channels
- Represent the department on EMJPIC and the NHEMRN to ensure coordinated public information across local, state and national governments; and other responding agencies
- Work with the State Control Centre to develop a whole of Victorian Government incident specific communications plan
- Develop a suite of public information and communications materials i.e. key messages, factsheets, FAQs.

16. Appendix 3 – Daily schedule

An initial, default ‘battle rhythm’ for frequency of key governance group meetings is proposed below for a public health emergency where the department is confirmed to be the control agency:

0730-0830	State Control Team
0830-0900	Each lead officer identifies decisions and issues within their function requiring report or decision from D-IMT;
0900-0930	State Coordination Team
0930-1000	D-IMT
1000-1045	State Emergency Management Team
1045-1130	State Relief and Recovery Team
1130	Emergency Management Joint Public Information Committee (EMJPIC)
1200	Census point for daily situation reporting data if relevant;
1300	Media lines and public data authorised and released if relevant;
1400-1430	Each functional lead officer identifies decisions and issues within their function requiring report or decision from D-IMT;
1500-1530	Additional D-IMT meeting if required;
1700	Situation Report authorised and released.

17. Appendix 4 – Processes and Instruments of delegations for Controller (Class 2)

These will be identified and added after further work on this Concept of Operations.

18. Appendix 5 - Scenario testing examples

This Concept of Operations will be reviewed and amended by testing through the following scenarios.

Emergency descriptor	D-IMT Chair
Example 1 (DHHS as Support agency) – e.g. significant power outage at a service agency • Minimal consequences to be managed across the health system • Minimal public health impacts • **Significant** impacts to clients and funded services • **Significant** relief and recovery coordination responsibilities • Public health advice is through the Public Health Advice Cell (PHAC) chaired by the Public Health Commander, who is also on the D-IMT	D-IMT Chair: State Departmental Commander
Example 2 (DHHS as Support agency) – e.g. significant water damage to a large funded service building requiring relocation • Minimal consequences to be managed across the health system • Minimal public health impacts • Minimal impacts to clients and funded services • **Significant** relief and recovery coordination responsibilities • Public health advice is through the Public Health Advice Cell (PHAC) chaired by the Public Health Commander	D-IMT Chair: State Departmental Commander (no S-HIMT within the D-IMT)
Example 3 (DHHS as Support agency) – e.g. major road trauma emergency • **Significant** consequences to be managed across the health system • Minimal public health impacts • Minor impacts to clients, funded services or relief and recovery coordination responsibilities • Public health advice is through the Public Health Advice Cell (PHAC) chaired by the Public Health Commander, who is also on the D-IMT	D-IMT Chair: State Health Coordinator
Example 4 (DHHS as Control agency) – e.g. large legionella outbreak • Minimal consequences to be managed across the health system • **Significant** public health impacts to manage • Minor impacts to clients, funded services or relief and recovery coordination responsibilities • Public Health Commander will chair the D-IMT as a 'Public Health Incident', which will also provide advice to the control agency	D-IMT Chair: Public Health Commander

Example 5 (DHHS as Support agency) – e.g. major smoke impacts from fires • **Significant** impacts on the health system • **Significant** public health impacts to manage • Minor impacts to clients, funded services • **Significant** relief coordination responsibilities • Public health advice is through the Public Health Advice Cell (PHAC) chaired by the Public Health Commander, who is also on the D-IMT	D-IMT Chair: Public Health Commander or State Health Coordinator
Example 6 (DHHS as Support agency) – e.g. major smoke impacts from fires with some evacuations of clients required • **Significant** impacts on the health system • **Significant** public health impacts to manage • **Significant** impacts to clients, funded services • **Significant** relief and recovery coordination responsibilities to be managed • Public health advice is through the Public Health Advice Cell (PHAC) chaired by the Public Health Commander, who is also on the D-IMT	D-IMT Chair: Public Health Commander or State Health Coordinator or State Departmental Commander
Example 7 (DHHS as Control agency) – e.g. pandemic influenza, MERS outbreak, major foodborne disease outbreak • **Significant** impacts on the health system • **Significant** public health impacts to manage • **Significant** impacts to clients, funded services &/or relief and recovery coordination responsibilities to be managed	D-IMT Chair: Public Health Commander **Plus –** Controller (Class 2) - Class 2
Example 8 (DHHS as Control agency and Support Agency) – e.g. major floods at same time as foodborne disease outbreak • **Significant** impacts on the health system • **Significant** public health impacts to manage • **Significant** impacts to clients, funded services &/or relief and recovery coordination responsibilities to be managed	D-IMT Chair: Public Health Commander (foodborne disease outbreak) and State Departmental Commander (flood relief and recovery) **Plus –** Controller (Class 2) - Class 2

Department of Health and Human Services response to enquiries from the Victorian Ombudsman under section 13A of the *Ombudsman Act 1973*

Matter	Enquiry from the VO on behalf of REDACTED in relation to persons returning from overseas and being detained at the Holiday Inn due to COVID-19 Directions.

Background from department

A State of Emergency exists in Victoria under s.198 of the *Public Health and Wellbeing Act 2008* (PHWA). In short, the State of Emergency empowers the Chief Health Officer to authorise use of emergency and public health risk powers under the PHWA. This includes detaining a person in an emergency area for a period reasonably necessary to reduce a serious risk to public health.

On 24 March 2020, the Commonwealth Government announced that from 29 March 2020 all travellers arriving in Australia by air or sea must be isolated in mandatory quarantine accommodation for 14 days from their arrival, with few exceptions. These requirements are managed and enforced by state and territory governments with Australian Government support, including from the Australian Defence Force and Australian Border Force.

Reasons for the Direction and Detention notice

Since midnight 28 March, all persons arriving in Victoria from overseas are subject to a Direction and Detention notice under section 200 of the *Public Health and Wellbeing Act 2008.* This notice requires a 14-day quarantine in a designated room within a hotel in Melbourne. As, according to public health advice, international travellers arriving in Victoria present a high risk of further transmission of COVID-19, detaining a person in a designated hotel room is necessary to reduce the serious risks to public health associated with the virus.

Ombudsman enquiry

1. *How many people are currently (as at 28 April 2020) detained in accordance with a Covid-19 related Direction and Detention Notice made pursuant to section 200(1)(a) of the Public Health and Wellbeing Act?*

Department response

There were 3,334 people in quarantine in hotels on 28 April 2020, as per the Direction and Detention Notice.

Ombudsman enquiry

2. *Who is authorised to grant a person permission to leave their room in accordance with clause 4(1)(a) of the Direction and Detention Notice?*

Department response

Authorised Officers (AO's) under the PHWA can grant permission to leave a room (access to open air). These Authorised Officers must be authorised to exercise powers under section 30 of PHWA and must also be authorised to exercise the public health risk powers and emergency powers given under section 199.

There are four circumstances under the Direction and Detention notice in which permission to leave the room can be granted:

- for the purposes of attending a medical facility to receive medical care;
- where it is reasonably necessary for physical or mental health;
- on compassionate grounds; and
- emergency situations.

Ombudsman enquiry

3. *What guidance or direction has the Department provided to detaining hotels about the treatment of detainees and conditions of detention?*

Department response

The hotel quarantine program (known as Operation Soteria) is led by the DHHS Commander COVID-19 Accommodation appointed by, and working to, the State Controller – Health. The State Controller – Health is from the Department of Health and Human Services as the control agency for the current COVID-19

pandemic class 2 public health emergency.

Support agencies, including Department of Jobs, Precincts and Regions (DJPR), Department of Transport (DOT), Victoria Police (VicPol), Department of Premier and Cabinet (DPC) support the Department of Health and Human Services (the Department/DHHS) as the control agency. Staff from the Victorian public sector and contractors, including contracted hotels also assist.

The Department provides hotels with guidance and information for their understanding and assistance about the:

- reasons for the detention, quarantine operation and processes
- Victorian Government Support Service operated by the DJPR, who provide assistance with managing food service and other accommodation queries
- Department's on-site and remote support services staff who identify individual needs, including special needs, check detainees' health, promote strategies to assist detainees to support their wellbeing and stay connected, and ensure response to detainee safety and welfare issues, and
- arrangements for departure of detainees from hotel accommodation.

Ombudsman enquiry

4. *Who is responsible for facilitating detainees' access to open air, medication and communication with family/friends?*
    a. *Are these people 'authorised officers' within the meaning of section 30 of the Public Health and Wellbeing Act?*

Department response

Authorised Officers under the PHWA that are authorised to exercise emergency and public health risk powers can grant permission to leave a room (access to open air). Authorised Officers who are authorised to exercise powers under s.30 of PHWA must also be authorised to exercise the public health risk powers and state emergency powers given under s.199.

Health and welfare arrangements are based on a set of Public Health Standards for care of returned travellers in mandatory quarantine and Guidelines for managing COVID-19 in mandatory quarantine. The first standard is that all policies and practices guiding decisions made about people in mandatory quarantine must consider the Victorian Charter of Human Rights and Responsibilities.

Standard 4, *health promotion and preventive care* states '*While in mandatory quarantine, health promotion and preventative care should be made available to all quarantined individuals. This includes access to fresh air and promotion of exercise where possible'*. This standard includes a criterion 4.2 Fresh air, which states:

- '*Individuals in quarantine should have access to fresh air where possible*
- *If the room has a balcony or windows that open, quarantined persons should be advised to use them for fresh air and ventilation*
- *Requests to go into the open air (for fresh air or exercise) should be accommodated where possible, where it can be safely and practically implemented at the hotel (weather permitting), taking into account infection control and physical distancing precautions. Only people who are well, and who are staying in the same room, should go outside to exercise at the same time*.'

Application of this policy is limited by the capacity of the hotel environment to enable fresh air and exercise while protecting the safety of staff and the wider community. Currently, between 20 to 30 minutes daily breaks are provided depending on the hotel. Longer breaks are more possible in small hotels. Priority is given to children and guests with medical or mental health needs. The process for determining break schedules at each hotel is done in consultation with nurses and AOs based on the current manifest numbers and in partnership with security at the hotel.

The physical space available to permit outside access is limited in all hotels and the department has reviewed our stock of hotels recently with this as one criterion for choosing the more suitable of the stock. To mitigate some constraints, negotiations recently started with Melbourne City Council to improve access to open space/laneways around certain hotels to improve access.

Security at the hotels generally facilitate the movement of individuals from their rooms to any other part of the hotel area.

Health and wellbeing staff such as on-site nurses facilitate any necessary medication.

A person being detained can use their mobile phone, laptop, tablet or other device as they would normally do – or use phones in their hotel room. The department assists detainees to access interpreter services

using department smartphones to connect with family, where required. The department helps detainees to access Australian SIM cards through online or local stores for those who only have international SIM cards. If a person being detained makes a reasonable request for communication to an Authorised Officer, the Authorised Officer must facilitate this request.

Ombudsman enquiry

5. *What monitoring / oversight is the Department undertaking in relation to persons detained under a Direction and Detention Notice to protect their human rights?*

Department response

The Department has measures to support and protect human rights, while balancing the need to reduce the serious risk to public health posed by COVID-19. These include:

- providing suitable standard hotel rooms to ensure persons are being detained in humane and good standard conditions.
- ensuring on-site security to help ensure the safety of people.
- providing support through the Victorian Government Support Service (GSS) phoneline.
- undertaking welfare checks.
- providing 24-hour medical support, including an on-site mental health nurse.
- providing on-site departmental staff to support health and wellbeing.
- advocating access to medical and mental health support services.
- seeking support from the Crisis Assessment Response Team for those with complex needs
- granting permission to leave the hotel room for a period on mental health grounds, attend a funeral, visit family members who have a terminal illness and obtain medical treatment.
- facilitating any reasonable request for communication, including access to a translator.
- granting approvals to alter the way in which quarantine applies, such as permitting: children to undertake quarantine at home with a parent or guardian; people whose health and welfare cannot be accommodated in a hotel environment to undertake quarantine in another environment.
- relocating an alleged perpetrator of family violence to a separate room. Support is provided to both parties.
- accommodating dietary requirements (including culturally appropriate food) for individuals when detainees arrive in Victoria. Complaints about food are addressed through the GSS phoneline and detainees are also free to purchase items from Woolworths or through UberEats and other similar delivery services.

All Department and contracted staff are responsible for timely and appropriate management, escalation and reporting of issues and any major incidents that involve or impact significantly upon persons being detained during airport reception, hotel quarantine, and other users or staff during provision of mandatory quarantine services during the COVID-19 emergency, in accordance with escalation and incident reporting processes.

Any issues returned travellers have can be escalated to an on-site Team Leader for each hotel. In addition, any issues can also be reported to the Department's complaints and feedback line.

Ombudsman enquiry

6. *Given the intersection between Commonwealth and State agencies in the identification, transportation and detention of returning overseas travellers, please provide a summary of the end-to-end process, including which agency is responsible for what, in relation to persons detained under a Direction and Detention Notice.*

Department response

Phase one: Airport intake & health screening – the Australian Federal Police, Australian Border Force, and the Department of Health and Human Services

Information required from Australian Border Force (ABF), for the successful intake of passengers and triage by DHHS includes:

- Identification of COVID-19 positive cases;
- Clinical history of all passengers; and
- Family composition (to configure for hotel).

Health screening – passengers and crew

All passengers participate in health screening by the on-site nurse (DHHS). This screening includes a temperature check and questions about respiratory symptoms.

All persons on the flight are safely and rapidly screened for symptoms and severity of COVID-19, and categorised into the following groups:

- If the health screening result is NEGATIVE and the passenger is not confirmed COVID-19 positive, the passenger is triaged to DHHS/concierge staff.
- If the health screening result is POSITIVE and the passenger is not already known to have COVID-19 infection, the Human Biosecurity Officer ((HBO), DHHS staff authorised under Commonwealth biosecurity legislation) will be engaged for further assessment and where appropriate triaged through Ambulance Victoria via the on-site Commander for transfer to hospital (usually Royal Melbourne Hospital) for assessment and testing.

All passengers who are directed to go straight to the hotel are handed a detention notice and an information sheet as they disembark the plane.

Department of Health and Human Services staff contact passengers during this period to ensure they have access to adequate medical and support services as required.

Follow-up of unwell passengers at the hospital

The DHHS Authorised Officer (authorised under the *Public Health and Wellbeing Act* 2008) record the details, clinical status and planned destination for each passenger and crew member. This should be provided to the HBO.

Phase two: Airport concierge & triage support – Department of Health and Human Services and the Department of Jobs, Precincts and Regions

All passengers who will be entering detention are provided with a detention notice outlining their requirement to self-isolate by the on-site DHHS Authorised Officer.

All passengers travelling to hotels are provided with a factsheet about the requirement to self-quarantine for 14 days (DJPR). They are also be provided with a needs screening form to identify any health, welfare or relief needs and a package of food and water to support them prior to and during their transport to the hotel.

Phase three: Transport – Victorian Department of Transport, Department of Health and Human Services, Australian Federal Police, Department of Jobs, Precincts and Regions, Victoria Police, Ambulance Victoria

A. Symptomatic case requiring testing (Ambulance Victoria (AV))
B. Asymptomatic – Skybus (Department of Transport (DOT))
C. Escort bus transports to assigned accommodation (Australian Federal Police (AFP))
D. Transfer manifest to Victoria Police (VicPol) on arrival at accommodation (AFP, VicPol)

Phase four: Self-isolation (Model of care at hotels) - Department of Health and Human Services, the Department of Jobs, Precincts and Regions and Victoria Police

Mandatory hotel quarantine for 14 days.

DJPR:

- Manage accommodation contracts.
- Manage transport arrangements/contracts for deliveries (i.e.: Commercial Passenger Vehicles).
- Manage private security contracts to enforce quarantine requirements at accommodation.
- Establish and coordinate reception parties at identified accommodation (with DHHS) to coordinate movement of passengers from transport into accommodation (with DHHS).
- Prepare for incoming passenger accommodation registration (with DHHS).
- Passenger data reconciled with airside entry data.
- Detailed identification of, capture and management of welfare needs (with DHHS).
- Management of services for all passengers including food, amenities and transport for deliveries.

DHHS:

- Assess inquiries and requests relating to directions.
- Enforce mandatory detention directions.
- Provide policy and processes relating to public health including use of Personal Protective Equipment and quarantine requirements for positive and non-positive passengers from the repatriation flight and provide health advice to key stakeholders involved in their care.
- Prepare for incoming passenger accommodation registration.
- Establish reception parties to coordinate movement of passengers from transport into accommodation (with DJPR).
- Undertake detailed identification of, capture and management of welfare needs (with DJPR).
- Identify, capture and manage special/social needs at hotels.
- Establish access to 24/7 medical and nursing support at accommodation points to support passengers with medical and pharmaceutical needs.
- Provided regular welfare calls to all quarantined passengers and support to meet identified needs, such as psychosocial, mental health, family violence.
- Undertake arrangements for any health and welfare needs including ongoing psychosocial support.

Phase five: Transitioning out of self-isolation (exit strategy)

DHHS:

- Assess permissions for temporary leave from place of detention.
- Conduct voluntary health reviews to allow release back into the community.
- Advise DOT and VicPol on numbers of passengers scheduled to exit quarantine.
- Issue release documents and legal release of detainees from detention.

COVID-19 Health Emergency Governance Structure – V2.0 (18.04.2020)

NATIONAL GOVERNANCE

Chief Health Officer*
Brett Sutton

Emergency Management Commissioner
Andrew Crisp

State Controller (Class 2)
Andrea Spiteri

State Control Team (Key relationships only)

Public Health Commander
Annaliese Van Diemen

State Health Coordinator
Prof. Euan Wallace

State Strategic Communications Manager
Appointed in SCC

State Consequence Manager
Appointed in SCC

State Relief Coordinator
Appointed in SCC

Deputy State Controller – Operation Soteria
Appointed in SCC

State Health Incident Management Team (see page 3 for details)

Public Health Emergency Operations and Coordination | Jacinda de Witts*

Public Health Incident Management Team

PATHOLOGY AND IPC |

Provide specialist advice to health and non-health sector on testing.

Pathology Operations |

Pathology Strategy & Policy |

IPC Operations |

IPC Strategy & Policy |

CASE, CONTACT & OUTBREAK | REDACT

Provide specialist advice to health and non-health sector on infection control, outbreak management and human biosecurity (Ports Of Entry).

Operations |

Strategy & Policy |

PHYSICAL DISTANCING |

Coordinate public health response planning, including compliance

Strategy & Policy |

PUBLIC INFORMATION |

Public Information Officer |

Strategic Communication |

Provide communications for Victorian community and health and human services sectors on COVID-19 pandemic.

INTELLIGENCE | Kira Loeb

Operations |

Strategy & Policy |

Undertake surveillance; epidemiological modelling; informatics; and situational reporting.

PUBLIC HEALTH OPERATION COORDINATION |

Logistics Advisor |

Provide corporate services to the Incident Management Team.

DHHS Senior Management Team, chaired by Secretary, Health Emergency Mission (Reports to DHHS Executive Board) (*member)

STATE HEALTH EMERGENCY RESPONSE PLANNING/PREPAREDNESS

Terry Symonds* | Helen Mason | Peter Breadon

Work with health sector – public and private hospitals, primary and community care, ambulance/telehealth, rural public health services, aged care – to enact pandemic preparedness plans.

HEALTH SECTOR LOGISTICS

Respond to emerging supply chain and infrastructure issues for the health sector.

Phuong Pham – Equipment and consumables

Deanne Leaver - Infrastructure

HEALTH AND WELLBEING PMO

Denise Ferrier | Jason Phillips

Coordinate Health and Wellbeing Division's response to COVID-19 pandemic.

E: covid-19projectmanagementoffice@dhhs.vic.gov.au

COMMUNICATIONS

Merita Tabain*

Interface between department and central government and coordinate all relevant approvals for public health communication related to COVID-19.

E: dhhscovidcomms@dhhs.vic.gov.au

PSYCHOSOCIAL SUPPORT

DHHS Senior Liaison Officer (EM-rostered)

Provide psychological and social support to community members impacted by COVID-19 as part of State Relief Team.

ACCOMMODATION (OPERATION SOTERIA)

Commander COVID-19 Accommodation

Pam Williams| Colleen Clark

Emergency Operations Centre for COVID-19 accommodation, including quarantine hotels and hotels for heroes.

DHHSOpSoteriaEOC@dhhs.vic.gov.au

CROSS-CUTTING DEPARTMENTAL SUPPORT AND COORDINATION

RHPEM COORDINATION

Melissa Skilbeck*

John Spasevski

Coordinate advice in response to inquiries, complaints and requests from DHHS Ministers' Offices, State Health Controller, DHHS Secretary and Senior Management Team regarding the department's response to COVID-19.

rhpem.coordination@dhhs.vic.gov.au

COMPLIANCE

Meena Naidu |

Public Health Directions compliance and enforcement strategy, policy and operations, including management of Authorised Officers

coviddirections@dhhs.vic.gov.au

LEGAL SERVICES

Sean Morrison | Ed Byrden

Provide legal advice and support to department and Public Health Command in response to COVID-19, including on issuing, interpreting and enforcing directions under Public Health and Wellbeing Act 2008.

CORPORATE SUPPORT

Greg Stenton*

Provide advice to Ministers, Secretary and DHHS Senior Management Team, and guidance to health and community services sectors, on employment matters related to COVID-19.

NATIONAL CABINET

REDAC (Health and Public Health) | Lauren Kaerger (Human Services) | Christina Dickinson

Coordinate advice for Premier & Secretary for National Cabinet. Secretariat for AHPPC. Intergovernmental COVID: national funding arrangements, ministerial councils.

intergovernmentalrelationsdirectorate@dhhs.vic.gov.au

Legend: OPERATIONS | PUBLIC INFORMATION | STRATEGIC POLICY /PLANNING | LOGISTICS | INTELLIGENCE

COVID-19 DHHS Governance Structure – V2.0 (18.04.2020) – HEALTH COORDINATION (preparedness)

NATIONAL GOVERNANCE

Chief Health Officer*
Brett Sutton

Public Health Commander
Annaliese Van Diemen

Emergency Management Commissioner
Andrew Crisp

State Controller (Class 2)
Andrea Spiteri

State Health Coordinator
Prof. Euan Wallace

State Control Team (Key relationships only)

DHHS Senior Management Team, chaired by Secretary, Health Emergency Mission (Reports to DHHS Executive Board) (*member)

State Health Emergency Response Planning / Preparedness
Terry Symonds* (Lead) | Helen Mason (Health Services) | Peter Breadon (Health Sector)

Sector Stream Leads
Metro Public Health Services – Ryan Heath [redacted]
Private Health Services – Deb Sudano [redacted]
Primary and Community Care – Louise Galloway [redacted]
Rural Public Health Services – Andrew Crow [redacted]
Aged Care – Jackie Kearney [redacted]
Health Services Workforce – Ross Broad [redacted]

Equipment and consumables - Phuong Pham [redacted]
Infrastructure - Deanne Leaver [redacted]

Health and Wellbeing Project Management Office (Governance would come into this and be white leadership box above)
Executive Lead – Denise Ferrier | Lead – [redacted]
covid-19projectmanagementoffice@dhhs.vic.gov.au

Planning
Co-Leads – [redacted] Laura Andrew
COVID-19PMO-Planning@dhhs.vic.gov.au

Information Management and Governance
[redacted]

Digital Health/TeleHealth
[redacted] | Neville Board

Communications
[redacted]
COVID-19PMO-Communications@dhhs.vic.gov.au

Data and Reporting
[redacted], Rosangela Merlo

COVID-19 DHHS Governance Structure – V2.0 (18.04.2020) – RHPEM COORDINATION

NATIONAL GOVERNANCE

Emergency Management Commissioner
Andrew Crisp

State Control Team (Key relationships only)

Chief Health Officer*
Brett Sutton

State Controller (Class 2)
Andrea Spiteri

Public Health Commander
Annaliese Van Diemen

State Health Coordinator
Prof. Euan Wallace

State Strategic Communications Manager
Appointed in SCC

State Consequence Manager
Deb Abbott

State Relief Coordinator
Sharon MacDonnell

Deputy State Health Controller - Accommodation
Chris Eagles

State Health Incident Management Team, including:

- Chief Health Officer
- Public Health Commander
- State Controller (Class 2)
- State Health Coordinator
- State Health Commander (AV)
- DHHS Commander

DHHS Senior Management Team, chaired by Secretary, Health Emergency Mission (Reports to DHHS Executive Board)

Deputy Secretary, Regulation, Health Protection and Emergency Management
Melissa Skilbeck

COVID Compliance
Executive Lead – Meena Naidu REDACTED

RHPEM Coordination Cell
Executive Lead – John Spasevski REDACTED
(REDACTED)

Compliance Operations

Compliance Policy Permissions and Exemptions

Complaints and Queries
REDACTED
Publichealth.admin@dhhs.vic.gov.au

Briefings and Cabinet
REDACTED
Rhpem.coordination@dhhs.vic.gov.au

COVID-19 DHHS Governance Structure – V2.0 (18.04.2020) – NATIONAL CABINET TEAM

NATIONAL CABINET
Chair – Prime Minister

AUSTRALIAN HEALTH PROTECTION PRINCIPAL COMMITTEE
Chair – Chief Medical Officer

Victorian Premier

Department of Premier and Cabinet

DHHS Secretary
Kym Peake

Deputy Secretary
Amity Durham

A/General Counsel
Sean Morrison

Director, National Cabinet (Human Services)
Lauren Kaerger
(Christina Dickinson, Amity Durham)

Director, National Cabinet (Health & Public Health)
Nicole Lynch – REDACTE
(Christina Dickinson, Amity Durham)

Chief Health Officer
Dr Brett Sutton

National Cabinet Directorate
REDACTED
IntergovernmentalRelationsDirectorate@dhhs.vic.gov.au

National Cabinet Policy and Projects Team

AHPPC Secretariat
REDACTE

COVID-19 Emergency Operation Centre (EOC) Operation Soteria v2.0 18 April 2020

Executive -
COVID Compliance

Human Services Regulator

Authorised Officers

State Health Controller

Deputy State Controller
Operation Soteria

COVID-19 Accommodation Commander

Public Health Liaison -
Policy Advisor

DJPR Liaison

Safety and Security Advisor

Deputy Commander
Ports of Entry - Reception

Deputy Commander
Detention Hotels

Deputy Commander
Welfare

Deputy Commander
Hotel for Heroes & Vulnerable

Operations Team Leader
- Field support
- Process
- Briefing/debriefing

Operations Team Leader
- Field support
- Process
- Briefing/debriefing

Operations Team Leader
- Field support
- Process
- Briefing/debriefing

Operations Team Leader
- Field support
- Process
- Briefing/debriefing

EOC Support

Health coordination accomodation

Planning Team leader
- Situation Reports
- Resourcing
- Plans coordination
- Rostering

Staff Safety Officer
- OHS
- PPE
- Health and wellbeing

Logistics Team leader
- Facilities
- Supply
- Deployment
- Finance

Communications Officer

Operation Soteria – on site teams v2.0 18 April 2020

Deputy Commander Ports of Entry

- **Authorised Officers**
- **DHHS Team Leader**
- **Labour Hire staff**
- **Nurses**

- **DOT –Transport / Skybus**
- **Vic Pol / AFP**
- **Melbourne Airport**
- **Australian Border Force**
- **DDJPR – Hotel Liaison**

Deputy Commander Detention Hotels

- **DHHS Team Leaders**
- **DHHS welfare support staff**
- **Authorised Officers**
- **Nurses and medical staff**
- **Exit team leader** (roving role on lead up and on day of exit)

- **Hotel employees**
- **DJPR team leader**
- **Escalation teams/ MH triage/ CART/ MCH**

Deputy Commander Welfare

- **DHHS Team Leaders**
- **Welfare support Callers**
- **COVID Accommodation Support Team (CART)**

Key — Non-DHHS staff on site

VICTORIA State Government | Health and Human Services

HHSD/20/58143

Secretary: Appointment of 2019 novel Coronavirus Class 2 controller and future contingencies

Action required by: nil

Recommendation/s

That you

1. **Note** the considerations in recommending appointment of the Class 2 controller for 2019 novel Coronavirus as discussed on 1 and 2 February 2020 — ☑ Noted / ☐ Please discuss

Comments

Thanks all for a ~~very~~ comprehensive and thoughtful response to a rapidly evolving emergency situation.

YP

KPeake

Kym Peake
Secretary
Date: 4/2/2020

Key issues

1. On Saturday 1 February 2020, you appointed the Director, Emergency Management Branch (and State Health Coordinator) as class 2 state controller for the 2019 novel Coronavirus (2019-nCov) outbreak. You made this appointment, after considering my advice, which is documented in this brief, consistent with our discussions over the weekend.
2. **Attachment 1** constitutes the instrument of appointment sufficient to satisfy my obligation as State Health Emergency Management Coordinator under the State Health Emergency Response Plan (SHERP) and your obligation as agency head under SHERP and the *Emergency Management Act* 2013 (EMA).
3. You did not specify a period of appointment as the appropriate period is not yet known. As you are aware, the department is resourcing its response assuming at least three months of dedicated response activity will be required.
4. I recommended (**Attachment 2**) the appointment of a Class 2 controller after the Australian Health Protection Principal Committee (AHPPC) advised that to contain the spread of 2019-nCov, entry to Australia should be denied for people who have left or transited through mainland China effective from 1 February. The adoption of this advice by the Australian Government escalated the department's response from Level 1 (management of outbreak cases and their contacts and recommendation for isolation of those who had travelled from Hubei province) to a Level 2 response (given the likely social and economic impacts of border closures to all Chinese citizens).
5. From 1 February, the 2019-nCov outbreak also met the definition of a 'major emergency' under the EMA as it then had potential to have significant adverse consequences for all or a part of the Victorian community.
6. In SHERP, it is presumed that the Public Health Commander (the Chief Health Officer or delegate) will be appointed State Controller for identified public health emergencies, and the State Health Coordinator is appointed for all other emergencies (per **Attachment 3**). However, I recommended the State Health Coordinator as controller for the 2019-nCov outbreak to manage the growing social and economic impacts of the virus across government and provide access to the needed logistics and communications support,

rather than hazard (virus) control. Specifically, through the State Co-ordination Team, departments are providing necessary planning, logistics and communications support to the public health response. For emergencies where the Public Health Commander is not appointed the State Controller, the Chief Health Officer's authority under the *Public Health and Wellbeing Act* 2008 (PHWA) remains unaffected, and public health decisions should not be overridden by a State Controller. In particular, he continues to approve all public health messaging.

7. Influencing my recommendation, is the key role the CHO plays in developing advice through the Australian Health Protection Principal Committee given the national and international dimensions of this outbreak, and has the central role in media and other interfaces. Also, as you are aware, we have few public health physicians, limiting the options for deputising or rostering of additional state roles while maintaining the core incident management in the department.
8. Utilising the State Co-ordination Team and the Emergency Management Joint Public Information Committee (EMJPIC) as clear support roles (and not response) requires a flexible approach by them and the Emergency Management Commissioner (EMC). I discussed my proposed recommendation with the EMC and he was supportive.
9. There are circumstances in which I would make a new recommendation that the CHO be appointed the class 2 state controller:
    - Should the 2019-nCov outbreak worsen significantly to impact overall community health, and the Minister declares a state of emergency under the PHWA
    - Should the CHO seek to use his powers under a state of emergency to require quarantine of classes of people due to pandemic conditions, potentially requiring direction of police resources
    - Should public responses to the outbreak and/or public health response warrant escalation to level 3 incident under the SHERP due to very high impact on normal health system operations or the need for much more complex multi-portfolio response management.
10. The need to escalate or de-escalate our response within the SHERP will be continually reviewed as the situation changes or new information becomes available.

Additional information

11. Under the EMA, health emergencies can be classified as Class 2 emergencies. The Emergency Management Manual Victoria designates DHHS as the control agency for health emergencies including human disease.
12. In addition to the EMA, the Public Health and Wellbeing Act 2008 provide authority to the Chief Health Officer (CHO) for control functions related to the management of public health incidents and emergencies.
13. The Emergency Management Commissioner is accountable for ensuring the response to emergencies in Victoria is systematic and coordinated. This includes ensuring that control arrangements are in place during a Class 2 emergency, responsibility for consequence management for a major emergency
14. Emergency Management Joint Public Information Committee (EMJPIC) provides strategic guidance for state-level messages across all state government departments and agencies. The State Controller (or delegate) will engage the support of the EMJPIC to ensure that state-level messages from all agencies with a role or responsibility in managing the impact and consequences of health emergencies are prioritised and included in key messages to the public.

Prepared and approved by: Melissa Skilbeck, Deputy Secretary, Regulation, Health Protection and Emergency Management, REDACTED...../...../2020

Department of Health and Human Services

50 Lonsdale Street
Melbourne Victoria 3000
Telephone: 1300 650 172
GPO Box 4057
Melbourne Victoria 3001
www.dhhs.vic.gov.au
DX 210081

EMERGENCY MANAGEMENT ACT 2013

INSTRUMENT OF APPOINTMENT

I, **Melissa Skilbeck**, Deputy Secretary Regulation Health Protection and Emergency Management, Department of Health and Human Services in accordance with the State Emergency Response Plan and State Health Emergency Response Plan Edition 4 (subplan) under the Emergency Management Act 2013 appoint **Andrea Spiteri**, Director Emergency Management as a Class 2 State Controller.

Commencement

This instrument commences today, Friday 1 November 2019.

Melissa Skilbeck
Deputy Secretary, Deputy Secretary, Regulation, Health Protection and Emergency Management
State Health Emergency Management Coordinator under State Health Emergency Response Plan 4

VICTORIA State Government

Operation Soteria

Mandatory Quarantine for all Victorian Arrivals

Approved for distribution

Emergency Management Commissioner	Signature	Date
Andrew Crisp		

Distribution

State Control Team	As per planning contacts list:
Strategic Planning Committee	DHHS
EMJPIC	DJPR
State Relief & Recovery Team / CAOG	DPC
	VicPol
	Department of Transport

Document Details

Version	Status	Author	Reviewer/s	Authorised for Release	Date/Time
0.1	Draft for initial discussion	REDACTED REDACTED	-	Andrew Crisp	27 March 2020
0.2	Draft for release as version	REDACTED	Operation Soteria Coordination meeting	Andrew Crisp	28 March 2020 - 1815 hours
1.0	Final Version released	REDACTED	-	Andrew Crisp	28 March 2020 - 2000 hours
2.0	New version released	DHHS Deputy Commander	Public Health Commander DHHS Commanders State Controller - Health	Andrew Crisp	24 April 2020
2.1	Updated version	Respective DHHS leads	Public Health Commander State Controller - Health	Andrew Crisp	8 May 2020

Abbreviations/Acronyms

ABF	Australian Border Force
AFP	Australian Federal Police
AO	Authorised Officer
AV	Ambulance Victoria
DFAT	Department of Foreign Affairs and Trade
DHHS	Department of Health and Human Services
DJPR	Department of Jobs, Department of Jobs, Precincts and Regions
DoT	Department of Transport Department of Transport
EOC	Operations Soteria Emergency Operations Centre
EMV	Emergency Management Victoria Emergency Management Victoria
VicPol	Victoria Police Victoria Police

Contents

1 Introduction

1.1 Purpose

The purpose of this plan is to document the arrangements in place under Operation Soteria, to achieve safe, authorised mandatory detention of returning travellers required to quarantine for 14 days on their arrival into Victoria.

1.2 Scope

This document addresses the legislative and operational requirements for maintaining returned travellers in mandatory detention.

1.3 Audience

This document is intended for use by DHHS staff, and staff from all other departments and organisations involved in Operation Soteria.

1.4 Background

Australian National Cabinet directed that all passengers returning from international destinations who arrive in Australia after midnight on Saturday 28 March 2020 are to undergo 14 days enforced quarantine in hotels to curb the spread of COVID-19. Passengers are to be quarantined in the city in which they land, irrespective of where they live.

A mandatory quarantine (detention) approach was introduced by the Victorian Government, consistent with the Commonwealth Government (Department of Health Information for International Travellers) policy that a detention order would be used for all people arriving from overseas into Victoria from midnight on Saturday 28 March 2020. The policy is given effect through a direction and detention notice under the *Public Health and Wellbeing Act 2008* (PHWA). See https://www.dhhs.vic.gov.au/state-emergency

The objectives for people returning from overseas to Victoria are:

- To identify any instance of illness in returned travellers in order to detect any instance of infection
- To ensure effective isolation of cases should illness occur in a returned traveller
- To provide for the health and welfare needs of returned travellers who are well or shown to be COVID-19 negative but are required to remain in quarantine for the required 14 days
- To implement the direction of the Deputy Chief Health Officer through meeting:
  - A requirement to detain anyone arriving from overseas for a period of 14 days at a hotel in specific room for a specified period unless an individual determination is made that no detention is required
  - A requirement to record provision of a detention notice showing that the order was served and to manage access to information on who is in detention using a secure database
  - A requirement to undertake checks every 24 hours by a department Compliance Lead during the period of detention
  - A requirement to fairly and reasonably assess any request for permission to leave the hotel room / detention. This may be undertaken as part of a wholistic approach involving AOs, DHHS welfare staff, medical practitioners, nurses and other specialist areas if needed.

1.5 Mission

To implement the safe and secure mandatory quarantine measures for all passengers entering Victoria through international air and sea points-of-entry to stop the spread of COVID-19.

1.6 Inter-agency cooperation

Agencies engaged to deliver Operation Soteria include:

- Department of Health and Human Services (DHHS)
- Department of Jobs, Precincts and Regions (DJPR)
- Department of Foreign Affairs and Trade (DFAT)
- Department of Transport (DoT)
- Ambulance Victoria (AV)
- Australian Border Force (ABF)
- Australian Federal Police (AFP)
- Victoria Police (VicPol)

1.7 Process Flow

The process flow for Operation is structured in five phases, including a preliminary phase.

These phases include the following:

- **Preliminary Phase (Plan & Prepare)** – identify incoming passengers and required hotel selection, and prepare for passenger arrival
- **Phase 1 (On the Flight)** – manage / process exemption requests and confirm passenger manifest
- **Phase 2 (Landed)** – Passengers land and are issued Detention Notices and are triaged. Passengers (Detainees) are transferred to Quarantine Hotels (or hospital if required)
- **Phase 3 (Arrival at Hotel)** – Passengers receive health checks, check in, provide completed questionnaires and specialist needs managed
- **Phase 4 (Quarantined)** – Passengers are quarantined in their hotel rooms and are provided with case management where health, welfare, FV, MH, etc issues arise. Quarantine compliance is also managed
- **Phase 5 (Exit)** – Managed release from quarantine, exit transfer and specialist case management. This also includes specialist hotel cleaning and refurbishment

See **Appendix 1** for an expanded description of the phases.

2 Governance

2.1 Governance

Operation Soteria is led by the DHHS Commander COVID-19 Accommodation working to the State Controller – Health, to give effect to the decisions and directions of the Public Health Commander and Enforcement and Compliance Commander. Support agencies, including Department of Transport, Victoria Police, Department of Premier and Cabinet support the Department of Health and Human Services as the control agency for COVID-19 pandemic class 2 public health emergency, as outlined in section 2.3.

Operational leads will meet three times per week (or more frequently as required) for the duration of the operation to ensure combined oversight of the operation. Meetings will be coordinated by SCC support and chaired by the DHHS Commander COVID-19 Accommodation. Membership includes:

- State Controller - Health
- Public Health Commander
- DHHS Enforcement and Compliance Commander
- DHHS COVID-19 Accommodation Commander
- DHHS Agency Commander
- DJPR Agency Commander
- SCC Strategic Communications
- Department of Premier and Cabinet representative
- Department of Transport representative
- Senior Police Liaison Officer – Victoria Police

2.2 Legislative powers

The *Public Health and Wellbeing Act 2008* (Vic) (the **Act**) contains the legislative powers that Operation Soteria gives effect to under the state of emergency has been declared under section 198 of the Act, because of the serious risk to public health posed by COVID-19.

Operation Soteria seeks to mitigate the serious risk to public health as a result of people travelling to Victoria from overseas. People who have been overseas are at the highest risk of infection and are one of the biggest contributors to the spread of COVID-19 throughout Victoria.

In accordance with section 200(1)(a) of the Act, all people travelling to Victoria from overseas will be detained at a hotel specified in the relevant clause in their detention notice, for a period of 14 days, because that is reasonably necessary for the purpose of eliminating or reducing a serious risk to public health.

Having regard to the medical advice, 14 days is the period reasonably required to ensure that returned travellers have not contracted COVID-19 as a result of their overseas travel.

Returned travellers must comply with the directions below because they are reasonably necessary to protect public health, in accordance with section 200(1)(d) of the Act.

Under sections 200(7) and (9) of the Act, the Chief Health Officer is notified of the detention of returned travellers and must advise the Minister for Health.

2.2 Organisational Structure

A diagram indicating the governance of strategy / policy and operation of the mandatory quarantine program is shown in Figure 2 below.

Appendix 2 provides an overview of the Enforcement and Compliance Command structure and **Appendix 3** the COVID-19 Accommodations Command Emergency Operations Centre structures.

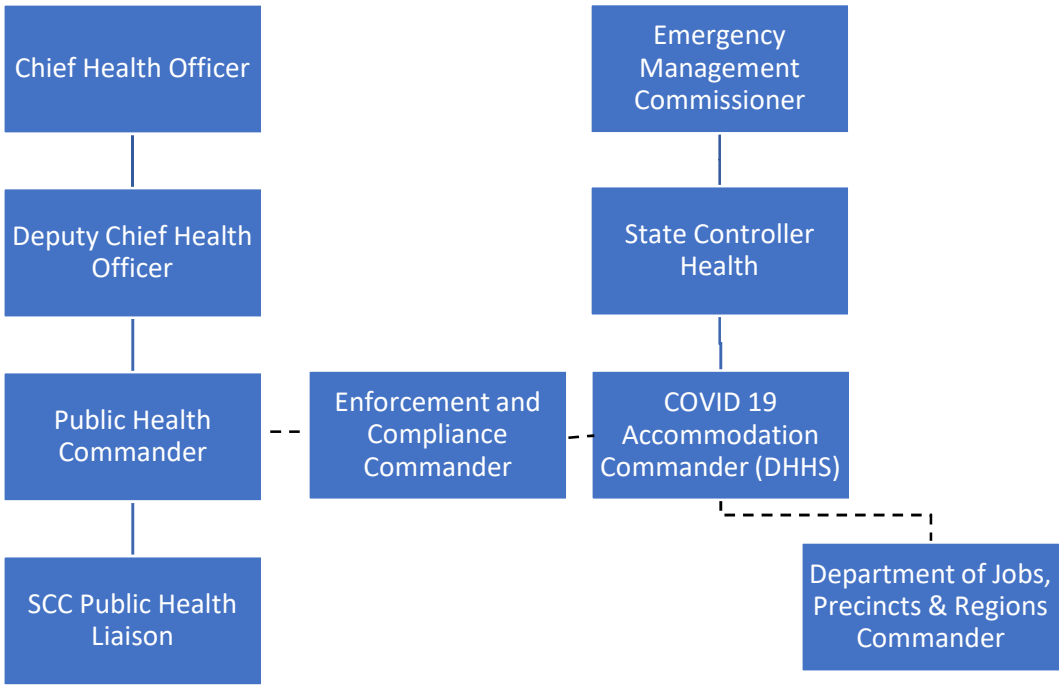


Figure 1: Operation Soteria governance structure

2.3 Roles and Responsibilities

The Emergency Management Commissioner is responsible for approving this plan for distribution.

The Public Health Commander (through the Deputy Public Health Commander / delegate) is responsible for approving this plan, in consultation with the Enforcement and Compliance Commander, DHHS Commander COVID-19 Accommodation, the State Health Coordinator and the State Controller – Health.

The State Controller - Health operating through the DHHS Commander COVID-19 Accommodation has operational accountability for the quarantine accommodation of returned travellers.

The DHHS Commander COVID-19 Accommodation is responsible for:

- provision of welfare to individuals in mandatory quarantine (through the Deputy Commander Welfare);
- ensuring the safety and wellbeing of individuals in mandatory quarantine and DHHS staff;
- ensuring a safe detention environment at all times.
- provision of healthcare to individuals in mandatory quarantine.

2.4 Department of Health and Human Services (DHHS)

DHHS, as the control agency for the COVID-19 pandemic Class 2 public health emergency, has responsibility for the oversight and coordination of Operation Soteria.

2.4.1 Airside operations - biosecurity

- Oversee as instructed by the Human Biosecurity Officer - **Ports of Operation lead, Public Health Incident Management Team**

2.4.2 Airport Operations - reception

- Detention notice issued by Authorised Officers (see Appendix 1) – **DHHS Compliance (AOs)**
- Provision of and conduct of health screening and other well-being services (including psycho-social support) – **DHHS Ports of Entry – Reception (EOC)**
- Arrangement of patient transport services – **DHHS Ports of Entry - Reception (EOC)**
- Provision of personal protective equipment for passengers – **DHHS Port of Entry - Reception (EOC)**
- Registration and initial needs identification of passengers for State-side use/application – **DHHS Ports of Entry - Reception (EOC)**
- Provision of information pack and food/water to passengers - **joint contributions: DHHS Ports of Entry - Reception (EOC)/Department Jobs, Precincts and Regions (DJPR)/VicPol**

2.4.3 Public Health Directions

- Assessment of inquiries and requests relating to directions – **DHHS Directions**
- Enforcement of mandatory detention directions – **DHHS Compliance (AOs)**
- Policy and processes relating to public health including use of Personal Protective Equipment and quarantine requirements for positive and non-positive passengers from the repatriation flight and provide health advice to key stakeholders involved in their care - **DHHS Public Health Command**

2.4.4 Health Coordination

- Maintenance of overall situational awareness of impacts to health services and support for the appropriate implementation of the model of care for those in isolation - **DHHS Health Coordination**

2.4.5 Health and Wellbeing of passengers at accommodation

- Prepare for incoming passenger accommodation registration – **DHHS Detention Hotels (EOC) with DJPR**
- Reception parties established to coordinate movement of passengers from transport into accommodation - **DHHS Ports of Entry – Reception (EOC) with DJPR**
- Detailed identification of, capture and management of welfare needs – **DHHS Detention Hotels (EOC) with DJPR**
- Reception parties established and coordinated at identified accommodation – **DHHS Detention Hotels (EOC) with DJPR**
- Detailed identification of, capture and management of welfare needs at hotels – **DHHS Detention Hotels (EOC) with DJPR**
- Detailed identification of, capture and management of special/social needs - **DHHS Detention Hotels (EOC) with DJPR**
- Establish access to 24/7 medical and nursing support at accommodation points to support passengers with medical and pharmaceutical needs - **DHHS Health Coordination (EOC)**
- Provision of regular welfare calls to all quarantined passengers and support to meet identified needs, such as psychosocial, mental health, family violence - **DHHS Welfare (EOC)**
- Arrangements for any health and welfare needs including ongoing psychosocial support – **DHHS Detention Hotels (EOC)**
- Permissions for temporary leave from place of detention – **DHHS Compliance (AOs)**
- Conduct of voluntary health reviews to allow release back into the community – **DHHS Detention Hotels**
- Advise DoT and VicPol on numbers of passengers scheduled to exit quarantine – **DHHS Detention Hotels**

- Issuing of release documents and legal release of detainees from detention **DHHS Compliance (AOs).**

2.4.6 Communications including public communications

- DHHS will manage communications according to the Operation Soteria Communication Plan.

2.5 Australian Federal Police (AFP)/Australian Border Force (ABF)

- Australian Border Force (ABF) coordinates the return of passengers during their flight.
- The Australian Federal Police (AFP) supports AFB and other agencies in the management of any compliance or criminal issues.

2.5.1 Airside operations

- Melbourne airport security and customs liaison
- Provide passengers with required information about Direction/requirements
- Collection of entry data (manifest)
- Marshall passengers in an area that is secure and be able to facilitate health screening
- Establish arrivals area for transport
- Marshall Passengers for boarding
- Assist boarding of passengers onto bus transport airside
- Escort bus transports to accommodation

2.6 AFP

- Escort bus transports to assigned accommodation
- Transfer manifest to VicPol on arrival at accommodation

2.7 Department of Foreign Affairs and Trade

- The Department of Home Affairs (DFAT) assesses and approves all applications for returning Australians.

2.8 Department of Transport (DoT)

- The transport provider Skybus has been engaged to transport passengers (who do not have any immediate health needs requiring hospitalisation) to quarantine accommodation.
- Provision of transport to passengers to airport or approved transit location.
- Skybus and other DoT solutions tasked in accordance with projected arrivals and exits from quarantine accommodation
- Ensure transport of passengers (who do not have any immediate health needs requiring hospitalisation) between point of entry, to quarantine accommodation and returning to approved transit location following exit from quarantine accommodation

2.9 Ambulance Victoria

- AV has responsibility for pre-hospital care and transport of passengers where required.

2.10 Victoria Police (VicPol)

- Victoria Police provide support to AFP, DHHS and DJPR for enforcement and compliance issues.
- Provision of support to private security as required
- Prepare for transition for State-side security
- Preparation and establishment of State-side security
- Liaise with AFP and Border Force
- Security and management of passenger disembarkation from transport to accommodation
- Marshalling and security of incoming passengers
- Receive manifest and passengers from AFP on arrival at accommodation

2.11 Department of Jobs, Precincts & Regions (DJPR)

DJPR has responsibility for sourcing appropriate accommodation contracts (including food, concierge and security) to support mandatory passenger isolation and providing ongoing support to passengers for these needs.

- Manage accommodation contracts
- Manage transport arrangements/contracts for deliveries (ie: Commercial Passenger Vehicles)
- Manage private security contracts to enforce quarantine requirements at accommodation
- Reception parties established to coordinate movement of passengers from transport into accommodation- with DHHS Accommodation
- Reception parties established and coordinated at identified accommodation –with DHHS Accommodation
- Prepare for incoming passenger accommodation registration –with DHHS Accommodation
- Passenger data reconciled with airside entry data
- Detailed identification of, capture and management of welfare needs- with DHHS Accommodation
- Detailed identification of, capture and management of special/social needs (with DHHS)
- Management of services for all passengers including food, amenities and transport for deliveries.

3 Detention Authorisation

Section approver: Enforcement and Compliance Commander

Last review date: 8 May 2020

3.1 Purpose

The purpose of this Detention Authorisation section is to:

- assist and guide departmental Authorised Officers (AOs) to undertake compliance and enforcement functions and procedures for the direction and detention notice issued under the *Public Health and Wellbeing Act 2008* (PHWA).
- provide clarity about the role and function of AOs.

3.2 Processes may be subject to change

- It is acknowledged that the COVID-19 response is a rapidly evolving situation and matters are subject to fluidity and change. This is particularly the case for the direction and detention notice and the use of hotels to facilitate this direction.
- To this end, this document will not cover every situation and will be subject to change. For example, the process for collecting data and signed direction and detention notices may change.
- This document aims to describe key responsibilities and provide a decision-making framework for AOs. AOs are encouraged to speak to compliance leads for further advice and guidance.

3.3 Enforcement and Compliance Command for Mandatory Quarantine

Deliverables of the enforcement and compliance function

Enforcement and Compliance Command is responsible for:

- overall public health control of the detention of people in mandatory quarantine
- oversight and control of authorised officers administering detention
- administration of decisions to detain and decision to grant leave from detention.

Authorised officer* and Chief Health Officer obligations

Sections 200(1)(a) and 200(2) – (8) of the *Public Health and Wellbeing Act 2008* (PHWA) set out several emergency powers including detaining any person or group of persons in the emergency area for the period reasonably necessary to eliminate or reduce a serious risk to health.

Departmental staff that are authorised to exercise powers under the PHWA may or may not also be authorised to exercise the public health risk powers and emergency powers given under s.199 of the PHWA by the Chief Health Officer (CHO). This authorisation under s.199 has an applicable end date; relevant authorised officers (AOs) must be aware of this date. The CHO has not authorised council Environmental Health Officers to exercise emergency powers.

3.4 Direction and detention notices

An initial notice was issued on 27 March 2020, which ordered the detention of all persons who arrive into Victoria from overseas on or after midnight on 28 March 2020, requiring they be detained in a hotel for a period of 14 days. A second notice (No 2) was issued on 13 April 2020 that requires the detention of all

person who arrived into Victoria from overseas on or after midnight on 13 April 2020, requiring they be detained in a hotel for a period of 14 days.

The directions are displayed on the department's website at https://www.dhhs.vic.gov.au/state-emergency and were made by the Deputy Chief Health Officer or Chief Health Officer:

More information can be obtained from:

https://www.dhhs.vic.gov.au/information-overseas-travellers-coronavirus-disease-covid-19

3.5 Exemptions and exceptional circumstances

Detainees may seek to be exempt from detention or have alternative arrangements for detention. The ECC will consider these where exceptional circumstances exist and where the health and wellbeing of the individual is unable to be met within the hotel environment. These are approved under the authorised approvals outlined in the policy in **Annex 1.**

3.6 Obligations under the Charter of Human Rights and Responsibilities Act 2006

Department AOs are public officials under the Charter of Human Rights. This means that, in providing services and performing functions in relation to persons subject to the Direction and Detention Notice, department AOs must, at all times: act compatibly with human rights; and give 'proper consideration' to the human rights of any person(s) affected by a department AO's decisions. This is outlined in the Charter of Human Rights obligations document.

3.7 Processes and Procedures

To assist the delivery of operations a set of Standard Operating Procedures (SOP) has been developed which outlines the powers, authority and responsibilities of the Authorised officer to provide safe, efficient and effective activities at Ports of Entry and Quarantine Hotels. This set of SOPs is designed to be a 'one stop shop' for Authorised Officers for the provision of duties and activities and services.

The document containing the SOPs will also contain hyperlinks to more detailed procedures and processes. The document is contained at:

- **Annex 1**: Operation Soteria – Authorised Officer Standard Operating Procedures

4 Operations

Section approver: DHHS Commander COVID-19 Accommodation

Last review date: 8 May 2020

4.1 Purpose

This set of guidelines outlines the activities and actions required to provide safe, efficient and effective hotel operations for those persons arriving in Australia via Victoria requiring mandatory quarantine, in accordance with the Standards contained in Annex 2. These guidelines are also designed as a one stop shop for the Team Leaders at ports of entry (both air and sea) and hotel operations as well as the broader team members. This will enable the efficient and effective provision of day to day services and activities required to operationally deliver Operation Soteria.

4.2 Method

This section outlines the operational (including basic health and welfare) arrangements for people in mandatory quarantine as part of Operation Soteria, in the following phases:

- **Preliminary planning** to identify and develop the organisational structures, physical resources and systems required to enact the operation efficiently and effectively.
- **Reception** of passengers entering Australia via Victorian international air or marine ports. Passengers transit customs, are issued a Detention Order, are medically assessed and are transferred via bus from their port of entry to a quarantine hotel.
- **Accommodation** begins when the passengers disembark from the bus at their allotted quarantine hotel to begin their 14-day isolation period. Passenger data is reconciled with air/sea-port arrival data, and they are screened for special/social/welfare/medical/pharmaceutical/food needs. Passengers are allocated accommodation and checked in to the hotel. Passengers are provided with daily health checks and regular welfare calls to identify special needs. Mandatory detention is enforced by DHHS via Authorised Officers.
- **Return to the Community** begins when the guest is reviewed for exit (14 days is elapsed), and involves assessment of whether passengers are safe to enter the Victorian community. Passengers released are briefed, exit quarantine and are transported to an approved transit location, which can include transferring passengers back to the airport for onward air movement.

To oversee these operations, an Emergency Control Centre (EOC) has been established. The role of the is to ensure appropriate and timely coordination and resourcing of the international Ports of Entry into Victoria, and the Mandatory Quarantine Hotels.

An organisational structure of the EOC and hotels on-site structure is attached at **Appendix 3**. The EOC is located at 145 Smith Street Fitzroy.

The EOC will also coordinate the de-escalation of Operation Soteria.

4.3 Processes and Procedures

To assist the delivery of operations a set of Operational Guidelines has been developed which outlines the activities, actions and forms required to provide safe, efficient and effective Port of Entry and quarantine hotel operations.

The document containing the guidelines will also contain hyperlinks to more detailed procedures and processes. The document is contained at:

- **Annex 3**: Operation Soteria – Operational Guidelines for Mandatory Quarantine

5 Health and Welfare

Section approver: Public Health Commander

Last review date: 8 May 2020

5.1 Purpose

The health and welfare of persons in detention is the highest priorities under Operation Soteria.

The Health and Welfare arrangements is based on a set of Public Health Standards for care of returned travellers in mandatory quarantine and Guidelines for managing COVID-19 in mandatory quarantine.

Clinical governance framework

The clinical governance framework for Operation Soteria will ensure that returned passengers in mandatory quarantine receive safe, effective and high-quality care that is consistent with best practice.

This framework integrates existing public health and operational oversight of the nursing, welfare, medical and mental health care provided to people in mandatory quarantine.

The framework ensures that risk from quarantine for individuals, families and the entirety of the passenger group in mandatory quarantine is proactively identified and managed. Information from welfare, nursing, mental health and medical providers will be provided in a secure digital tool which protects passengers' confidentiality and privacy.

This information will be available in real-time to Public Health Command and to Operational Command. Additionally, a daily clinical governance report will identify compliance with Health & Welfare Standards. The daily clinical governance report will also identify and address individual health and welfare issues to ensure that passengers are receiving the right care in the right place at the right time, and that health and welfare staff are able to work safely and effectively to deliver care.

5.2 Standards

The Public Health Standards for care of returned travellers in mandatory quarantine have been developed to ensure that ADEQUATE, APPROPRIATE and TIMELY measures are established and delivered to care for the health and welfare of quarantined persons.

Each standard is composed of a series of criteria to underpin the care of quarantined persons and a suite of indicators to monitor and evaluate the delivery of services. These standards, in **Annex 2**, include:

Standard 1. Rights of people in mandatory quarantine

Criterion 1.1 Charter of Human Rights and Responsibilities

Criterion 1.2 People with disabilities

Criterion 1.3 Use of interpreters

Criterion 1.4 Feedback and complaints process

Standard 2. Screening and follow up of health and welfare risk factors

Criterion 2.1 Health and welfare risk factors

Criterion 2.2 Schedule for screening

Criterion 2.3 Methods of screening

Criterion 2.4 Staff undertaking screening

5.3 Operational Guidelines

The Operational Guidelines for mandatory quarantine (**Annex 3**) have been developed to ensure that public health management principles and processes, and appropriate procedures are applied for each stage of the mandatory quarantine process to ensure the health, wellbeing and safety of detainees. They have been written to follow the path of a returned traveller entering mandatory quarantine.

They are intended for use by DHHS staff, healthcare workers and other departments involved in the care of individuals detained in mandatory quarantine. They will be updated as internal processes change.

Annex 3 contains the Operational Guidelines for managing mandatory quarantine, as per the following heading links.

At the airport

Airport health screening

Management of an unwell person at the airport

Refusal of testing

- At the airport
- At the hotel

At the hotel

Quarantine and isolation arrangements

- Accommodation options to promote effective quarantine
- Room sharing
- COVID floors and hotels

Confirmed cases entering detention

- Current infectious cases
- Recovered cases

Throughout detention

Clinical assessment and testing for COVID-19

- Timing of testing
- Pathology arrangements
- Communication of results

Case management

- Management of suspected cases
- Management of confirmed cases

Hospital transfer plan

- Transfer from hospital to hotel

Exiting detention

Release from isolation

- Criteria for release from isolation
- Process for release from isolation
- Release from detention of a confirmed case

Exit arrangements

- Suspected cases
- Confirmed cases
- Quarantine domestic travel checklist

- Care after release from mandatory quarantine

Operational guidance for mandatory quarantine

- Process for mandatory hotel quarantine
- Quarantined individual becomes a confirmed case
- Quarantined individual becomes a close contact

Infection control and hygiene

- Cleaning
- Laundry
- Personal protective equipment

6 Information and Data Management

6.1 Information management systems

The number of secure databases used for the storage and handling of confidential data on people in detention is minimised to prevent fragmentation of records management and to reduce the risk of critical information not being available to DHHS, health or welfare staff providing for the health and welfare needs of people in detention.

The following information management systems are authorised for use in this operation:

- The Public Health Event Surveillance System (PHESS);
- The healthcare and wellbeing database for mandatory quarantine (Dynamic CRM Database);
- Best Practice general practice software (see 3.3);
- Paper records (where necessary).

6.2 Data access, storage and security

The State Controller - Health, DHHS Commander COVID-19 Accommodation (or delegate) and Public Health Commander (or delegate) are authorised to access any record within these systems to enable oversight of the health and welfare of people in detention.

Information on people arriving internationally is shared with DHHS by DJPR to enable the operational functions under sections 3-5. While multiple applications/systems may be used during the operation, all information will be uploaded to PHESS, which will then hold the complete medical and compliance records for a person who was in detention in Victoria as part of this operation.

6.2.1 Privacy

Respecting the privacy of individuals who are detained under this operation is an important consideration, as information collected contains personal details and other sensitive information.

DHHS staff must comply with the Department of Health and Human Services privacy policy whenever personal and/or health information about passengers/detainees, staff or others is collected, stored, transmitted, shared, used or disclosed.

The privacy policy is an integrated policy, which supports the sensitive protection and management of personal information and seeks to meet the legislative requirements of the *Privacy and Data Protection Act 2014* and *Health Records Act 2001*. Information relating to privacy is available at intranet.dhhs.vic.gov.au/privacy.

6.2.2 Sending information by email

For communication within the department, there are risks to privacy in sending information by email. These include misdirection due to errors in typing the address and the ease of copying, forwarding, amending or disclosing emailed information to others. Care should be taken with the list of addressees, and the title of the email should not contain any identifying information.

6.2.3 Electronic security of passenger/detainee information

In addition to email, passenger/detainee information is stored, accessed and transmitted using systems and devices such as computers, laptops, and smartphones. These systems and devices must be as carefully protected as the passenger/detainee information itself.

An 'information security incident' occurs when the security of the information, system or device is compromised. Some examples of these incidents are:

- the details of a passenger is accidentally sent to the wrong email address
- a case worker's smartphone is lost or stolen and there was information about a passenger/detainee stored on it
- a virus infects a computer that stores or accesses passenger/detainee information.

Information security incidents must be reported to the Emergency Operations Centre who, in turn, will report it to the IT Service Centre.

6.3 Medical records

Medi7 is currently implementing a Best Practice medical record system for record-keeping. This will be uploaded to the DHHS Dynamic CRM Database.

6.3.1 Requirement for accessible medical records

Each quarantined individual must have a medical record accessible to all health care providers who require access to it and who are providing care. This record captures the person's significant medical history, current medications, allergies and any other significant components of the medical history, where these have been revealed by the person in detention or discussed as part of medical care provided to the person during detention. Each time health care is requested **and** provided it must be documented in this record.

6.3.2 Confidentiality and access to medical records

Any medical record created or held by DHHS for a person in detention is confidential and must only be accessed by persons coordinating and providing care for the person. The records will belong to DHHS and can be required to be provided at any time by the medical service contractor to DHHS for review, from the Best Practice software.

These records should be stored securely and should not be accessed by anyone not providing care for the person. Specifically, these medical records must only be accessed or viewed by an AHPRA-registered health practitioner employed by DHHS to provide services to people in detention, an authorised officer, or the Public Health Commander, State Controller - Health, DHHS Commander COVID-19 Accommodation or their named delegate. Other persons involved in Operation Soteria should not access a medical record for an individual unless authorised on a named basis by the Public Health Commander (or delegate) or the State Controller - Health (or delegate).

Accurate and comprehensive medical record keeping is essential for the health and safety of all individuals in mandatory quarantine and will ensure continuity of care for healthcare providers in subsequent shifts. If medical notes are recorded on paper, these should be stored securely and uploaded to the information management system as soon as is practicable and within 72 hours at most. If a doctor completes an assessment, they must provide a written record of this to the nursing staff, either on paper or via email, if an electronic medical record system is not available.

Any medical records documents that are potentially contaminated with COVID-19 (SARS-CoV-2) should be safely placed in plastic pockets to reduce the risk of infection transmission.

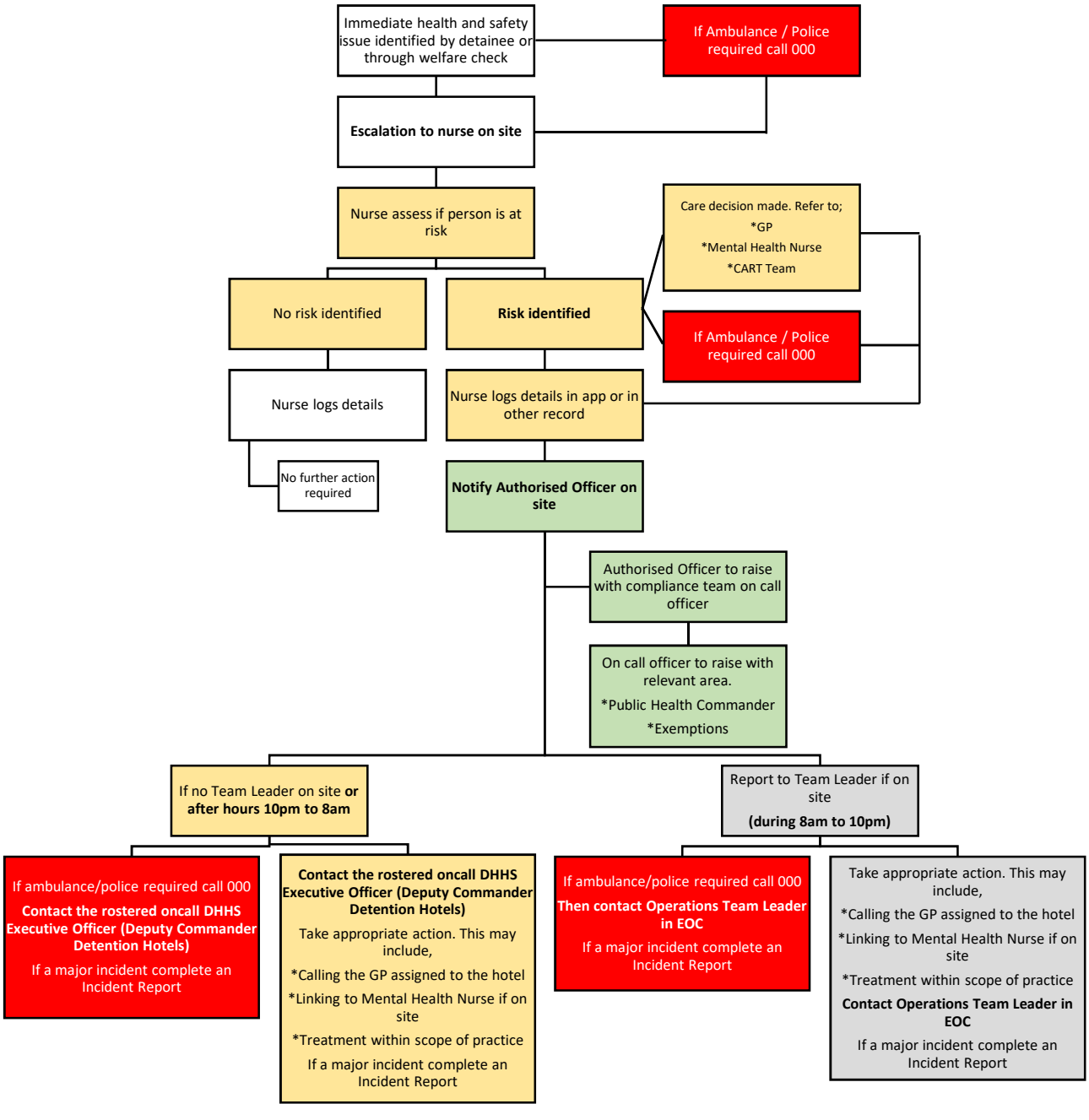
7 Issues escalation and incident reporting

The safety of staff, passengers/detainees and the Victorian community is a key priority of this operation.

All staff undertaking roles under Operation Soteria are responsible for timely and appropriate management and escalation of issues arising under the operation. All risks and incidents must be reported to the Department of Health and Human Services, via the on site Authorised Officer or relevant Commander.

7.1 Hotel escalation process

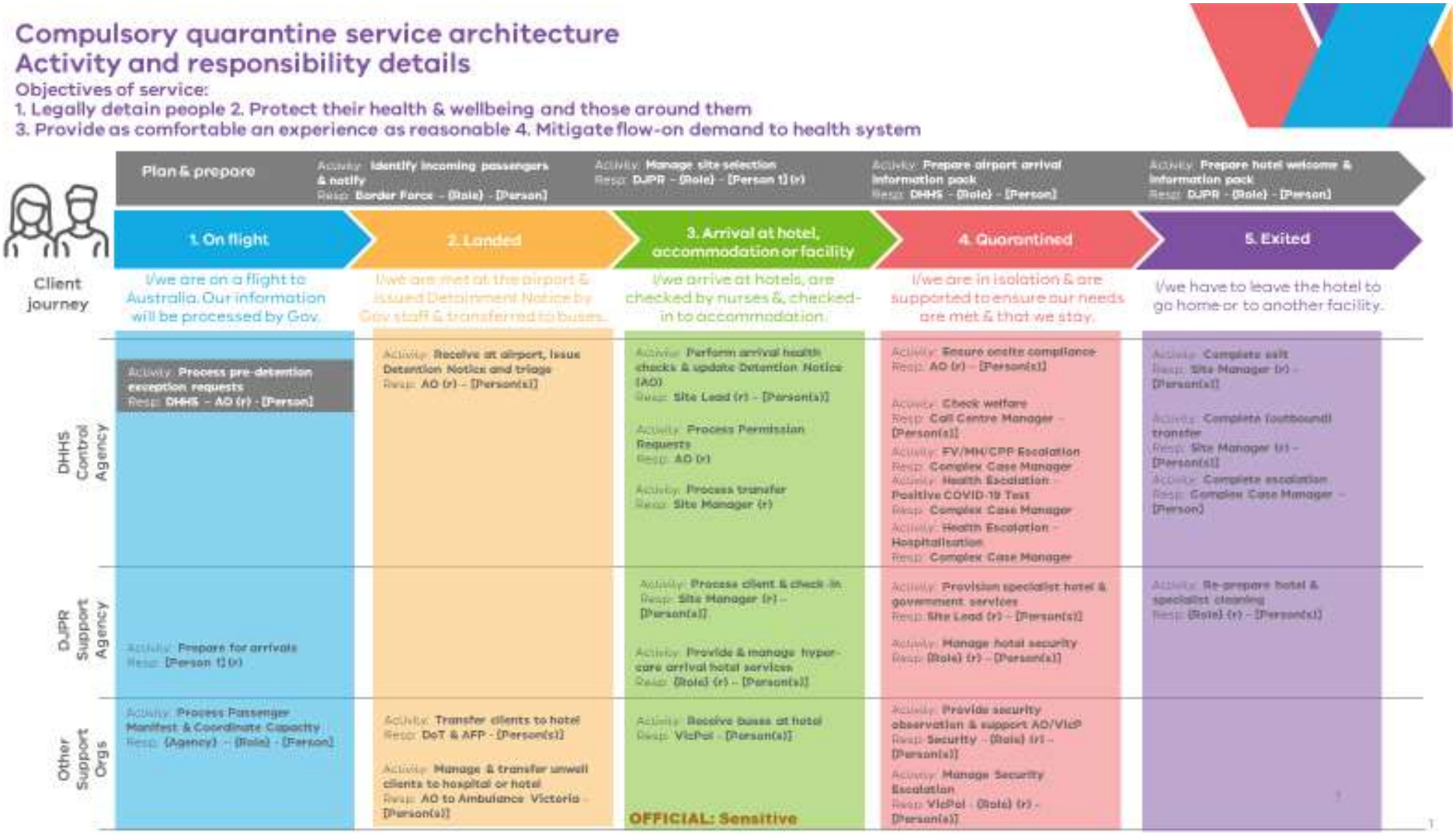
The escalation process in Figure 2 below must be followed for all health and medical risks arising in quarantine hotels.



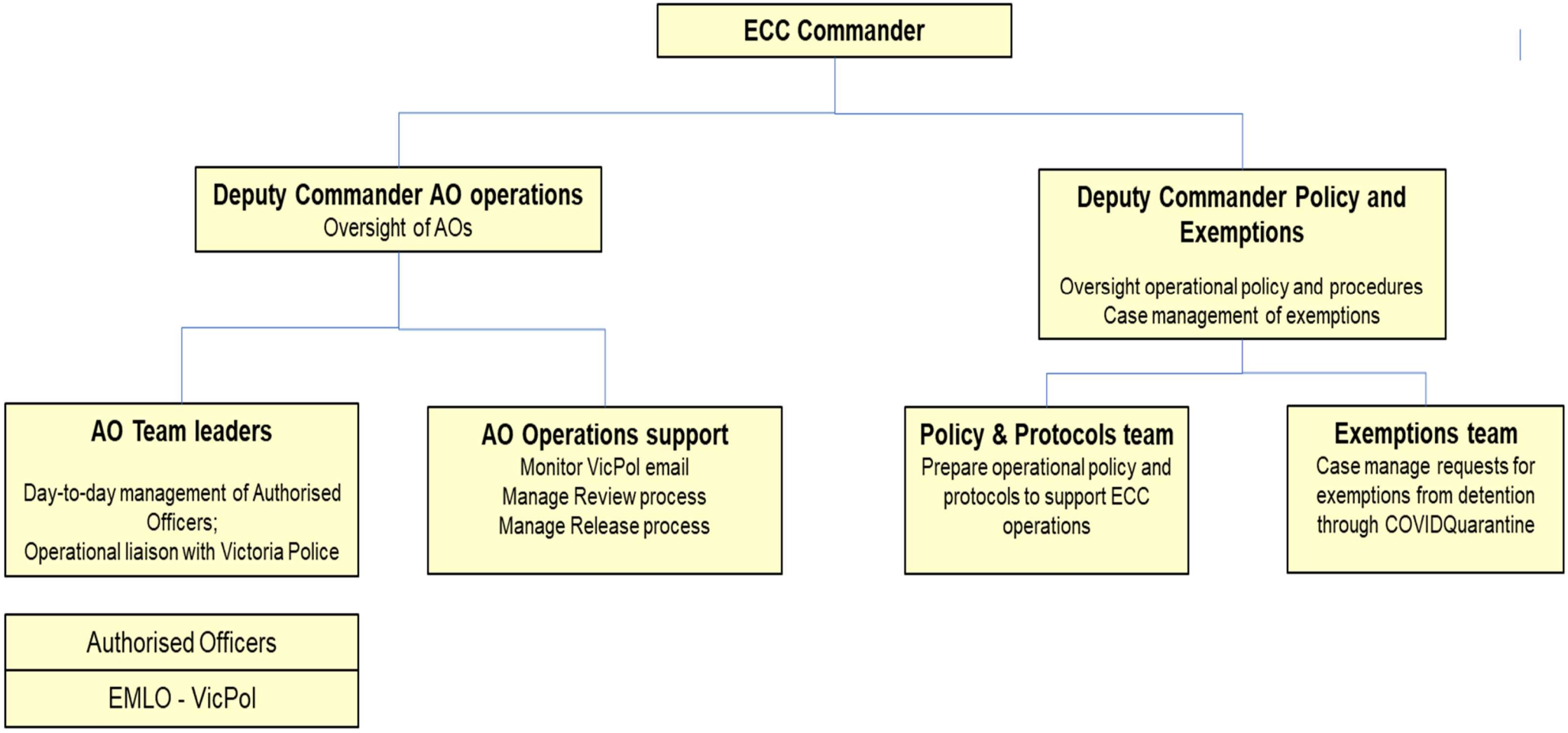
7.2 Incident reporting

The incident reporting process in **Appendix 4** outlines the Department of Health and Human Services management requirements for major incidents or alleged major incidents that involve or impact significantly upon passengers/detainees during airport reception, hotel quarantine, and other users or staff during provision of accommodation services during the COVID-19 emergency. Examples include injury, death, sustaining/diagnosis of a life threatening or serious illness, and assault/crime.

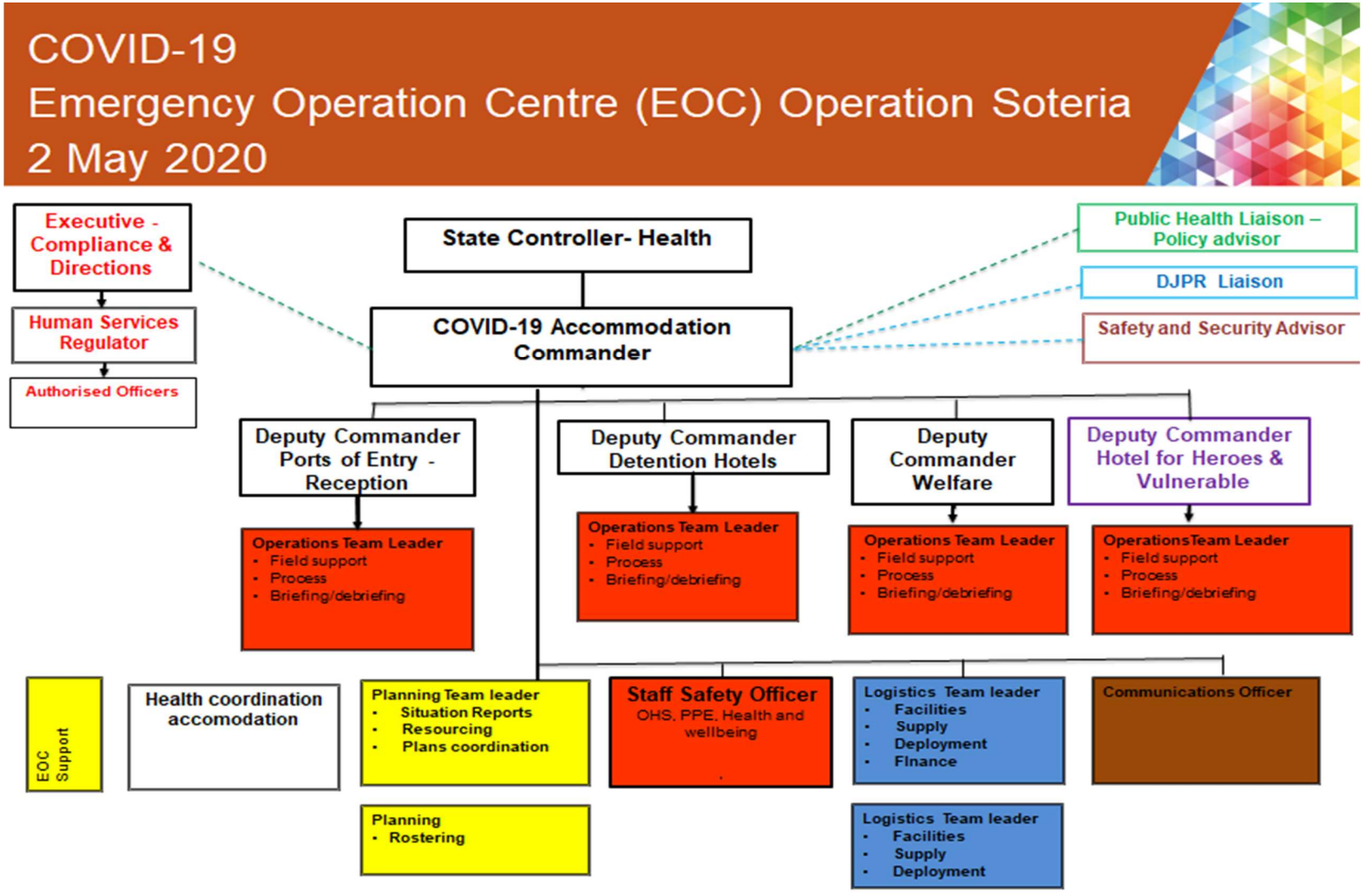
Appendix 1 - Operation Soteria process phases



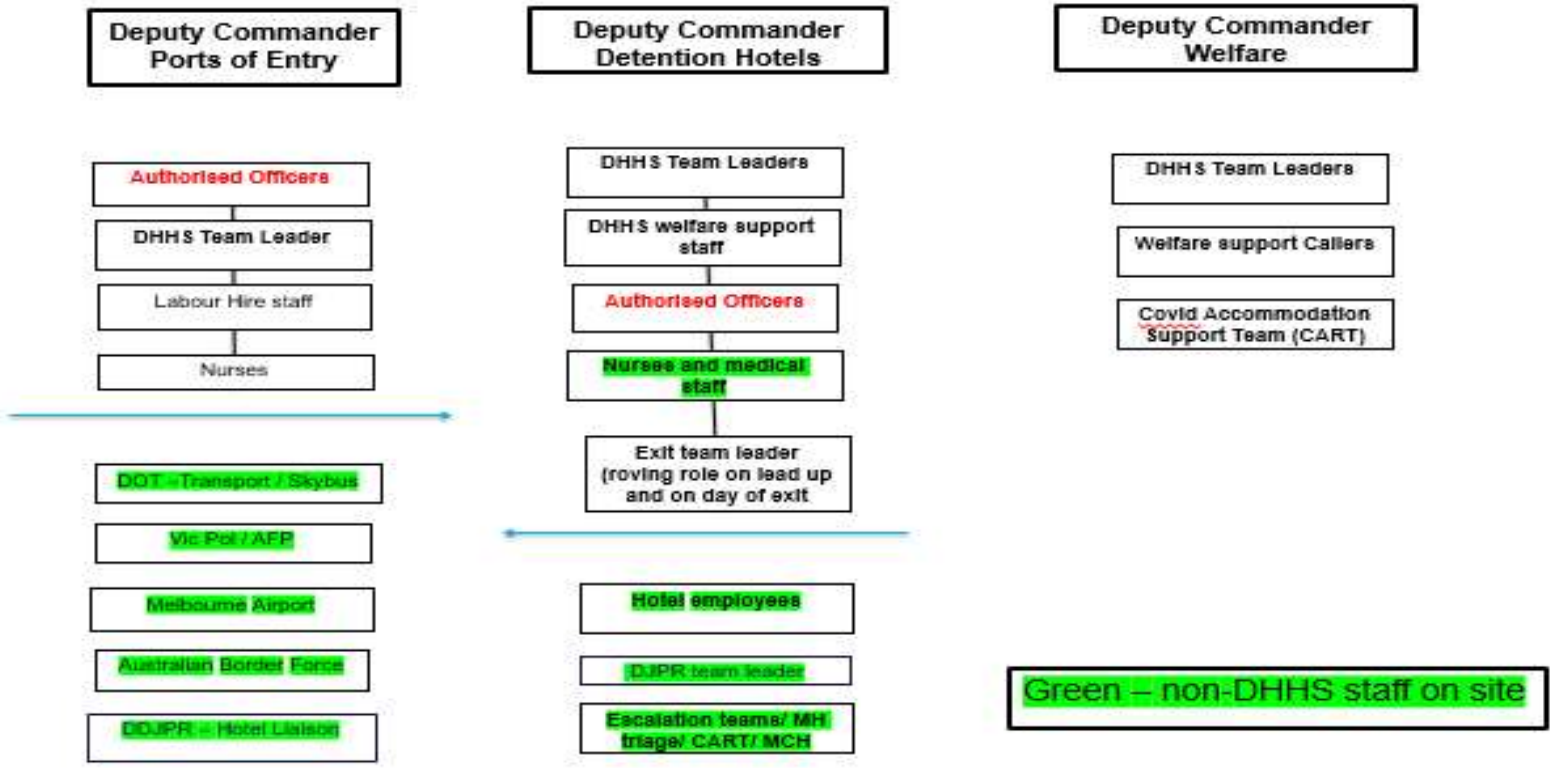
Appendix 2 - Enforcement and Compliance Command structure



Appendix 3 - Emergency Operations Centre Structure



Operation Soteria – on site teams



Appendix 4 - DHHS COVID-19 Quarantine – incident reporting

1. Introduction

This document outlines the Department of Health and Human Services 'the department' management requirements for major incidents or alleged major incidents that involve or impact significantly upon passengers/detainees during airport reception, hotel quarantine, and other users or staff during provision of accommodation services during the COVID-19 emergency. Examples include injury, death, sustaining/diagnosis of a life threatening or serious illness, and assault/crime.

The primary audience for this document is departmental staff on site and senior officers who are involved in reviewing, endorsing, processing, recording and analysing incident reports after Parts 1–6 of the incident report have been completed at the service delivery level supported by the appropriate Deputy Commander.

This document was last reviewed on 29 April 2020.

2. Reviewing and endorsing incident reports

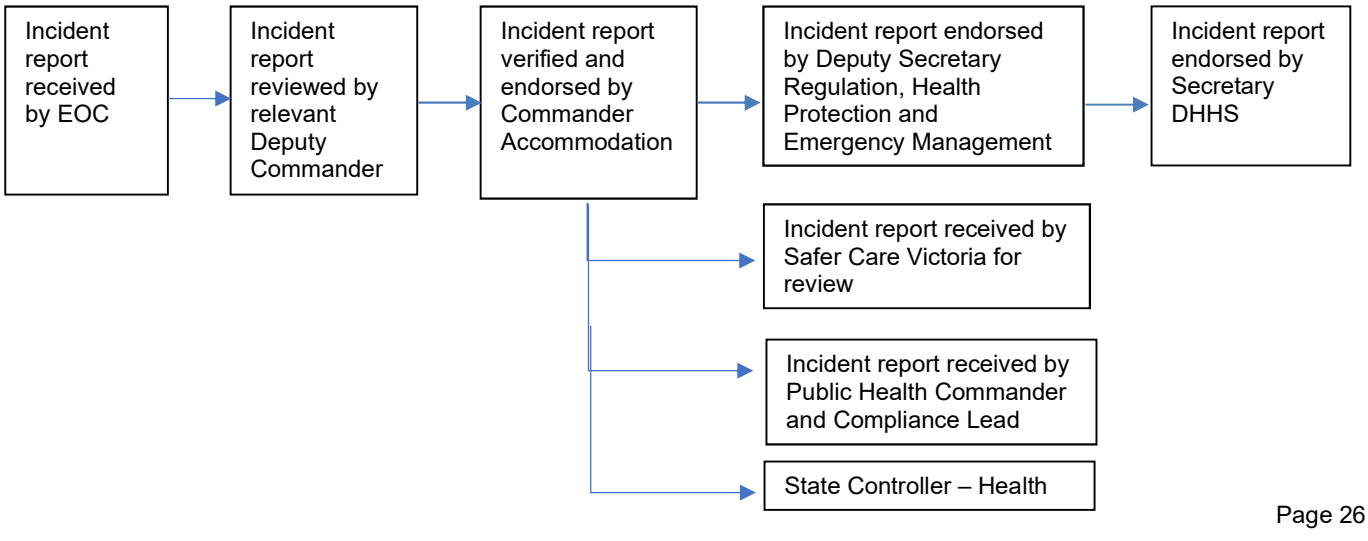
This section outlines the steps required for reviewing and endorsing incident reports, once provided to the DHHS Commander Accommodation via dhhsopsoteriaeoc@dhhs.vic.gov.au following verbal report from the relevant Deputy Commander. Figure 1 below provides an overview of the process.

2.1. Overview

Incident reports (Parts 1–6) are completed by the most senior departmental staff immediately involved in the management of the incident onsite, with support of the relevant Deputy Commander. In the case of any incident, the first priority is making sure passengers/detainees and staff are safe, and in hotels, appropriate care provided (see escalation process for hotel detention). After that, an incident report must be completed and sent to the Commander COVID-19 Accommodation via dhhsopsoteriaeoc@dhhs.vic.gov.au following verbal report. The report includes immediate actions that have been taken and planned follow-up actions.

The specified department officers review the incident report, and complete parts 7-9. The Commander Accommodation is also responsible for sending the report to Safer Care Victoria, the Public Health Commander, State Controller – Health and the Compliance Lead.

Figure 1: High Level flowchart for reviewing and endorsing an incident report



The incident report form is available from the Operation Soteria Emergency Operations Centre (EOC), dhhsopsoteriaeoc@dhhs.vic.gov.au or relevant Deputy Commander. All reports must be legible and presented in the specified report format.

2.2. Deputy Commander receives an incident report

When an incident report is forwarded to the DHHS EOC, the report is registered in the EOC's electronic file system, TRIM, and allocated a reference number. It is then forwarded to the relevant Deputy Commander as soon as possible (within 1 hour). The staff completing the report will contact the relevant Deputy Commander to advise of the incident.

2.2.1. Reports about passengers/detainees who are also clients

If a passenger/detainee is a client of other service types, service providers or government departments, information regarding a major incident may be disclosed to other agencies or departments to lessen or prevent a serious or imminent threat to a client's life, health, safety or welfare; and/or with the intent of preventing similar incidents from occurring in the future. The Commander Accommodation is responsible for notifying within the department and/or other organisations where the passenger/detainee is known to be a client, with the lead division will inform any community service organisations involved in providing services if applicable.

2.3. Review of the incident report

The relevant Deputy Commander endorses the incident report by completing Part 6 of the incident report (refer to attachment 1).

They must review the incident report and:

- check that the immediate needs of the passenger/detainee(s) have been addressed
- check that appropriate immediate actions have been taken in response to the incident and that any planned further actions are appropriate
- if a particular requirement has not been undertaken, the reasons why are documented
- ensure that the passenger/detainee and location details have been recorded and are accurate
- ensure all sections of the incident report are completed
- record any additional or required follow-up action (if any).

2.4. Verify and endorse the incident category

The Commander Accommodation verifies and endorses the incident report.

The Commander Accommodation is responsible for escalating an incident report to the Deputy Secretary Regulation, Health Protection and Emergency Management to endorse, and sending the report to the Public Health Commander, the Compliance Lead and Safer Care Victoria via irtreviews@safercare.vic.gov.au for review.

The Deputy Secretary Regulation, Health Protection and Emergency Management is responsible to escalate the incident report to the Secretary Department of Health and Human Services for endorsement.

2.5. File the completed incident report

After Parts 7-9 have been completed and endorsed, the incident report is returned to the Emergency Operations Centre for records management. This constitutes the final completed report.

The final completed report must be placed in a TRIM record must be updated in accordance with the department's record management policy.

Where allegations are made against a staff member, the incident report and any subsequent reports are to be retained in the staff file.

2.6. Incident report records management and privacy

Incident reports (paper versions and related electronic data) must be stored securely and only accessed by staff that have a business purpose for doing so. Paper reports are discouraged, and if required, should be stored in locked filing cabinets. Access to electronic data should be limited to appropriate staff only.

2.7. Local investigation and causal analysis

The Commander Accommodation will ensure that the incident is subject to an appropriate level of local investigation and causal analysis and that, where relevant, an improvement strategy is prepared.

Incident investigations should:

- identify reasons for the incident occurring
- identify opportunities for improvement in management systems or service delivery practice
- make local recommendations and implement improvement strategies in order to prevent or minimise recurrences. These strategies should be actionable and measurable and include an assessment of their effectiveness in delivering improvement
- satisfy mandatory reporting or review requirements (for example, notifying the Coroner or WorkSafe).

3. Privacy

Respecting the privacy of individuals who are involved in or witness to an incident is an important consideration in dealing with incident reports, which often contain personal details and other sensitive information.

Departmental staff must comply with the Department of Health and Human Services privacy policy whenever personal and/or health information about passengers/detainees, staff or others is collected, stored, transmitted, shared, used or disclosed.

The privacy policy is an integrated policy, which supports the sensitive protection and management of personal information and seeks to meet the legislative requirements of the *Privacy and Data Protection Act 2014* and *Health Records Act 2001*. Information relating to privacy is available at intranet.dhhs.vic.gov.au/privacy.

3.1. Sending information by email

For communication within the department, there are risks to privacy in sending information by email. These include misdirection due to errors in typing the address and the ease of copying, forwarding, amending or disclosing emailed information to others. Care should be taken with the list of addressees, and the subject line of the email should not contain any identifying information.

3.2. Electronic security of passenger/detainee information

In addition to email, passenger/detainee information is stored, accessed and transmitted using emergency management systems and devices (including computers, laptops, and smartphones). These systems and devices must be as carefully protected as the passenger/detainee information itself.

An 'information security incident' occurs when the security of the information, system or device is compromised. Some examples of these incidents are:

- the details of a passenger is accidentally sent to the wrong email address
- a case worker's smartphone is lost or stolen and there was information about a passenger/detainee stored on it
- a virus infects a computer that stores or accesses passenger/detainee information.

Information security incidents must be reported to the Emergency Operations Centre who, in turn, will report it to the IT Service Centre.

DHHS Quarantine – incident reporting template

Reference number	
Impact (Major only) *e.g. injury, death, sustaining/diagnosing life threatening condition, assault/crime*	

1. Service provider details

Reporting organisation	
Address of service delivery	
DHHS Service Area *(e.g. Emergency Management)*	
Service type	

2. Incident dates

Date of incident	
Date accuracy (exact/approximate)	
Time of incident	
Time accuracy (exact/approximate)	
Date incident disclosed	
Time incident disclosed	

3. Incident description

Location of incident	
Detailed incident description	

4. Individual details – Passenger/detainee 1 [duplicate for each person involved]

Passenger/detainee's full name	
Passenger/detainee incident impact	
Sex	
Indigenous status	
Date of birth	
Passenger/detainee address	
Passenger/detainee unique identifier number *(if applicable)*	
Incident type	
Involvement in the incident (victim, witness, subject of abuse allegation, participant)	
Passenger/detainee's immediate safety needs met (Yes/No)	
Medical attention provided (Yes/No)	
Passenger/detainee debriefing or counselling (Yes/No	
Referral to support services (Yes/No)	
Change passenger/detainee care (support plan) (Yes/No)	
Notified next of kin, guardian or key support person (Yes/No)	

5. Other/s involved in incident [duplicate for each other person involved]

Person's full name	
Date of birth	
Person's job title or relationship to passenger/detainee (carer, paid staff, other)	
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	

6. Service provider response details

Brief summary of incident	
Reported to police (Yes/No)	
Name of officer and date reported to police	
Police investigation initiated (Yes/No)	
Staff member stood down/removed (Yes/No)	
Manager's full name	
Manager's job title	

Date incident report reviewed	
Manager telephone number	
Manager email	
Immediate actions taken by the organisation in response to the incident	
Deputy Commander full name and signature	
Deputy Commander job title	
Date incident report approved	
Comments	

7. Incident report authorisation – EOC Command

Delegated authority full name and signature	
Delegated authority job title	Commander COVID-19 Accommodation
Date incident report approved	
Delegated authority phone number	
Delegated authority email address	
Comments	

8. Incident report authorisation – Deputy Secretary

Delegated authority full name and signature	
Delegated authority job title	
Date incident report endorsed	
Delegated authority phone number	
Delegated authority email address	
Comments (optional)	

9. Incident report authorisation - Secretary

Delegated authority full name	
Delegated authority job title	
Date incident report endorsed	

Operation Soteria

Forced Quarantine
for all Australian Arrivals
from Midnight 28 March 2020
State of Victoria

Operations Plan

Approved for distribution by:

Emergency Management Commissioner	Signature	Date / Time
Andrew Crisp	Signed and scanned	28/3/2020 2000

Operation Soteria

Distribution

State Control Team	As per planning contacts list:
Strategic Planning Committee	DHHS
EMJPIC	DJPR
State Relief & Recovery Team / CAOG	DPC
	VicPol
	Department of Transport

Document Details

Version	Status	Author	Reviewer	Authorised for Release	Date
0.1	Draft for initial discussion	Kaylene Jones / Angus Hindmarsh		Andrew Crisp	27 March 2020
0.2	Draft for release as version 1.0	Deb Abbott / Kaylene Jones	Operation Soteria Coordination Meeting	Andrew Crisp	28 March 2020 1815 hours
1.0	Final Version released			Andrew Crisp	28 March 2020 2000 hours

Operation Soteria

1. SITUATION

Prime Minister Scott Morrison has announced that all passengers who arrive in Australia after midnight on Saturday 28 March 2020 will go into mandatory quarantine in hotels for a fortnight.

- Passengers will be quarantined in the city in which they land, irrespective of where they live
- Two thirds of Australia's coronavirus cases are from people travelling from overseas
- Defence personnel will help State and Territory Police enforce self-isolation rules

1.1 Background

- Australian National Cabinet has directed that all passengers returning to Australia from international destinations are to undergo 14 days enforced quarantine.
- Expected volume of international passenger arrivals is 1500 per day.
- Direction from the Chief Health Officer is pending
- Heightened measures to curb the spread of COVID-19
- Assume small window of opportunity will lead to a spike in arrivals
- Primary port is assumed as Melbourne Airport.
- Alternate ports of entry may include Essendon Airport (Corporate Charter); Port of Melbourne, Geelong Port, Portland Port, Western Port (Cargo); Station Pier (passenger)
- Control for every movement upon arrival remains the authority of the Chief Health Officer

1.2 Authorising Environment - TBC

Public Health and Wellbeing Act 2008 (Vic)

Supporting documentation – Detention Notice issued pursuant to Public Health and Wellbeing Act 2008 (Vic) Section 200 (*to be provided - Appendix 1*)

1.3 Definitions

Passengers:	Are all individuals who arrive in Australia after midnight on Saturday 28 March 2020 and who are quarantined in hotels for 14 days

2. MISSION

To implement enforced quarantine measures for all passengers entering Victoria through international air and sea points-of-entry to stop the spread of COVID-19.

Operation Soteria

3. EXECUTION

- **Purpose**. Slow the spread of COVID-19 through Victoria
- **Method**. Implement enforced quarantine of passengers arriving internationally into Victoria.
- **End state**. All passengers that have arrived internationally to Victoria are quarantined for 14 days in order to mitigate the spread of COVID-19 within the Victorian community.

3.1 Phases to achieve identified objectives

3.1.1 Preliminary Actions

- During this period, all preparatory activities, to receive and comfortably accommodate arriving passengers that support each of the phases to be completed

3.1.2 Phase 1 – Reception

- Begins when passengers arrive via international airport or maritime port, separated from the general population to prevent transmission, transit through customs and prepared for travel to quarantine locations.
- This phase ends once passengers have embarked on bus transport

3.1.3 Phase 2 – Transport

- Begins with buses leaving international airport or maritime port.
- It involves the transit of passengers to quarantine accommodation in vicinity of COVID testing centres.
- This phase ends once passengers exit transport vehicles

3.1.4 Phase 3 – Accommodation

- This phase begins when reception party receives passengers for quarantine.
- This will involve 14 days of isolation within commercial hotel/motel solutions in vicinity of their entry points.
- This phase ends once 14 days has lapsed and members are reviewed for approval to exit quarantine accommodation.

3.1.5 Phase 4 – Return to the Community

- This phase begins when the member is reviewed for exit by quarantine management
- This will involve an assessment whether the passengers are safe to be allowed into the Victorian community.
- This phase ends once the member has been briefed on their health responsibilities and exits quarantine.

Operation Soteria

3.2 Preliminary Phase

- Information is developed, distributed and executed as per communications plan
- All resources (physical and human) are in position ready to execute phases as required

3.3 Phase 1 – Reception

REDACTED
REDACTED Department of Health and Human Services (DHHS) are lead State-side

3.3.1 Communications

- DHHS will manage communications according to the Communications Plan
- DPC provide authorisation to overall Communications Plan

3.3.2 Airside Operations

3.3.2.1 AFP/ABF

- Melbourne airport security and customs liaison
- Provide passengers with required information about Direction/requirements
- Collection of entry data (manifest)
- Marshall passengers in an area that is secure and be able to facilitate health screening

3.3.2.2 DHHS

- Provision of and conduct of health screening and other well-being services (including psycho-social support)
- Provision of personal protective equipment for passengers
- Registration and initial needs identification of passengers for State-side use/application
- Provision of information pack for passengers [Joint contributions: DHHS/Department Jobs, Precincts and Regions (DJPR)/VicPol]

3.3.2.3 AFP/ABF

- Establish arrivals area for transport
- Marshall Passengers for boarding
- Assist boarding of passengers onto bus transport airside
- Escort bus transports to accommodation

3.3.2.4 Department of Transport (DoT)

- Manage bus transport State-side to accommodation

3.3.2.5 VicPol

REDACTED

Operation Soteria

3.3.3 State-side Operations

3.3.3.1 DHHS and DJPR

- Reception parties established and coordinated at all identified accommodation

3.3.3.2 VicPol

REDACTED

3.4 Phase 2 – Transport

Note: DoT are lead

3.4.1 Communications

- DHHS will manage communications according to the Communications Plan
- DPC provide authorisation to overall Communications Plan

3.4.2 DoT

- Skybus and other DoT solutions tasked in accordance with projected arrivals
- Ensure transport of passengers between point of entry and accommodation

3.4.3 AFP

- Escort passengers to assigned accommodation
- Transfer manifest to VicPol on arrival at accommodation

3.4.4 VicPol

- Security and management of passenger disembarkation
- Marshalling and security of incoming passengers
- Receive manifest and passengers from AFP on arrival at accommodation

3.4.5 DHHS and DJPR

- Prepare for incoming passenger accommodation registration

3.5 Phase 3 – Accommodation

3.5.1 Communications

- DHHS will manage communications according to the Communications Plan
- DPC provide authorisation to overall Communications Plan

3.5.2 DJPR

- Manage accommodation contracts
- Manage private security contracts to enforce quarantine requirements at accommodation
- Reception parties established to coordinate movement of passengers from transport into accommodation (with DHHS)
- Detailed identification of, capture and management of special/social needs (with DHHS)

Operation Soteria

- Management of services for all passengers including food and amenities

3.5.3 DHHS

- Passenger data reconciled with airside entry data
- Detailed identification of, capture and management of special/social needs (with DJPR)
- Establish FEMO teams at accommodation points to undertake initial health screening
- If required, social workers to provide support to passengers with complex needs
- Provision of psycho-social first aid
- Access to 24/7 nursing support for emerging health needs
- Provision of regular welfare calls to all quarantined passengers

3.5.4 VicPol

- Provision of support to private security as required

3.6 Phase 4 – Return to the Community

3.6.1 Communications

- DHHS will manage communications according to the Communications Plan
- DPC provide authorisation to overall Communications Plan

3.6.2 DHHS

- Conduct of health reviews to allow release back into the community
- Outgoing passenger responsibilities brief
- Arrangements for any ongoing Psycho-social support

3.6.3 DoT

- Provision of transport to passengers to original destination/transit node

3.7 Strategies and tactics proposed to achieve tasks and objectives

3.7.1 Coordinating Instructions

3.7.1.1 Timings

Preliminary Phase

- Arrival data and maritime ports confirmed no later than 28 1000 Mar 20
- Transport confirmed no later than 28 1300 Mar 20
- Quarantine Accommodation confirmed no later than 28 1600 Mar 20
- International terminal at Tullamarine prepared for quarantine by 28 2200 Mar 20

Phase 1

- Reception party at international airport and maritime port no later than one hour prior to scheduled flights/vessel arrivals

Phase 2

- Transport in position no later than 1 hour prior to scheduled flights/vessel arrivals

Phase 3

- Service provision is in place for passenger quarantine for a minimum of 14 days

Operation Soteria

Phase 4

- Release party in place to meet passenger needs for an effective return to community

3.7.1.2 Locations

Airports

- Tullamarine

Maritime Ports

- TBC

Quarantine Accommodation

- TBC

3.8 Daily arrivals schedule – *see Appendix 2*

3.9 Synchronisation matrix - *See Appendix 4*

4. COORDINATION

State Control Centre is the central coordination point for all phases

4.1 Communications Plan (Lead DHHS - Marita Tabain)

4.1.1 Authorisation of communications plan by DPC

4.1.2 Communications plan to incorporate:

- To returning citizens/residents
- To returning citizens/residents family
- Media release plan

4.2 Planning Points of Contact – *See Appendix 3*

Operation Soteria

Appendix 1

Detention Order pending

Operation Soteria

Appendix 2

DAILY TIMINGS (AS AT 28 1609 MAR 20)

Arrivals for 29 March 2020

Passenger arrivals MEL (Tullamarine)

Flight Number	Sched. Date	Depart. Airport	Sched. Arrival time	Aircraft type	Gate	Pax	Comment
QR994	29/3/2020	DOH	0700	77W	9	17	Doha
AC037	29/3/2020	YVR	0835	789	7	119	Vancouver
CZ321	29/3/2020	CAN	0940	333	16	38	Guangzhou
MU737	29/3/2020	PVG	1000	789	18	18	Shanghai Pudong
NZ123	29/3/2020	AKL	1050	77W	11	100	Auckland 1 X UNACCOMP. MINOR
QR904	29/3/2020	DOH	1830	351	9	200	Doha
Total Passengers						**492**	

Flights in transit 28 March 2020 – Flight tracking on time as at 1955 hrs 28 March 2020

Flight Number	Sched. Date	Depart. Airport	Sched. Arrival time	Aircraft type	Gate	Pax	Comment
CX163	28/3/2020	HKG	2252		16		Hong Kong

Operation Soteria

Appendix 3

Contacts List

Department	Contact Name	Email	Phone
State Control Centre – Deputy Controller Class 2 – Health.. Operation Soteria	Chris Eagle	REDACTE @delwp.vic.gov.au	REDACTED
Department of Transport	Jeroen Weimar Kim Schriner	REDACTED @ptv.vic.gov.au REDACTED @transport.vic.gov.au	
Department of Jobs, Precincts and Regions	Claire Febey Rob Holland	REDACTE @ecodev.vic.gov.au REDACTED @ecodev.vic.gov.au	
Department of Health and Human Services - SCC	Michael Mefflin	REDACTED @dhhs.vic.gov.au	
VicPol	Mick Grainger Sussan Thomas	REDACTED @police.vic.gov.au REDACTED @police.vic.gov.au	
Department of Premier and Cabinet – Communications	Marita Tabain Sarah Caines		
Department of Premier and Cabinet	Helen Stitt	REDACT @dpc.vic.gov.au	
Department of Health and Human Services – Melbourne Airport Representative			
Emergency Management Victoria	Deb Abbott Kaylene Jones	REDACTED @scc.vic.gov.au	
ADF	John Molnar	REDACTED @scc.vic.gov.au	

Operation Soteria

Appendix 4

Outline of agency involvement across the stages of enforced quarantine

Function	Lead agency	Preliminary Stage	Stage 1 : Receive passengers at point of entry	Stage 2: Move passengers from point of entry to accommodation	Stage 3: Accommodate passengers for 14 days	Stage 4: Release of passengers from accommodation
Command and Control	SCC	Queue and trigger DHHS as required	Monitoring the task and coordinate actions	Monitoring the task and coordinate actions	Monitoring the task and coordinate actions	Monitoring the task and coordinate actions
	DHHS	Plan/organise	Operational command	Operational command	Operational command	Operational command
Process	Australian Border Force/ Australian Federal Police	Preparation	Receive and process passengers (airside). REDACTED			
Process	DJPR	Preparation		Transfer of responsibility from DJPR to DoT	Assist DHHS	Assist DHHS
Transport	DoT	Organisation of transport for stage 2	Position buses at the point of entry, ready for stage 2	Receiving transfer of responsibility from DJPR. Executive move of passengers from point of entry to accommodation	Transfer of responsibility to DHHS	Prepared to provide transport solutions for passengers to their home/intended residence while in Victoria
Accommodation	DHHS	Organisation of transport for stage 3	Confirm readiness of accommodation, ready for stage 3	Receive travellers at accommodation	Receiving responsibility from DoT Manage, monitor and respond to passengers at accommodation	Manage release of passengers →
Strategic Messaging	DPC	Conduct messaging to: • passengers • any persons intending to receive passengers • general public • media	Monitoring adverse media/public reaction (external stakeholders)			
Security	VicPol	Prepare for response, contain	Support containment and respond as needed			
Health and Wellbeing	DHHS	Prepare for support	Supporting			

Victorian State Control Centre

Operation Soteria

Mandatory Quarantine for all Victorian Arrivals

Approved for distribution

Emergency Management Commissioner	Signature	Date
Andrew Crisp	Signed copy kept on file	26/04/2020

Distribution

State Control Team	As per planning contacts list:
Strategic Planning Committee	DHHS
EMJPIC	DJPR
State Relief & Recovery Team / CAOG	DPC
	VicPol
	Department of Transport

Document Details

Version	Status	Author	Reviewer/s	Authorised for Release	Date/Time
0.1	Draft for initial discussion	Kaylene Jones / Angus Hindmarsh	-	Andrew Crisp	27 March 2020
0.2	Draft for release as version	Deb Abbott / Kaylene Jones	Operation Soteria Coordination meeting	Andrew Crisp	28 March 2020 -1815 hours
1.0	Final Version released	Deb Abbott / Kaylene Jones	-	Andrew Crisp	28 March 2020 -2000 hours
2.0	New version released	DHHS Deputy Commander	Public Health Commander DHHS Commanders State Controller - Health	Andrew Crisp	

Abbreviations/Acronyms

ABF	Australian Border Force
AFP	Australian Federal Police
AV	Ambulance Victoria
DFAT	Department of Foreign Affairs and Trade
DHHS	Department of Health and Human Services
DJPR	Department of Jobs, Department of Jobs, Precincts and Regions
DoT	Department of Transport Department of Transport
EOC	Operations Soteria Emergency Operations Centre
EMV	Emergency Management Victoria Emergency Management Victoria
VicPol	Victoria Police Victoria Police

Contents

1 Introduction

1.1 Purpose

The purpose of this plan is to document the arrangements in place under Operation Soteria, to achieve safe, authorised mandatory detention of returning travellers required to quarantine for 14 days on their arrival into Victoria.

1.2 Scope

This document addresses the legislative and operational requirements for maintaining returned travellers in mandatory detention.

1.3 Audience

This document is intended for use by DHHS staff, and staff from all other departments and organisations involved in Operation Soteria.

1.4 Background

Australian National Cabinet directed that all passengers returning from international destinations who arrive in Australia after midnight on Saturday 28 March 2020 are to undergo 14 days enforced quarantine in hotels to curb the spread of COVID-19. Passengers are to be quarantined in the city in which they land, irrespective of where they live.

A mandatory quarantine (detention) approach was introduced by the Victorian Government, consistent with the Commonwealth Government (Department of Health Information for International Travellers) policy that a detention order would be used for all people arriving from overseas into Victoria from midnight on Saturday 28 March 2020. The policy is given effect through a direction and detention notice under the *Public Health and Wellbeing Act 2008* (PHWA). See https://www.dhhs.vic.gov.au/state-emergency

The objectives for people returning from overseas to Victoria are:

- To identify any instance of illness in returned travellers in order to detect any instance of infection
- To ensure effective isolation of cases should illness occur in a returned traveller
- To provide for the health and welfare needs of returned travellers who are well or shown to be COVID-19 negative but are required to remain in quarantine for the required 14 days
- To implement the direction of the Deputy Chief Health Officer through meeting:
  - A requirement to detain anyone arriving from overseas for a period of 14 days at a hotel in specific room for a specified period unless an individual determination is made that no detention is required
  - A requirement to record provision of a detention notice showing that the order was served and to manage access to information on who is in detention using a secure database
  - A requirement to undertake checks every 24 hours by a department Compliance Lead during the period of detention
  - A requirement to fairly and reasonably assess any request for permission to leave the hotel room / detention. This may be undertaken as part of a wholistic approach involving AOs, DHHS welfare staff, medical practitioners, nurses and other specialist areas if needed.

1.5 Mission

To implement the safe and secure mandatory quarantine measures for all passengers entering Victoria through international air and sea points-of-entry to stop the spread of COVID-19.

1.6 Inter-agency cooperation

Agencies engaged to deliver Operation Soteria include:

- Department of Health and Human Services (DHHS)
- Department of Jobs, Precincts and Regions (DJPR)
- Department of Foreign Affairs and Trade (DFAT)
- Department of Transport (DoT)
- Ambulance Victoria (AV)
- Australian Border Force (ABF)
- Australian Federal Police (AFP)
- Victoria Police (VicPol)

1.7 Process Flow

The process flow for Operation is structured in five phases, including a preliminary phase.

These phases include the following:

- **Preliminary Phase (Plan & Prepare)** – identify incoming passengers and required hotel selection, and prepare for passenger arrival
- **Phase 1 (On the Flight)** – manage / process exemption requests and confirm passenger manifest
- **Phase 2 (Landed)** – Passengers land and are issued Detention Notices and are triaged. Passengers (Detainees) are transferred to Quarantine Hotels (or hospital if required)
- **Phase 3 (Arrival at Hotel)** – Passengers receive health checks, check in, provide completed questionnaires and specialist needs managed
- **Phase 4 (Quarantined)** – Passengers are quarantined in their hotel rooms and are provided with case management where health, welfare, FV, MH, etc issues arise. Quarantine compliance is also managed
- **Phase 5 (Exit)** – Managed release from quarantine, exit transfer and specialist case management. This also includes specialist hotel cleaning and refurbishment

See **Appendix 1** for an expanded description of the phases.

2 Governance

2.1 Governance

Operation Soteria is led by the Deputy State Controller (Operation Soteria) working to the State Controller – Health, to give effect to the decisions and directions of the Public Health Commander and Enforcement and Compliance Commander. Support agencies, including Department of Transport, Victoria Police, Department of Premier and Cabinet support the Department of Health and Human Services as the control agency for COVID-19 pandemic class 2 public health emergency, as outlined in section 2.3.

Operational leads will meet daily (or more frequently as required) for the duration of the operation to ensure combined oversight of the operation. Meetings will be coordinated by SCC support and chaired by the Deputy State Controller – Health. Membership includes:

- State Controller - Health
- Deputy State Controller – Health
- Public Health Commander
- DHHS Enforcement and Compliance Commander
- DHHS COVID-19 Accommodation Commander
- DHHS Agency Commander
- DJPR Agency Commander
- SCC Strategic Communications
- Department of Premier and Cabinet representative
- Department of Transport representative
- Senior Police Liaison Officer – Victoria Police

2.2 Legislative powers

The *Public Health and Wellbeing Act 2008* (Vic) (the **Act**) contains the legislative powers that Operation Soteria gives effect to under the state of emergency has been declared under section 198 of the Act, because of the serious risk to public health posed by COVID-19.

Operation Soteria seeks to mitigate the serious risk to public health as a result of people travelling to Victoria from overseas. People who have been overseas are at the highest risk of infection and are one of the biggest contributors to the spread of COVID-19 throughout Victoria.

In accordance with section 200(1)(a) of the Act, all people travelling to Victoria from overseas will be detained at a hotel specified in the relevant clause in their detention notice, for a period of 14 days, because that is reasonably necessary for the purpose of eliminating or reducing a serious risk to public health.

Having regard to the medical advice, 14 days is the period reasonably required to ensure that returned travellers have not contracted COVID-19 as a result of their overseas travel.

Returned travellers must comply with the directions below because they are reasonably necessary to protect public health, in accordance with section 200(1)(d) of the Act.

Under sections 200(7) and (9) of the Act, the Chief Health Officer is notified of the detention of returned travellers, and must advise the Minister for Health.

2.2 Organisational Structure

A diagram indicating the governance of strategy / policy and operation of the mandatory quarantine program is shown in Figure 2 below.

Appendix 2 provides an overview of the Enforcement and Compliance Command structure and **Appendix 3** the COVID-19 Accommodations Command Emergency Operations Centre structures.

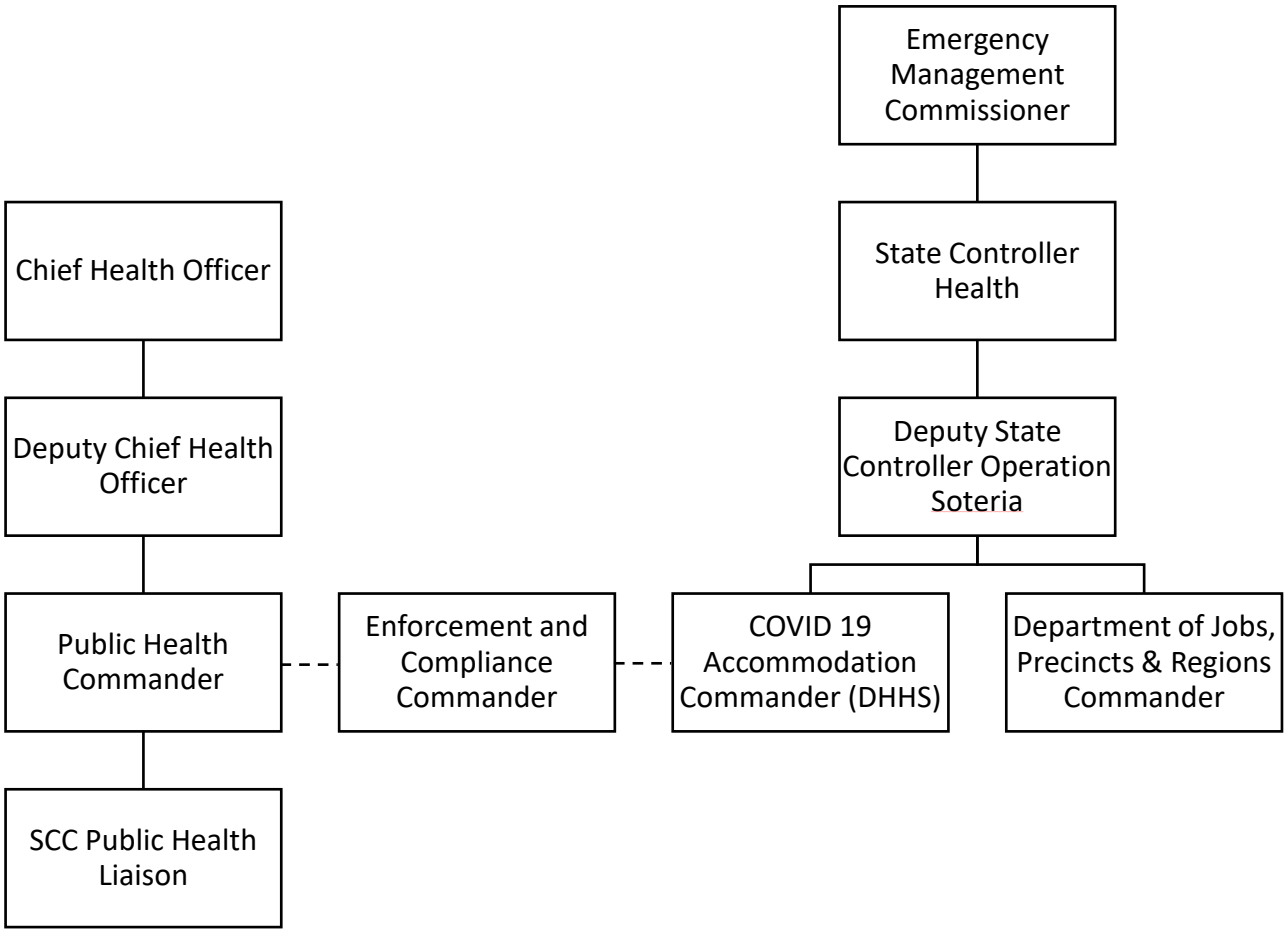


Figure 1: Operation Soteria governance structure

2.3 Roles and Responsibilities

The Emergency Management Commissioner is responsible for approving this plan for distribution.

The Public Health Commander (through the Deputy Public Health Commander / delegate) is responsible for approving this plan, in consultation with the Enforcement and Compliance Commander, Commander COVID-19 Accommodation, the State Health Coordinator and the State Controller – Health.

The State Controller - Health (through the Deputy State Controller Operations Soteria), operating through the Commander COVID-19 Accommodation has operational accountability for the quarantine accommodation of returned travellers.

The DHHS Commander COVID-19 Accommodation is responsible for:

- provision of welfare to individuals in mandatory quarantine (through the Deputy Commander Welfare);
- ensuring the safety and wellbeing of individuals in mandatory quarantine and DHHS staff;
- ensuring a safe detention environment at all times.
- provision of healthcare to individuals in mandatory quarantine.

2.4 Department of Health and Human Services (DHHS)

DHHS, as the control agency for the COVID-19 pandemic Class 2 public health emergency, has responsibility for the oversight and coordination of Operation Soteria.

2.4.1 Airside operations - biosecurity

- Oversee as instructed by the Human Biosecurity Officer - Ports of Operation lead, Public Health Incident Management Team

2.4.2 Airport Operations - reception

- Detention notice issued by Authorised Officers (see Appendix 1) – **DHHS Compliance (AOs)**
- Provision of and conduct of health screening and other well-being services (including psycho-social support) – **DHHS Ports of Entry – Reception (EOC)**
- Arrangement of patient transport services – **DHHS Ports of Entry - Reception (EOC)**
- Provision of personal protective equipment for passengers – **DHHS Port of Entry - Reception (EOC)**
- Registration and initial needs identification of passengers for State-side use/application – **DHHS Ports of Entry - Reception (EOC)**
- Provision of information pack and food/water to passengers - **joint contributions: DHHS Ports of Entry - Reception (EOC)/Department Jobs, Precincts and Regions (DJPR)/VicPol**

2.4.3 Public Health Directions

- Assessment of inquiries and requests relating to directions – **DHHS Directions**
- Enforcement of mandatory detention directions – **DHHS Compliance (AOs)**
- Policy and processes relating to public health including use of Personal Protective Equipment and quarantine requirements for positive and non-positive passengers from the repatriation flight and provide health advice to key stakeholders involved in their care - **DHHS Public Health Command**

2.4.4 Health Coordination

- Maintenance of overall situational awareness of impacts to health services and support for the appropriate implementation of the model of care for those in isolation - **DHHS Health Coordination**

2.4.5 Health and Wellbeing of passengers at accommodation

- Prepare for incoming passenger accommodation registration – **DHHS Detention Hotels (EOC) with DJPR**
- Reception parties established to coordinate movement of passengers from transport into accommodation - **DHHS Ports of Entry – Reception (EOC) with DJPR**
- Detailed identification of, capture and management of welfare needs – **DHHS Detention Hotels (EOC) with DJPR**
- Reception parties established and coordinated at identified accommodation – **DHHS Detention Hotels (EOC) with DJPR**
- Detailed identification of, capture and management of welfare needs at hotels – **DHHS Detention Hotels (EOC) with DJPR**
- Detailed identification of, capture and management of special/social needs - **DHHS Detention Hotels (EOC) with DJPR**
- Establish access to 24/7 medical and nursing support at accommodation points to support passengers with medical and pharmaceutical needs - **DHHS Health Coordination (EOC)**
- Provision of regular welfare calls to all quarantined passengers and support to meet identified needs, such as psychosocial, mental health, family violence - **DHHS Welfare (EOC)**

- Arrangements for any health and welfare needs including ongoing psychosocial support – **DHHS Detention Hotels (EOC)**
- Permissions for temporary leave from place of detention – **DHHS Compliance (AOs)**
- Conduct of voluntary health reviews to allow release back into the community – **DHHS Detention Hotels**
- Advise DoT and VicPol on numbers of passengers scheduled to exit quarantine – **DHHS Detention Hotels**
- Issuing of release documents and legal release of detainees from detention **DHHS Compliance (AOs).**

2.4.6 Communications including public communications

- DHHS will manage communications according to the Operation Soteria Communication Plan.

2.5 Australian Federal Police (AFP)/Australian Border Force (ABF)

REDACTED

2.5.1 Airside operations

- Melbourne airport security and customs liaison
- Provide passengers with required information about Direction/requirements
- Collection of entry data (manifest)
- Marshall passengers in an area that is secure and be able to facilitate health screening
- Establish arrivals area for transport
- Marshall Passengers for boarding
- Assist boarding of passengers onto bus transport airside
- Escort bus transports to accommodation

2.6 AFP

- Escort bus transports to assigned accommodation
- Transfer manifest to VicPol on arrival at accommodation

2.7 Department of Foreign Affairs and Trade

- The Department of Home Affairs (DFAT) assesses and approves all applications for returning Australians.

2.8 Department of Transport (DoT)

- The transport provider Skybus has been engaged to transport passengers (who do not have any immediate health needs requiring hospitalisation) to quarantine accommodation.
- Provision of transport to passengers to airport or approved transit location.
- Skybus and other DoT solutions tasked in accordance with projected arrivals and exits from quarantine accommodation
- Ensure transport of passengers (who do not have any immediate health needs requiring hospitalisation) between point of entry, to quarantine accommodation and returning to approved transit location following exit from quarantine accommodation

2.9 Ambulance Victoria

- AV has responsibility for pre-hospital care and transport of passengers where required.

2.10 Victoria Police (VicPol)

- Victoria Police provide support to AFP, DHHS and DJPR for enforcement and compliance issues.
- Provision of support to private security as required

REDACTED

- Security and management of passenger disembarkation from transport to accommodation
- Marshalling and security of incoming passengers
- Receive manifest and passengers from AFP on arrival at accommodation

2.11 Department of Jobs, Precincts & Regions (DJPR)

DJPR has responsibility for sourcing appropriate accommodation contracts (including food, concierge and security) to support mandatory passenger isolation and providing ongoing support to passengers for these needs.

- Manage accommodation contracts
- Manage transport arrangements/contracts for deliveries (ie: Commercial Passenger Vehicles)
- Manage private security contracts to enforce quarantine requirements at accommodation
- Reception parties established to coordinate movement of passengers from transport into accommodation- with DHHS Accommodation
- Reception parties established and coordinated at identified accommodation –with DHHS Accommodation
- Prepare for incoming passenger accommodation registration –with DHHS Accommodation
- Passenger data reconciled with airside entry data
- Detailed identification of, capture and management of welfare needs- with DHHS Accommodation
- Detailed identification of, capture and management of special/social needs (with DHHS)
- Management of services for all passengers including food, amenities and transport for deliveries.

3 Detention Authorisation

Section approver: Enforcement and Compliance Commander.

Last review date: 24 April 2020

3.1 Purpose

The purpose of this Detention Authorisation section is to:

- assist and guide departmental Authorised Officers (AOs) to undertake compliance and enforcement functions and procedures for the direction and detention notice issued under the *Public Health and Wellbeing Act 2008* (PHWA).
- provide clarity about the role and function of AOs.

3.2 Processes may be subject to change

- It is acknowledged that the COVID-19 response is a rapidly evolving situation and matters are subject to fluidity and change. This is particularly the case for the direction and detention notice and the use of hotels to facilitate this direction.
- To this end, this document will not cover every situation and will be subject to change. For example, the process for collecting data and signed direction and detention notices may change.
- This document aims to describe key responsibilities and provide a decision-making framework for AOs. AOs are encouraged to speak to compliance leads for further advice and guidance.

3.3 Enforcement and Compliance Command for Mandatory Quarantine

Deliverables of the enforcement and compliance function

Enforcement and Compliance Command is responsible for:

- overall public health control of the detention of people in mandatory quarantine
- oversight and control of authorised officers administering detention
- administration of decisions to detain and decision to grant leave from detention.

Authorised officer* and Chief Health Officer obligations

Sections 200(1)(a) and 200(2) – (8) of the *Public Health and Wellbeing Act 2008* (PHWA) set out several emergency powers including detaining any person or group of persons in the emergency area for the period reasonably necessary to eliminate or reduce a serious risk to health.

Departmental staff that are authorised to exercise powers under the PHWA may or may not also be authorised to exercise the public health risk powers and emergency powers given under s.199 of the PHWA by the Chief Health Officer (CHO). This authorisation under s.199 has an applicable end date; relevant authorised officers (AOs) must be aware of this date. The CHO has not authorised council Environmental Health Officers to exercise emergency powers.

3.4 Direction and detention notices

An initial notice was issued on 27 March 2020, which ordered the detention of all persons who arrive into Victoria from overseas on or after midnight on 28 March 2020, requiring they be detained in a hotel for a period of 14 days. A second notice (No 2) was issued on 13 April 2020 that requires the detention of all person who arrived into Victoria from overseas on or after midnight on 13 April 2020, requiring they be detained in a hotel for a period of 14 days.

The directions are displayed on the department's website at https://www.dhhs.vic.gov.au/state-emergency and were made by the Deputy Chief Health Officer or Chief Health Officer:

More information can be obtained from:

https://www.dhhs.vic.gov.au/information-overseas-travellers-coronavirus-disease-covid-19

3.5 Exemptions and exceptional circumstances

Detainees may seek to be exempt from detention or have alternative arrangements for detention. The ECC will consider these where exceptional circumstances exist and where the health and wellbeing of the individual is unable to be met within the hotel environment. These are approved under the authorised approvals outlined in the policy in **Annex 1.**

3.6 Obligations under the Charter of Human Rights and Responsibilities Act 2006

Department AOs are public officials under the Charter of Human Rights. This means that, in providing services and performing functions in relation to persons subject to the Direction and Detention Notice, department AOs must, at all times: act compatibly with human rights; and give 'proper consideration' to the human rights of any person(s) affected by a department AO's decisions. This is outlined in the Charter of Human Rights obligations document.

3.7 Processes and Procedures

To assist the delivery of operations a set of Standard Operating Procedures (SOP) has been developed which outlines the powers, authority and responsibilities of the Authorised officer to provide safe, efficient and effective activities at Ports of Entry and Quarantine Hotels. This set of SOPs is designed to be a 'one stop shop' for Authorised Officers for the provision of duties and activities and services.

The document containing the SOPs will also contain hyperlinks to more detailed procedures and processes. The document is contained at:

- **Annex 1**: Operation Soteria – Authorised Officer Standard Operating Procedures

3.7.1 Enforcement and compliance information

Further information is available at the links below

- At a glance: Roles and responsibilities
- Authorised officers: Operational contacts
- Authorised officers: Powers and obligations
- Authorised officers: Charter of Human Rights obligations
- Authorised officers: Responsibilities at the Airport
- Authorised officers: Responsibilities at the Hotel
- Authorised officers: Responsibilities for departure from mandatory detention
- End of Detention Notice
- End of Detention Notice (confirmed case or respiratory illness symptoms)
- Compliance and Infringements
- Authorised officers: Occupational Health and Safety
- Unaccompanied minors
- Direction and Detention Notice – Solo Children
- Ensuring physical and mental welfare of international arrivals in individual detention (unaccompanied minors)

- Management of an unwell person at the airport
- Transfer of an uncooperative person
- Request for exemption or temporary leave from quarantine
- Permission for temporary leave from detention
- Requests for to leave room/facility for exercise or smoking
- Hospital transfer plan
- Hospital and Pharmacy contacts for each hotel

4 Operations

Section approver: COVID-19 Accommodation Commander.

Last review date: 24 April 2020

4.1 Purpose

This set of standard operating procedures outlines the activities and actions required to provide safe, efficient and effective hotel operations for those persons arriving in Australia via Victoria requiring Mandatory Quarantine. This set of procedures is also designed as a one stop shop for the Team Leaders at ports of entry (both air and sea) and Hotel operations as well as the broader team members. This will enable the efficient and effective provision of day to day services and activities required to operationally achieve Operation Soteria.

4.2 Method

This plan will outline the operational (including basic health and welfare) arrangements or people in mandatory quarantine as part of Operation Soteria. This has been conducted through:

- **Preliminary planning** to identify and develop the organisational structures, physical resources and systems required to enact the operation efficiently and effectively.
- **Reception** of passengers entering Australia via Victorian international air or marine ports. Passengers transit customs, are issued a Quarantine Order, are medically assessed and are transferred via bus from their port of entry to a Quarantine Hotel.
- **Accommodation** begins when the passengers disembark from the bus at their allotted Quarantine Hotel to begin their 14-day isolation period. Passenger data is reconciled with air/sea-port arrival data, and they are screened for special/social/welfare/medical/pharmaceutical/food needs. Passengers are allocated accommodation and checked in to the hotel. Passengers are provided with regular welfare calls and special needs identified. Mandatory detention is enforced by DHHS via authorised officers.
- **Return to the Community** begins when the guest is reviewed for exit (14 days is elapsed), and involves assessment of whether passengers are safe to enter the Victorian community. Passengers released are briefed, exit quarantine and are transported to an approved transit location, which can include transferring passengers back to the airport for onward air movement.

To oversee these operations, an Emergency Control Centre (EOC) has been established. The role of the is to ensure appropriate and timely coordination and resourcing of the international Ports of Entry into Victoria, and the Quarantine Hotels.

An organisational structure of the EOC and hotels on-site structure is attached at **Appendix 3**. The EOC is located at 145 Smith Street Fitzroy.

The EOC will also coordinate the de-escalation of Operation Soteria.

4.3 Processes and Procedures

To assist the delivery of operations a set of Standard Operating Procedures (SOP) has been developed which outlines the activities, actions and forms required to provide safe, efficient and effective Port of Entry and Quarantine Hotel operations. This set of SOPs is designed to be a ‘one stop shop’ for Team Leaders and members, and EOC staff for the provision of day to day activities and services.

The document containing the SOPs will also contain hyperlinks to more detailed procedures and processes. The document is contained at:

- **Annex 2**: Operation Soteria – Operations Standard Operating Procedures

5 Health and Welfare

Section approver: Public Health Commander.

Last review date: 24 April 2020

5.1 Purpose

The health and welfare of persons in detention is of the highest priorities under Operation Soteria.

The Health and Welfare arrangements is based on a set of Public Health Standards for care of returned travellers in mandatory quarantine and Guidelines for managing COVID-19 in mandatory quarantine.

Clinical governance framework

The clinical governance framework for Operation Soteria will ensure that returned passengers in mandatory quarantine receive safe, effective and high-quality care that is consistent with best practice.

This framework integrates existing public health and operational oversight of the nursing, welfare, medical and mental health care provided to people in mandatory quarantine.

The framework ensures that risk from quarantine for individuals, families and the entirety of the passenger group in mandatory quarantine is proactively identified and managed. Information from welfare, nursing, mental health and medical providers will be provided in a secure digital tool which protects passengers' confidentiality and privacy.

This information will be available in real-time to Public Health Command and to Operational Command. Additionally, a daily clinical governance report will identify compliance with Health & Welfare Standards. The daily clinical governance report will also identify and address individual health and welfare issues to ensure that passengers are receiving the right care in the right place at the right time, and that health and welfare staff are able to work safely and effectively to deliver care.

5.2 Standards

The Public Health Standards for care of returned travellers in mandatory quarantine have been developed to ensure that ADEQUATE, APPROPRIATE and TIMELY measures are established and delivered to care for the health and welfare of quarantined persons.

Each standard is composed of a series of criteria to underpin the care of quarantined persons and a suite of indicators to monitor and evaluate the delivery of services. These standards, in Annex 3, include:

Standard 1. Rights of people in mandatory quarantine

Criterion 1.1 Charter of Human Rights and Responsibilities

Criterion 1.2 People with disabilities

Criterion 1.3 Use of translators

Criterion 1.4 Feedback and complaints process

Standard 2. Screening and follow up of health and welfare risk factors

Criterion 2.1 Health and welfare risk factors

Criterion 2.2 Schedule for screening

Criterion 2.3 Methods of screening

Criterion 2.4 Staff undertaking screening

Criterion 2.5 Risk assessment and follow up of persons ‘at risk’

Standard 3. Provision of health and welfare services

Criterion 3.1 Meeting the needs of people in mandatory quarantine

Criterion 3.2 Provision of on-site clinical services

Criterion 3.3 Provision of welfare services

Criterion 3.4 Provision of pharmacy and pathology services

Criterion 3.5 COVID-19 guidelines in mandatory quarantine

Standard 4. Health promotion and preventive care

Criterion 4.1 Smoking

Criterion 4.2 Fresh air

Criterion 4.3 Exercise

Criterion 4.4 Alcohol and drugs

Standard 5. Infection control

Criterion 5.1 Personal protective equipment (PPE)

Criterion 5.2 Cleaning and waste disposal

Criterion 5.3 Laundry

Criterion 5.4 Isolation protocols

Standard 6. Allergies and dietary requirements

Standard 7. Information and data management (including medical records)

Criterion 7.1 Confidentiality and privacy of personal information (including medical records)

Criterion 7.2 Information security

Criterion 7.3 Transfer of personal information (including medical records)

Criterion 7.4 Retention of personal information (including medical records)

Standard 8. Health and welfare reporting to the Public Health Commander

5.3 Guidelines

The ‘Guidelines for managing COVID-19 in mandatory quarantine’ have been developed to ensure that public health management principles and processes are outlined for each stage of the mandatory quarantine process. They have been written to follow the path of a returned traveller entering mandatory quarantine.

They are intended for use by DHHS staff, healthcare workers and other departments involved in the care of individuals detained in mandatory quarantine. They will be updated as internal processes change.

At the airport

Airport health screening

Management of an unwell person at the airport

Refusal of testing

- At the airport
- At the hotel

At the hotel

Quarantine and isolation arrangements

- Accommodation options to promote effective quarantine
- Room sharing
- COVID floors and hotels

Confirmed cases entering detention

- Current infectious cases
- Recovered cases

Throughout detention

Clinical assessment and testing for COVID-19

- Timing of testing
- Pathology arrangements
- Communication of results

Case management

- Management of suspected cases
- Management of confirmed cases

Hospital transfer plan

- Transfer from hospital to hotel

Exiting detention

Release from isolation

- Criteria for release from isolation
- Process for release from isolation
- Release from detention of a confirmed case

Exit arrangements

- Suspected cases
- Confirmed cases
- Quarantine domestic travel checklist
- Care after release from mandatory quarantine

Operational guidance for mandatory quarantine

- Process for mandatory hotel quarantine
- Quarantined individual becomes a confirmed case
- Quarantined individual becomes a close contact

Infection control and hygiene

- Cleaning
- Laundry

- Personal protective equipment

Further information is available at the links below

- Infection control and hygiene
- Personal protective equipment
- Authorised officers: Occupational Health and Safety
- Hospital transfer plan
- Nutrition and food safety (including allergies),
- Process for people with food allergies,
- Meal order information for people with food allergies,
- Food Safety Questionnaire

Further information is available at the links below:

- Hospital and Pharmacy contacts for each hotel
- Standards for healthcare and welfare provision
- Provision of welfare
- Separation of people in travelling parties to promote effective quarantine: options for accommodation
- Health and welfare assessments (arrival, during detention, preparation for discharge)
- Confirmed cases of COVID-19 in people in mandatory quarantine
- Escalation and Reporting of health and welfare concerns
- Infection control and hygiene
- Personal protective equipment
- Food allergies
- Nutrition and food safety (including allergies),
- Process for people with food allergies,
- Meal order information for people with food allergies,
- Food Safety Questionnaire
- Release Process ‘Running Sheet’
- Welfare survey
- COVID-19 Victorian Hotel Isolation: Reimbursement Form for meal purchases
- Register of permissions granted under 4(1) of the Direction and Detention Notice
- Operations contact list
- Outline of agency involvement across the stages of enforced quarantine

6 Information and Data Management

6.1 Information management systems

The number of secure databases used for the storage and handling of confidential data on people in detention is minimised to prevent fragmentation of records management and to reduce the risk of critical information not being available to DHHS, health or welfare staff providing for the health and welfare needs of people in detention.

The following information management systems are authorised for use in this operation:

- The Public Health Event Surveillance System (PHESS);
- The healthcare and wellbeing database for mandatory quarantine (Dynamic CRM Database);
- Best Practice general practice software (see 3.3);
- Paper records (where necessary).

6.2 Data access, storage and security

The State Controller - Health, DHHS Commander COVID-19 Accommodation (or delegate) and Public Health Commander (or delegate) are authorised to access any record within these systems to enable oversight of the health and welfare of people in detention.

Information on people arriving internationally is shared with DHHS by DJPR to enable the operational functions under sections 3-5. While multiple applications/systems may be used during the operation, all information will be uploaded to PHESS, which will then hold the complete medical and compliance records for a person who was in detention in Victoria as part of this operation.

6.2.1 Privacy

Respecting the privacy of individuals who are detained under this operation is an important consideration, as information collected contains personal details and other sensitive information.

DHHS staff must comply with the Department of Health and Human Services privacy policy whenever personal and/or health information about passengers/detainees, staff or others is collected, stored, transmitted, shared, used or disclosed.

The privacy policy is an integrated policy, which supports the sensitive protection and management of personal information and seeks to meet the legislative requirements of the *Privacy and Data Protection Act 2014* and *Health Records Act 2001*. Information relating to privacy is available at intranet.dhhs.vic.gov.au/privacy.

6.2.2 Sending information by email

For communication within the department, there are risks to privacy in sending information by email. These include misdirection due to errors in typing the address and the ease of copying, forwarding, amending or disclosing emailed information to others. Care should be taken with the list of addressees, and the title of the email should not contain any identifying information.

6.2.3 Electronic security of passenger/detainee information

In addition to email, passenger/detainee information is stored, accessed and transmitted using systems and devices such as computers, laptops, and smartphones. These systems and devices must be as carefully protected as the passenger/detainee information itself.

An 'information security incident' occurs when the security of the information, system or device is compromised. Some examples of these incidents are:

- the details of a passenger is accidentally sent to the wrong email address
- a case worker's smartphone is lost or stolen and there was information about a passenger/detainee stored on it
- a virus infects a computer that stores or accesses passenger/detainee information.

Information security incidents must be reported to the Emergency Operations Centre who, in turn, will report it to the IT Service Centre.

6.3 Medical records

Medi7 is currently implementing a Best Practice medical record system for record-keeping. This will be uploaded to the DHHS Dynamic CRM Database.

6.3.1 Requirement for accessible medical records

Each quarantined individual must have a medical record accessible to all health care providers who require access to it and who are providing care. This record captures the person's significant medical history, current medications, allergies and any other significant components of the medical history, where these have been revealed by the person in detention or discussed as part of medical care provided to the person during detention. Each time health care is requested **and** provided it must be documented in this record.

6.3.2 Confidentiality and access to medical records

Any medical record created or held by DHHS for a person in detention is confidential and must only be accessed by persons coordinating and providing care for the person. The records will belong to DHHS and can be required to be provided at any time by the medical service contractor to DHHS for review, from the Best Practice software.

These records should be stored securely and should not be accessed by anyone not providing care for the person. Specifically, these medical records must only be accessed or viewed by an AHPRA-registered health practitioner employed by DHHS to provide services to people in detention, an authorised officer, or the Public Health Commander, State Controller - Health, DHHS Commander COVID-19 Accommodation or their named delegate. Other persons involved in Operation Soteria should not access a medical record for an individual unless authorised on a named basis by the Public Health Commander (or delegate) or the State Controller - Health (or delegate).

Accurate and comprehensive medical record keeping is essential for the health and safety of all individuals in mandatory quarantine and will ensure continuity of care for healthcare providers in subsequent shifts. If medical notes are recorded on paper, these should be stored securely and uploaded to the information management system as soon as is practicable and within 72 hours at most. If a doctor completes an assessment, they must provide a written record of this to the nursing staff, either on paper or via email, if an electronic medical record system is not available.

Any medical records documents that are potentially contaminated with COVID-19 (SARS-CoV-2) should be safely placed in plastic pockets to reduce the risk of infection transmission.

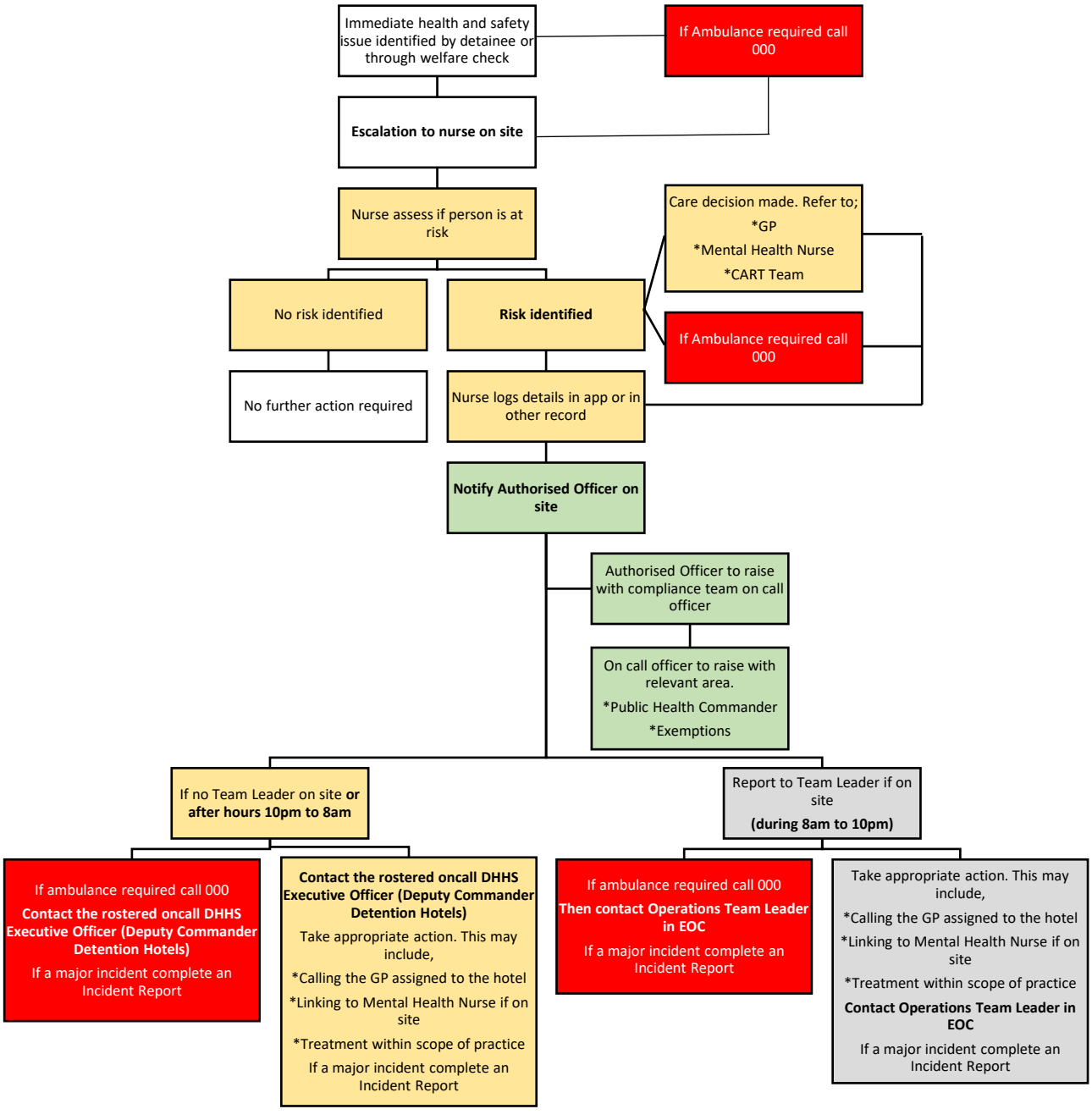
7 Issues escalation and incident reporting

The safety of staff, passengers/detainees and the Victorian community is a key priority of this operation.

All staff undertaking roles under Operation Soteria are responsible for timely and appropriate management and escalation of issues arising under the operation. All risks and incidents must be reported to the Department of Health and Human Services, via the on site Authorised Officer or relevant Commander.

7.1 Hotel escalation process

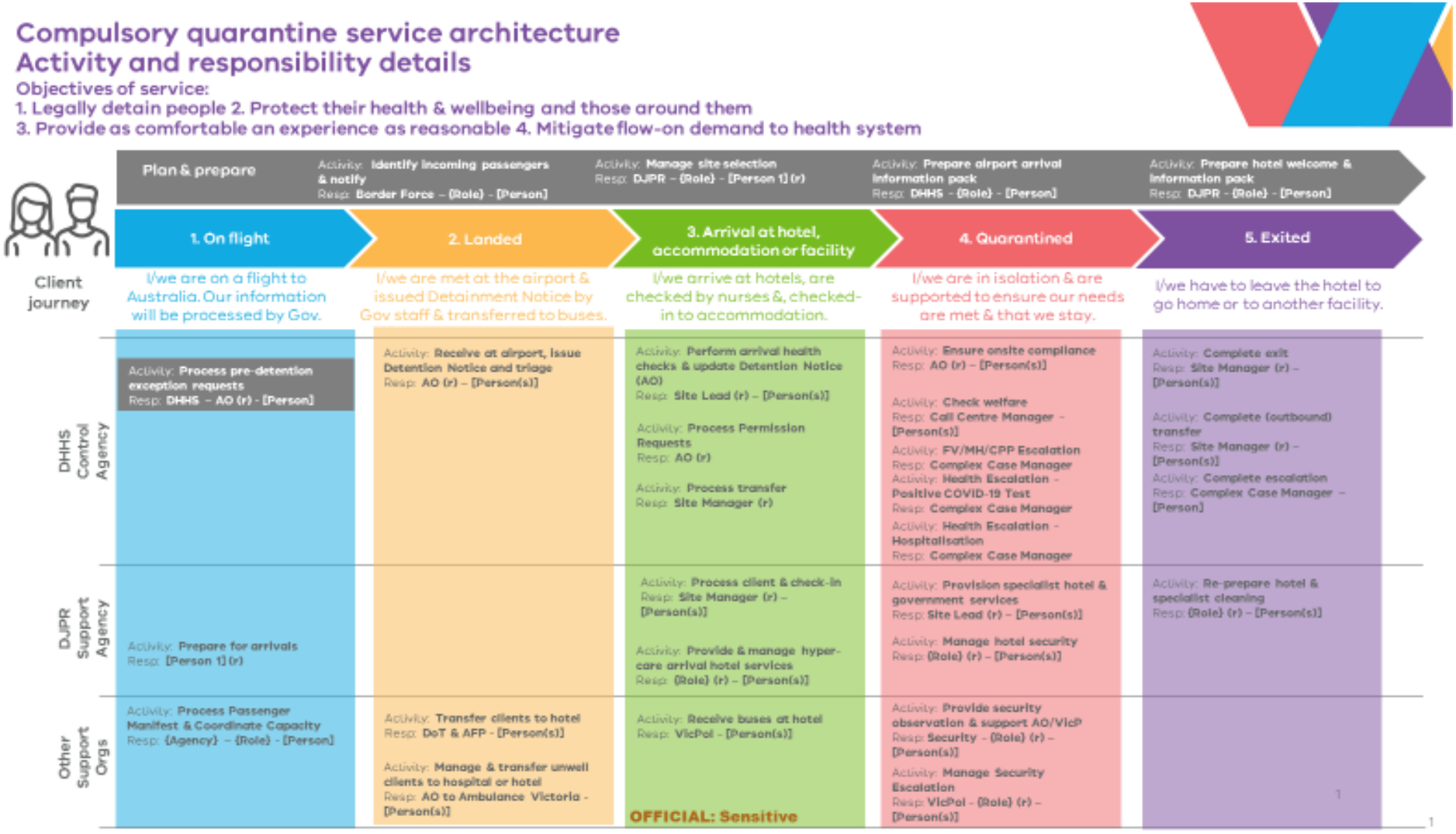
The escalation process in Figure 2 below must be followed for all health and medical risks arising in quarantine hotels.



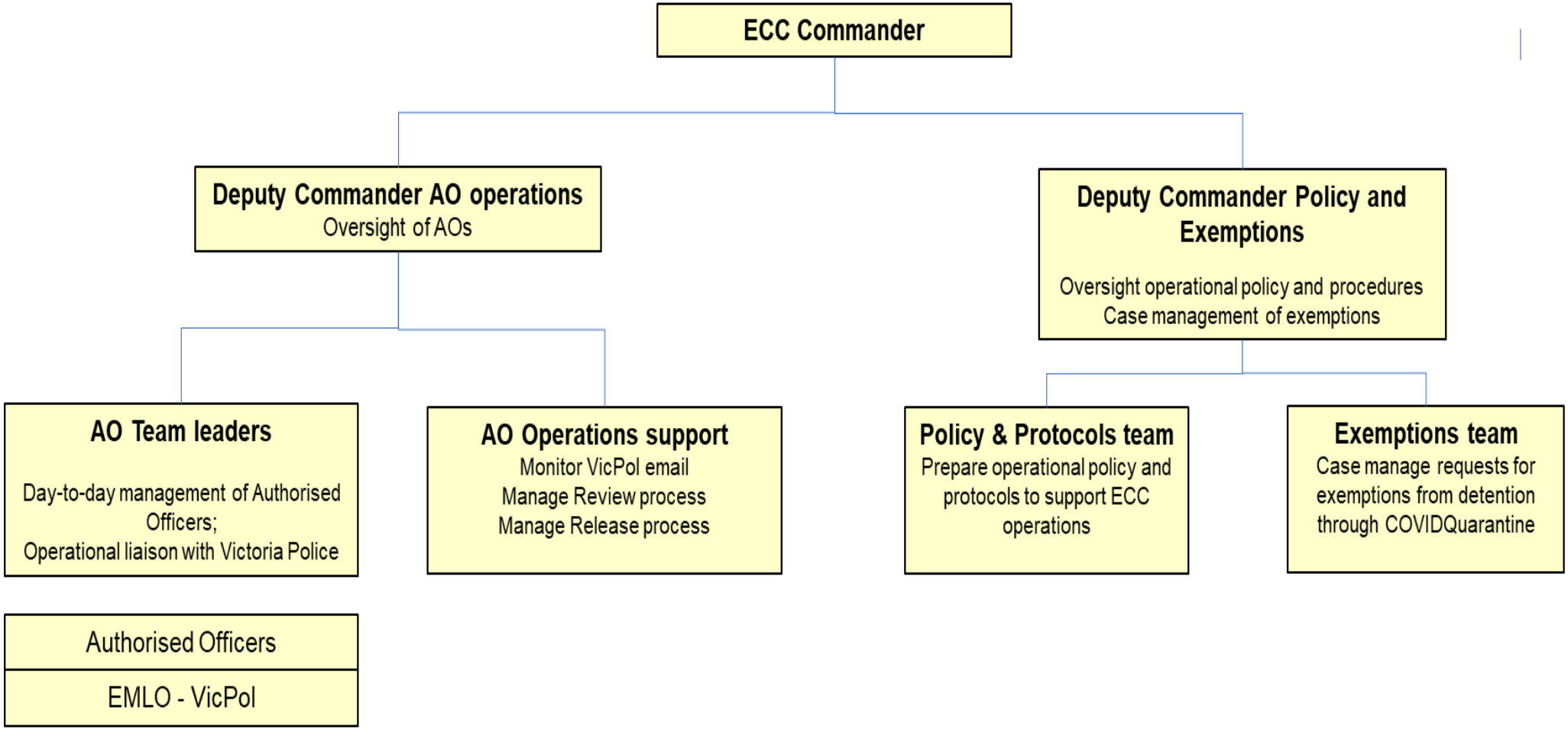
7.2 Incident reporting

The incident reporting process and template in **Appendix 4** outlines the Department of Health and Human Services management requirements for major incidents or alleged major incidents that involve or impact significantly upon passengers/detainees during airport reception, hotel quarantine, and other users or staff during provision of accommodation services during the COVID-19 emergency. Examples include injury, death, sustaining/diagnosis of a life threatening or serious illness, and assault/crime.

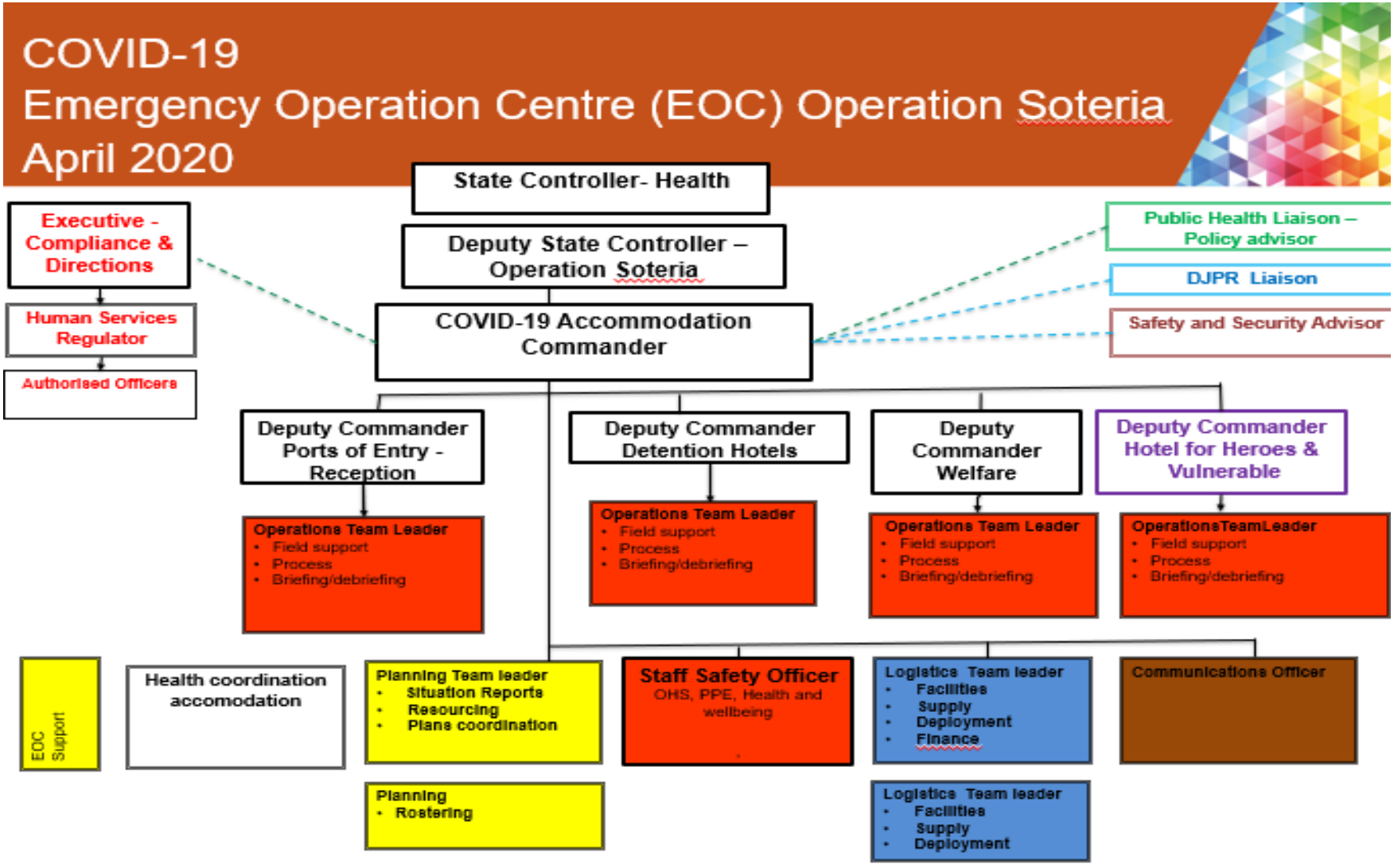
Appendix 1 - Operation Soteria process phases



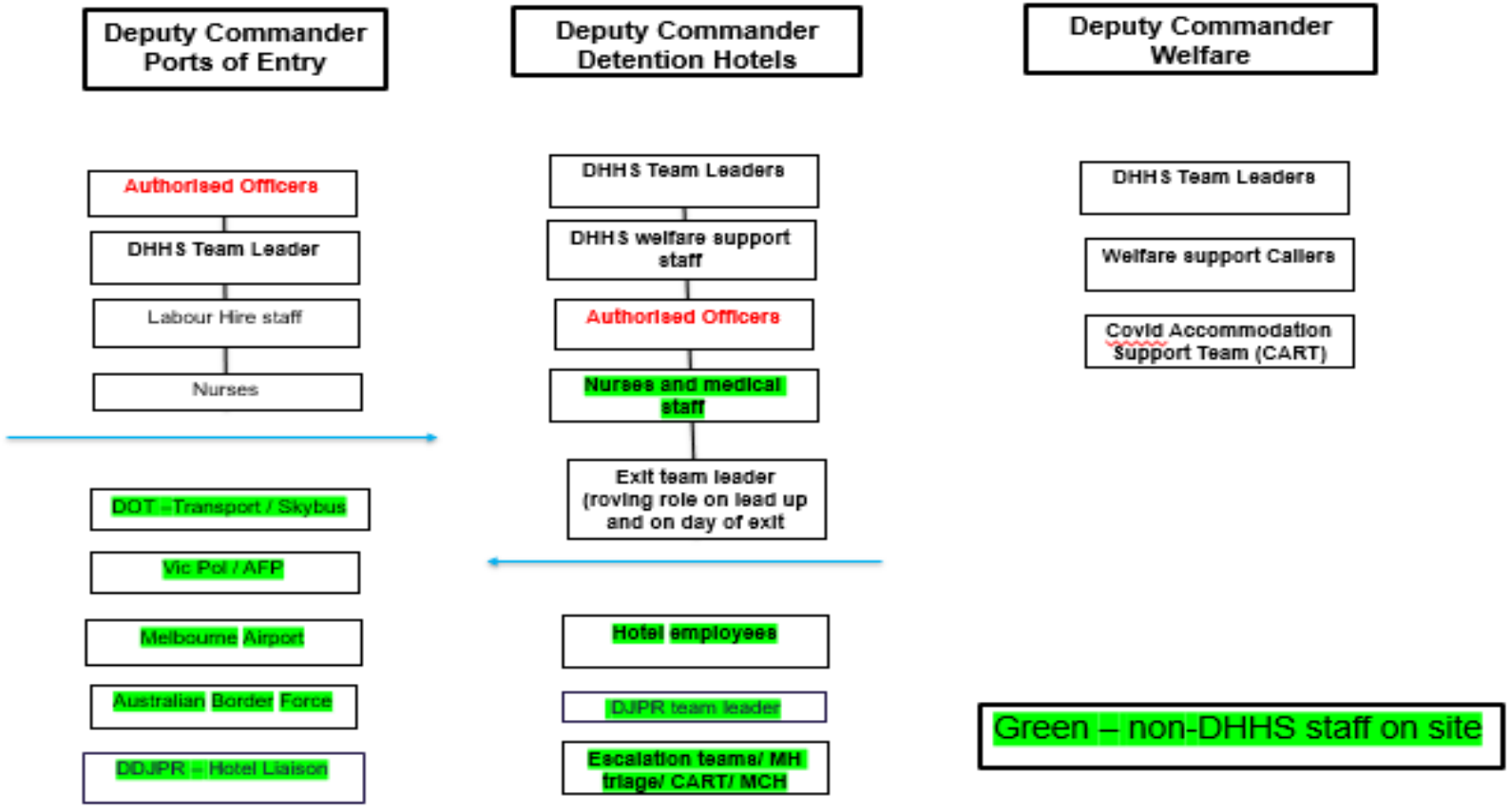
Appendix 2 - Enforcement and Compliance Command structure



Appendix 3. Emergency Operations Centre Structure



Operation Soteria – on site teams



Appendix 4 - DHHS COVID-19 Quarantine – incident reporting

1. Introduction

This document outlines the Department of Health and Human Services (the department) management requirements for major incidents or alleged major incidents that involve or impact significantly upon passengers/detainees during airport reception, hotel quarantine, and other users or staff during provision of accommodation services during the COVID-19 emergency. Examples include injury, death, sustaining/diagnosis of a life threatening or serious illness, and assault/crime.

The primary audience for this document is departmental staff on site and senior officers who are involved in reviewing, endorsing, processing, recording and analysing incident reports after Parts 1–6 of the incident report have been completed at the service delivery level supported by the appropriate Deputy Commander.

This document was last reviewed on 21 April 2020.

2. Reviewing and endorsing incident reports

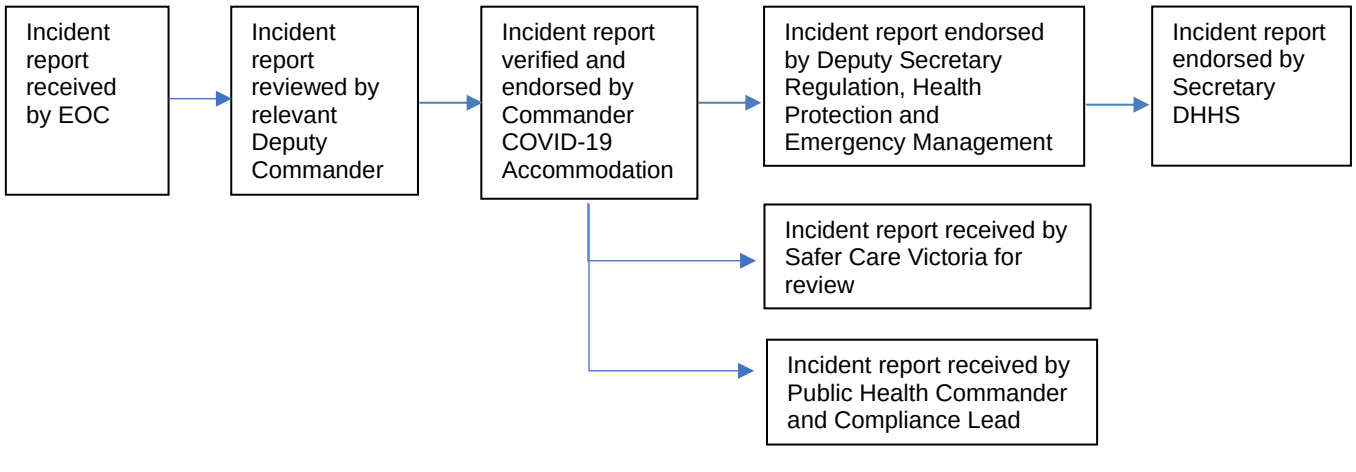
This section outlines the steps required for reviewing and endorsing incident reports, once provided to the DHHS Commander COVID-19 Accommodation via dhhsopsoteriaeoc@dhhs.vic.gov.au following verbal report via phone from the relevant Deputy Commander. Figure 1 below provides an overview of the process.

2.1. Overview

Incident reports (Parts 1–6) are completed by the most senior departmental staff immediately involved in the management of the incident onsite, with support of the relevant Deputy Commander. In the case of any incident, the first priority is making sure passengers/detainees and staff are safe, and in hotels, appropriate care provided (see escalation process for hotel detention). After that, an incident report must be completed and sent to the Commander COVID-19 Accommodation via dhhsopsoteriaeoc@dhhs.vic.gov.au following verbal report via phone. The report includes immediate actions that have been taken and planned follow-up actions.

The specified department officers review the incident report, and complete parts 7-9. The Commander COVID-19 Accommodation is also responsible for sending the report to Safer Care Victoria, the Public Health Commander and the Compliance Lead.

Figure 1: High Level flowchart for reviewing and endorsing an incident report



The incident report form is available from the Operation Soteria Emergency Operations Centre (EOC), dhhsopsoteriaeoc@dhhs.vic.gov.au or relevant Deputy Commander. All reports must be legible and presented in the specified report format.

2.2. Deputy Commander receives an incident report

When an incident report is forwarded to the DHHS EOC, the report is registered in the EOC's electronic file system, TRIM, and allocated a reference number. It is then forwarded to the relevant Deputy Commander as soon as possible (within 1 hour). The staff completing the report will contact the relevant Deputy Commander by mobile to advise of the incident.

2.2.1. Reports about passengers/detainees who are also clients

If a passenger/detainee is a client of other service types, service providers or government departments, information regarding a major incident may be disclosed to other agencies or departments to lessen or prevent a serious or imminent threat to a client's life, health, safety or welfare; and/or with the intent of preventing similar incidents from occurring in the future. The Commander COVID-19 Accommodation is responsible for notifying within the department and/or other organisations where the passenger/detainee is known to be a client, with the lead division will inform any community service organisations involved in providing services if applicable.

2.3. Review of the incident report

The relevant Deputy Commander endorses the incident report by completing Part 6 of the incident report (refer to attachment 1).

They must review the incident report and:

- check that the immediate needs of the passenger/detainee(s) have been addressed
- check that appropriate immediate actions have been taken in response to the incident and that any planned further actions are appropriate
- if a particular requirement has not been undertaken, the reasons why are documented
- ensure that the passenger/detainee and location details have been recorded and are accurate
- ensure all sections of the incident report are completed
- record any additional or required follow-up action (if any).

2.4. Verify and endorse the incident category

The Commander COVID-19 Accommodation verifies and endorses the incident report.

The Commander COVID-19 Accommodation is responsible for escalating an incident report to the Deputy Secretary Regulation, Health Protection and Emergency Management to endorse, and sending the report to the Public Health Commander, the Compliance Lead and Safer Care Victoria via irtreviews@safercare.vic.gov.au for review.

The Deputy Secretary Regulation, Health Protection and Emergency Management is responsible to escalate the incident report to the Secretary Department of Health and Human Services for endorsement.

2.5. File the completed incident report

After Parts 7-9 have been completed and endorsed, the incident report is returned to the Emergency Operations Centre for records management. This constitutes the final completed report.

The final completed report must be placed in a TRIM record must be updated in accordance with the department's record management policy.

Where allegations are made against a staff member, the incident report and any subsequent reports are to be retained in the staff file.

2.6. Incident report records management and privacy

Incident reports (paper versions and related electronic data) must be stored securely and only accessed by staff that have a business purpose for doing so. Paper reports are discouraged, and if required, should be stored in locked filing cabinets. Access to electronic data should be limited to appropriate staff only.

2.7. Local investigation and causal analysis

The Commander COVID-19 Accommodation will ensure that the incident is subject to an appropriate level of local investigation and causal analysis and that, where relevant, an improvement strategy is prepared.

Incident investigations should:

- identify reasons for the incident occurring
- identify opportunities for improvement in management systems or service delivery practice
- make local recommendations and implement improvement strategies in order to prevent or minimise recurrences. These strategies should be actionable and measurable and include an assessment of their effectiveness in delivering improvement
- satisfy mandatory reporting or review requirements (for example, notifying the Coroner or WorkSafe).

3. Privacy

Respecting the privacy of individuals who are involved in or witness to an incident is an important consideration in dealing with incident reports, which often contain personal details and other sensitive information.

Departmental staff must comply with the Department of Health and Human Services privacy policy whenever personal and/or health information about passengers/detainees, staff or others is collected, stored, transmitted, shared, used or disclosed.

The privacy policy is an integrated policy, which supports the sensitive protection and management of personal information and seeks to meet the legislative requirements of the *Privacy and Data Protection Act 2014* and *Health Records Act 2001*. Information relating to privacy is available at intranet.dhhs.vic.gov.au/privacy.

3.1. Sending information by email

For communication within the department, there are risks to privacy in sending information by email. These include misdirection due to errors in typing the address and the ease of copying, forwarding, amending or disclosing emailed information to others. Care should be taken with the list of addressees, and the title of the email should not contain any identifying information.

3.2. Electronic security of passenger/detainee information

In addition to email, passenger/detainee information is stored, accessed and transmitted using a emergency management systems and devices (including computers, laptops, and smartphones). These systems and devices must be as carefully protected as the passenger/detainee information itself.

An 'information security incident' occurs when the security of the information, system or device is compromised. Some examples of these incidents are:

- the details of a passenger is accidentally sent to the wrong email address
- a case worker's smartphone is lost or stolen and there was information about a passenger/detainee stored on it
- a virus infects a computer that stores or accesses passenger/detainee information.

Information security incidents must be reported to the Emergency Operations Centre who, in turn, will report it to the IT Service Centre.

DHHS Quarantine – incident reporting template

Reference number	
Impact (Major only) *e.g. injury, death, sustaining/diagnosing life threatening condition, assault/crime*	

1. Service provider details

Reporting organisation	
Address of service delivery	
DHHS Service Area *(e.g. Emergency Management)*	
Service type	

2. Incident dates

Date of incident	
Date accuracy (exact/approximate)	
Time of incident	
Time accuracy (exact/approximate)	
Date incident disclosed	
Time incident disclosed	

3. Incident description

Location of incident	
Detailed incident description	

4. Individual details – Passenger/detainee 1 [duplicate for each person involved]

Passenger/detainee's full name	
Passenger/detainee incident impact	
Sex	
Indigenous status	
Date of birth	
Passenger/detainee address	
Passenger/detainee unique identifier number *(if applicable)*	
Incident type	
Involvement in the incident (victim, witness, subject of abuse allegation, participant)	
Passenger/detainee's immediate safety needs met (Yes/No)	
Medical attention provided (Yes/No)	
Passenger/detainee debriefing or counselling (Yes/No	
Referral to support services (Yes/No)	
Change passenger/detainee care (support plan) (Yes/No)	
Notified next of kin, guardian or key support person (Yes/No)	

5. Other/s involved in incident [duplicate for each other person involved]

Person's full name	
Date of birth	
Person's job title or relationship to passenger/detainee (carer, paid staff, other)	
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	

6. Service provider response details

Brief summary of incident	
Reported to police (Yes/No)	
Name of officer and date reported to police	
Police investigation initiated (Yes/No)	
Staff member stood down/removed (Yes/No)	
Manager's full name	

Manager's job title	
Date incident report reviewed	
Manager telephone number	
Manager email	
Immediate actions taken by the organisation in response to the incident	
Deputy Commander full name and signature	
Deputy Commander job title	
Date incident report approved	
Comments	

7. Incident report authorisation – EOC Command

Delegated authority full name and signature	
Delegated authority job title	Commander COVID-19 Accommodation
Date incident report approved	
Delegated authority phone number	
Delegated authority email address	
Comments	

8. Incident report authorisation – Deputy Secretary

Delegated authority full name and signature	
Delegated authority job title	
Date incident report endorsed	
Delegated authority phone number	
Delegated authority email address	
Comments (optional)	

9. Incident report authorisation - Secretary

Delegated authority full name	
Delegated authority job title	
Date incident report endorsed	

Operation Soteria -Quarantine Hotels Options Analysis

24 June 2020

Purpose

To identify options for the improved safety of operations across all quarantine hotels operating to support Operation Soteria.

Current Situation

Current operations utilise a combination of Department of Health and Human Services (DHHS) staff, private security contractors, contract nurses and hotel support staff.

This model, whilst largely effective, has been built through a series of complex contractual arrangements across multiple departments, which include Department of Jobs, Precincts and Regions (DJPR) acting as contract procurer and manager of some operational elements. The contractual arrangements are further complicated by security subcontract arrangements.

Hotel quarantine is supported by Public Health Command and Operation Soteria Command operation policy, guidelines and an overarching plan. The plan, policy and guidelines have evolved quickly and essentially form a robust set of operational doctrine to support all elements of the hotel quarantine, from arrival to departure, including health, welfare, safety, infection control and response to other risks.

Implementation of plans, policy and guidelines have been supported with inductions, training and contractual discussions, in an attempt, to achieve compliance across all staff.

To date compliance, particularly from sections of the security staff has been *ad hoc*, with incidents of noncompliance with infection prevention control, physical distancing and other CHO directions resulting in outbreaks in hotel quarantine.

The highest risk activities in hotel quarantine are:

- Failure to use PPE correctly
- Goods handling, particularly luggage
- Entry and Exits of large numbers of detainees
- Provision of fresh air, exercise breaks for detainees
- Swabbing and other medical procedures.

Current Situation

Options for improved hotel quarantine operations are detailed in this document for consideration.

Recommendation –

Accept Option 1

- Requiring approximately 400 per day, on average, Police resourcing (650 – 800 FTE)
- ADF logistics expertise of 50

- Further use of Spotless contractors through Alfred for 'orderly' equivalent tasks as described as Customer Service Officers
- Strengthening of operational roles at hotel sites as underway and in progress
- Noting the option can be implemented by within 3 days of agreement to the provision of Police resources is provided.

Further noting all staff numbers are approximate and are calculated on an average of 20 hotels operating, the staff numbers are averaged and do not account for rostering nuances or different floor and capacity layout across our hotels. Staff numbers are calculated as FTE per week based on 38 to 40 hours per week worked (pending awards).

Staffing elements of options could be altered based on final allocations and agreement but provide in principle variation of options for consideration. For example, ADF and Police resources ratios could alter given similarity of roles. On any given day we utilise approximately 1000 (1200 to 1600 per week FTE) security in the current staffing model.

All options are capable of rapid implementation, subject to staff availability and initial training the options can be implemented on a hotel by hotel or staffing cohort by cohort basis immediately.

Additional Compliance

All models require a significant number of security staff to be employed onsite at hotels, the availability of other workforces does not reasonably allow a replacement of security for all roles. Additional compliance is required regardless of the option, whilst option A and B provide greater supervision and pairing of security staff, which of itself will increase compliance, all models require additional measures to prevent further non-compliance of the staff.

Options for improved compliance include:

- Amended contracts, requiring increased accountabilities for the contracted company, minimum standards of conduct and penalties for breaches
- Investigation by the Enforcement and Compliance Team of all breaches with a view to issuing warnings or penalties, 6 investigators required
- Direct penalty from Victoria Police for non-compliance of CHO directions (subject to discretion of Victoria Police).

Victoria Police

Each of the options, including additional compliance measures for current rostering, require resourcing from Victoria Police. This includes Victoria Police sworn personal, PSOs and possible supplementation through the use of Sheriff's Officers.

Options A and B require a substantial increase in Police, particularly option A, Victoria Police could potentially offset the impact on other operational duties using rostering options that currently exist:

- Voluntary duties
- Overtime model, like TAC funded road policing operations.

Option A – Optimal Model

This model provides for a significant increase in trained and professional resources to support the current staffing model in hotels. Victoria Police, PSO, Sheriffs and ADF staff are trained to a higher standard, have a greater understanding of compliance and work to a standard of discipline, and they have customer service and de-escalation skills.

Drawing Customer Service Officers (CSOs) from across the hospital network, including additional nurses, orderlies and hospital ancillary staff will increase infection prevention and control standards across hotel quarantine. These staff are used to compliance with policy and guidelines and have customer service and de-escalation skills.

CSO staff model can be built into the Alfred Hospital and Spotless contracts.

This model could eliminate the need for security staff.

This model provides an optimum mix of staff with skills and training relevant disciplines to supervise and provide safe and secure detention, and it provides the opportunity to eliminate or significantly reduce security staff numbers.

Staffing	Number Required	Role	Comment
Victoria Police, PSO, Sheriffs [PROPOSED] It is preferable that Victoria Police lead the rostering of these staff with a mix of Police and PSOs, they currently roster Police and PSO and could augment the PSO's with available Sheriffs. A minimum of 3 sworn Police officers per shift per hotel.	@ 650 to 800 Minimum 6 per shift X 20 hotels X 3 shifts X 7 days per week	Reporting to hotel team leader. Supervision and security role, support hotel detention under authority of Authorised Officers (AOs) and respond to safety and public order issues in the hotel, first response to all incidents. Potentially paired with CSOs for multi-disciplinary response.	Victoria Police at this stage are concerned at balancing this operation due to competing COVID demands. An offer of 30 Sheriffs for 4 weeks only has been made which creates unacceptable uncertainty in quarantine resourcing.
ADF [LOGISITICS ROLE PROPOSED]	@ 50-100 7 days per week	Support role for AOs, monitor compliance with directions.	ADF could complement the Police operation and/or provide logistics support to the hotel quarantine model..
Cluster Manager – DHHS [UNDERWAY]	@16 5 hotels each X 2 day and afternoon shifts X 7 days per week. 1 Manager across all hotels night shift X 7 days per week	Manage all activities across 5 hotels, roving patrols to ensure compliance and an escalation point for hotel team leaders.	Currently recruiting to these positions.
Hotel Team Leader – DHHS [IN PLACE]	@ 80 1 hotel X 20 hotels X 3 shifts X 7 days per week	* Onsite Safety Officer Manage all operational activities in the hotel, manage safety, risk, operations, escalation point for all staff in hotels roles.	In place, currently recruiting to ongoing positions.

Staffing	Number Required	Role	Comment
Authorised Officers [IN PLACE and UNDERWAY]	@ 64 1 AO per hotel X day and afternoon shift 1 AO per 2 hotels night shift	Ensure compliance with CHO & DCHO orders at quarantine hotels and international ports of entry.	In place, roster challenging at present, recruiting additional AO's.
Nurses – Clinical role [IN PLACE]	Minimum – 3 per shift day and afternoon X 20 hotels X 7 days 2 per shift Night X 20 hotels X 7 days Number may increase based on complexity of care required	Clinical nurse care	
Nurses – Mental Health [IN PLACE]	1 per shift X 3 shifts X 20 hotels X 7 days Number may increase based on complexity of care required	Mental Health care	
Customer Service Officers – CSOs (Nurses, Orderlies, hospital ancillary staff, other) [PROPOSED] * consideration could be given to use of airline staff currently not employed as they have relevant training and customer service skills.	@ 440 6 per shift X 20 hotels X 2 shifts (day, afternoon shift), X 7 days per week	Reporting to the hotel team leader, manage detainee contact, goods movement, fresh air and exercise breaks, respond to detainee requests. Potentially paired with Police/PSO's for multi-disciplinary response.	Resources available through Spotless, pending contract negotiations and staff availability.
Security [PROPOSED]	Nil		Contractual obligations to be reviewed to plan exit.

Option B – Hybrid Model

This model provides for a smaller increase in trained and professional resources to support existing security and customer service functions within hotels. Victoria Police, PSO, Sheriffs and ADF staff are trained to a higher standard, and have a greater understanding of compliance and work to a standard of discipline, they have customer service and de-escalation skills.

Drawing Customer Service Officers (CSOs) from across the hospital network, including additional nurses, orderlies and hospital ancillary staff will increase infection prevention and control standards across hotel quarantine, as they are used to compliance with policy and guidelines and have customer service and de-escalation skills.

CSO staff model can be built into the Alfred Hospital contracts.

This model provides a small increased mix of staff with skills and training in relevant disciplines to supervise and support existing security, it provides the opportunity to reduce security staff numbers across all hotels.

Staffing	Number Required	Role	Comment
Victoria Police, PSO, Sheriffs It is preferable that Victoria Police lead the rostering of these staff with a mix of Police and PSOs, they currently roster Police and PSO and could augment the PSOs with available Sheriffs. A minimum of 1 sworn Police officer per shift	@ 150 2 per shift X 20 hotels X 3 shifts X 7 days per week	Reporting to hotel team leader. Supervision and security role, support hotel detention under authority of Authorised Officers (AOs) and respond to safety and public order issues in the hotel, first response to all incidents. Potentially paired with CSOs for multi-disciplinary response.	
ADF	@ 50 - 100 7 days per week	Support role for AOs, monitor compliance with directions	
Cluster Manager – DHHS	@16 5 hotels each X 3 shifts X 7 days per week.	Manage all activities across 5 hotels, roving patrols to ensure compliance with PPE and social distancing, and an escalation point for hotel team leaders.	Currently recruiting to these positions.
Hotel Team Leader - DHHS	@ 80 1 hotel X 20 hotels X 3 shifts X 7 days per week	* Onsite Safety Officer Manage all operational activities in the hotel, manage safety, risk, operations, escalation point for all staff in hotels roles.	In place, currently recruiting to ongoing positions.
Authorised Officers	@ 64 1 AO per hotel X day and afternoon shift 1 AO per 2 hotels night shift	Ensure compliance with CHO & DCHO orders at quarantine hotels and international ports of entry.	In place, roster challenging at present, recruiting additional AO's.
Nurses – Clinical role	Minimum – 3 per shift day and afternoon X 20 hotels X 7 days 2 per shift Night X 20 hotels X 7 days Number may increase based on complexity of care required	Clinical nurse care	
Nurses – Mental Health	1 per shift X 3 shifts X 20 hotels X 7 days	Mental Health care	

Staffing	Number Required	Role	Comment
	Number may increase based on complexity of care required		
Customer Service Officers – CSOs (Nurses, Orderlies, hospital ancillary staff, other) * consideration could be given to use of airline staff currently not employed as they have relevant training and customer service skills.	@ 440 6 per shift X 20 hotels X 2 shifts (day, afternoon shift), X 7 days per week	Reporting to the hotel team leader, paired with a security guard (day and afternoon shift), manage detainee contact, goods movement, fresh air and exercise breaks, respond to detainee calls for assistance, provide security and ensure compliance with directions, policy and guidelines	Resources available through Spotless, pending contract negotiations and staff availability.
Security	@ 750 - 900 Minimum 10 – 12 per shift X 20 hotels X 3 shifts X 7 days per week	Reporting to the hotel team leader, paired with a CSO's (day and afternoon shift), manage detainee contact, goods movement, fresh air and exercise breaks, respond to detainee calls for assistance, provide security and ensure compliance with directions, policy and guidelines. Night shift provide security across the hotel.	In place, additional contractual obligations required.

Option C – Current Staffing

This option keeps the current staffing mix (@1200 - 1600 security FTE) with a view to increased contractual arrangements, increased focus on staff compliance with directions, policy and guidelines and increased training and supervision. The current model could be further supported through:

- Increased tasking of Victoria Police patrols, with direct tasking requiring them to enter hotels regularly and monitor compliance
- Addition of Sheriffs rostered across all shifts in a compliance, supervision role
- Addition of a small cohort of ADF personal to work with security to improve compliance
- Increased IPC audits.

Training and Induction

All options will require all new staff to be inducted and trained, particularly in PPE and IPC standards. This can be done rapidly with ongoing refresher training built into operational planning.

Rostering

Whilst complex, particularly with increased staff mix and differences in IR requirements and changes in numbers of detainees in hotels, efforts should continue to be made to reduce cross over of staff between hotels. At a minimum no staff (with the exception of the cluster manager) should work across different hotels on the same or consecutive days. This will allow some time for staff to identify as unwell prior to entering a new hotel.

Operation Soteria

Mandatory Quarantine for all Victorian Arrivals

Approved for distribution

Emergency Management Commissioner	Signature	Date
Andrew Crisp		

Distribution

State Control Team	As per planning contacts list:
Strategic Planning Committee	DHHS
EMJPIC	DJPR
State Relief & Recovery Team / CAOG	DPC
	VicPol
	Department of Transport

Document Details

Version	Status	Author	Reviewer/s	Authorised for Release	Date/Time
0.1	Draft for initial discussion	Kaylene Jones / Angus Hindmarsh	-	Andrew Crisp	27 March 2020
0.2	Draft for release as version	Deb Abbott / Kaylene Jones	Operation Soteria Coordination meeting	Andrew Crisp	28 March 2020 -1815 hours
1.0	Final Version released	Deb Abbott / Kaylene Jones	-	Andrew Crisp	28 March 2020 -2000 hours
2.0	New version released	DHHS Deputy Commander	Public Health Commander DHHS Commanders State Controller - Health	Andrew Crisp	24 April 2020
2.1	Updated version	Respective DHHS leads	Public Health Commander State Controller - Health	Andrew Crisp	8 May 2020

3	Updated (overarching plan)	Respective DHHS leads	Public Health Commander DHHS Commanders State Controller - Health	Andrew Crisp	26 May 2020

Abbreviations/Acronyms

ABF	Australian Border Force
AFP	Australian Federal Police
AO	Authorised Officer
AV	Ambulance Victoria
DFAT	Department of Foreign Affairs and Trade
DHHS	Department of Health and Human Services
DJPR	Department of Jobs, Department of Jobs, Precincts and Regions
DoT	Department of Transport Department of Transport
EOC	Operations Soteria Emergency Operations Centre
EMV	Emergency Management Victoria Emergency Management Victoria
VicPol	Victoria Police Victoria Police

Contents

1 Introduction

1.1 Purpose

The purpose of this plan is to document the arrangements in place under Operation Soteria, to achieve safe, authorised mandatory detention of returning travellers required to quarantine for 14 days on their arrival into Victoria.

1.2 Scope

This document addresses the legislative and operational requirements for maintaining returned travellers in mandatory detention.

1.3 Audience

This document is intended for use by DHHS staff, and staff from all other departments and organisations involved in Operation Soteria.

1.4 Background

Australian National Cabinet directed that all passengers returning from international destinations who arrive in Australia after midnight on Saturday 28 March 2020 are to undergo 14 days enforced quarantine in hotels to curb the spread of COVID-19. Passengers are to be quarantined in the city in which they land, irrespective of where they live.

A mandatory quarantine (detention) approach was introduced by the Victorian Government, consistent with the Commonwealth Government (Department of Health Information for International Travellers) policy that a detention order would be used for all people arriving from overseas into Victoria from midnight on Saturday 28 March 2020. The policy is given effect through a direction and detention notice under the *Public Health and Wellbeing Act 2008* (PHWA). See https://www.dhhs.vic.gov.au/state-emergency

The objectives for people returning from overseas to Victoria are:

To identify any instance of illness in returned travellers in order to detect any instance of infection

To ensure effective isolation of cases should illness occur in a returned traveller

To provide for the health and welfare needs of returned travellers who are well or shown to be COVID-19 negative but are required to remain in quarantine for the required 14 days

To implement the direction of the Deputy Chief Health Officer through meeting:

- A requirement to detain anyone arriving from overseas for a period of 14 days at a hotel in specific room for a specified period unless an individual determination is made that no detention is required
- A requirement to record provision of a detention notice showing that the order was served and to manage access to information on who is in detention using a secure database
- A requirement to undertake checks every 24 hours by a department Compliance Lead during the period of detention
- A requirement to fairly and reasonably assess any request for permission to leave the hotel room / detention. This may be undertaken as part of a wholistic approach involving AOs, DHHS welfare staff, medical practitioners, nurses and other specialist areas if needed.

1.5 Mission

To implement the safe and secure mandatory quarantine measures for all passengers entering Victoria through international air and sea points-of-entry to stop the spread of COVID-19.

1.6 Inter-agency cooperation

Agencies engaged to deliver Operation Soteria include:

Department of Health and Human Services (DHHS)
Department of Jobs, Precincts and Regions (DJPR)
Department of Foreign Affairs and Trade (DFAT)
Department of Transport (DoT)
Ambulance Victoria (AV)
Australian Border Force (ABF)
Australian Federal Police (AFP)
Victoria Police (VicPol)

1.7 Process Flow

The process flow for Operation is structured in five phases, including a preliminary phase.

These phases include the following:

Preliminary Phase (Plan & Prepare) – identify incoming passengers and required hotel selection, and prepare for passenger arrival

Phase 1 (On the Flight) – manage / process exemption requests and confirm passenger manifest

Phase 2 (Landed) – Passengers land and are issued Detention Notices and are triaged. Passengers (Detainees) are transferred to Quarantine Hotels (or hospital if required)

Phase 3 (Arrival at Hotel) – Passengers receive health checks, check in, provide completed questionnaires and specialist needs managed

Phase 4 (Quarantined) – Passengers are quarantined in their hotel rooms and are provided with case management where health, welfare, FV, MH, etc issues arise. Quarantine compliance is also managed

Phase 5 (Exit) – Managed release from quarantine, exit transfer and specialist case management. This also includes specialist hotel cleaning and refurbishment

See **Appendix 1** for an expanded description of the phases.

2 Governance

2.1 Governance

Operation Soteria is led by the DHHS Commander COVID-19 Accommodation working to the State Controller – Health, to give effect to the decisions and directions of the Public Health Commander and Enforcement and Compliance Commander. Support agencies, including Department of Transport, Victoria Police, Department of Premier and Cabinet support the Department of Health and Human Services as the control agency for COVID-19 pandemic class 2 public health emergency, as outlined in section 2.3.

Operational leads will meet three times per week (or more frequently as required) for the duration of the operation to ensure combined oversight of the operation. Meetings will be coordinated by SCC support and chaired by the DHHS Commander COVID-19 Accommodation. Membership includes:

- State Controller - Health
- Public Health Commander
- DHHS Enforcement and Compliance Commander
- DHHS COVID-19 Accommodation Commander
- DHHS Agency Commander
- DJPR Agency Commander
- SCC Strategic Communications
- Department of Premier and Cabinet representative
- Department of Transport representative
- Senior Police Liaison Officer – Victoria Police

2.2 Legislative powers

The *Public Health and Wellbeing Act 2008* (Vic) (the **Act**) contains the legislative powers that Operation Soteria gives effect to under the state of emergency has been declared under section 198 of the Act, because of the serious risk to public health posed by COVID-19.

Operation Soteria seeks to mitigate the serious risk to public health as a result of people travelling to Victoria from overseas. People who have been overseas are at the highest risk of infection and are one of the biggest contributors to the spread of COVID-19 throughout Victoria.

In accordance with section 200(1)(a) of the Act, all people travelling to Victoria from overseas will be detained at a hotel specified in the relevant clause in their detention notice, for a period of 14 days, because that is reasonably necessary for the purpose of eliminating or reducing a serious risk to public health.

Having regard to the medical advice, 14 days is the period reasonably required to ensure that returned travellers have not contracted COVID-19 as a result of their overseas travel.

Returned travellers must comply with the directions below because they are reasonably necessary to protect public health, in accordance with section 200(1)(d) of the Act.

Under sections 200(7) and (9) of the Act, the Chief Health Officer is notified of the detention of returned travellers and must advise the Minister for Health.

2.2 Organisational Structure

A diagram indicating the governance of strategy / policy and operation of the mandatory quarantine program is shown in Figure 2 below.

Appendix 2 provides an overview of the Enforcement and Compliance Command structure and **Appendix 3** the COVID-19 Accommodations Command Emergency Operations Centre structures.

17

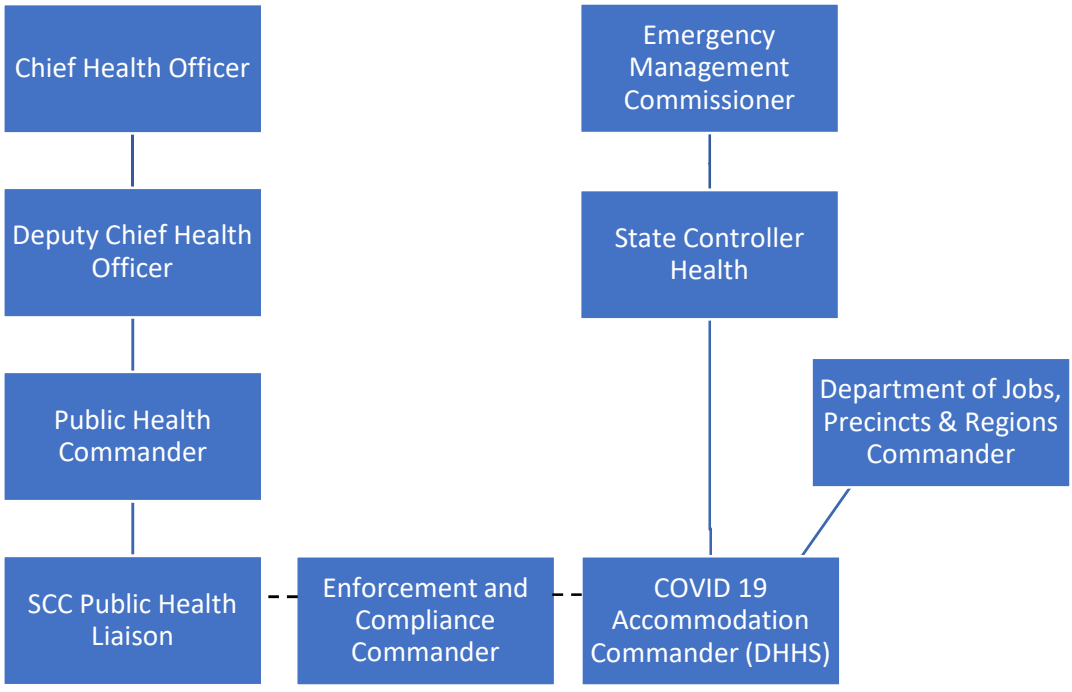


Figure 1: Operation Soteria governance structure

2.3 Roles and Responsibilities

The Emergency Management Commissioner is responsible for approving this plan for distribution.

The Public Health Commander (through the Deputy Public Health Commander / delegate) is responsible for approving this plan, in consultation with the Enforcement and Compliance Commander, DHHS Commander COVID-19 Accommodation, the State Health Coordinator and the State Controller – Health.

The State Controller - Health operating through the DHHS Commander COVID-19 Accommodation has operational accountability for the quarantine accommodation of returned travellers.

The DHHS Commander COVID-19 Accommodation is responsible for:

- provision of welfare to individuals in mandatory quarantine (through the Deputy Commander Welfare);
- ensuring the safety and wellbeing of individuals in mandatory quarantine and DHHS staff;
- ensuring a safe detention environment at all times.
- provision of healthcare to individuals in mandatory quarantine.

2.4 Department of Health and Human Services (DHHS)

DHHS, as the control agency for the COVID-19 pandemic Class 2 public health emergency, has responsibility for the oversight and coordination of Operation Soteria.

2.4.1 Airside operations - biosecurity

Oversee as instructed by the Human Biosecurity Officer - **Ports of Operation lead, Public Health Incident Management Team**

2.4.2 Airport Operations - reception

- Detention notice issued by Authorised Officers (see Appendix 1) – **DHHS Compliance (AOs)**
- Provision of and conduct of health screening and other well-being services (including psycho-social support) – **DHHS Ports of Entry – Reception (EOC)**
- Arrangement of patient transport services – **DHHS Ports of Entry - Reception (EOC)**
- Provision of personal protective equipment for passengers – **DHHS Port of Entry - Reception (EOC)**
- Registration and initial needs identification of passengers for State-side use/application – **DHHS Ports of Entry - Reception (EOC)**
- Provision of information pack and food/water to passengers - **joint contributions: DHHS Ports of Entry - Reception (EOC)/Department Jobs, Precincts and Regions (DJPR)/VicPol**

2.4.3 Public Health Directions

- Assessment of inquiries and requests relating to directions – **DHHS Directions**
- Enforcement of mandatory detention directions – **DHHS Compliance (AOs)**
- Policy and processes relating to public health including use of Personal Protective Equipment and quarantine requirements for positive and non-positive passengers from the repatriation flight and provide health advice to key stakeholders involved in their care - **DHHS Public Health Command**

2.4.4 Health Coordination

Maintenance of overall situational awareness of impacts to health services and support for the appropriate implementation of the model of care for those in isolation - **DHHS Health Coordination**

2.4.5 Health and Wellbeing of passengers at accommodation

- Prepare for incoming passenger accommodation registration – **DHHS Detention Hotels (EOC) with DJPR**
- Reception parties established to coordinate movement of passengers from transport into accommodation - **DHHS Ports of Entry – Reception (EOC) with DJPR**
- Detailed identification of, capture and management of welfare needs – **DHHS Detention Hotels (EOC) with DJPR**
- Reception parties established and coordinated at identified accommodation – **DHHS Detention Hotels (EOC) with DJPR**
- Detailed identification of, capture and management of welfare needs at hotels – **DHHS Detention Hotels (EOC) with DJPR**
- Detailed identification of, capture and management of special/social needs - **DHHS Detention Hotels (EOC) with DJPR**
- Establish access to 24/7 medical and nursing support at accommodation points to support passengers with medical and pharmaceutical needs - **DHHS Health Coordination (EOC)**
- Provision of regular welfare calls to all quarantined passengers and support to meet identified needs, such as psychosocial, mental health, family violence - **DHHS Welfare (EOC)**
- Arrangements for any health and welfare needs including ongoing psychosocial support – **DHHS Detention Hotels (EOC)**
- Permissions for temporary leave from place of detention – **DHHS Compliance (AOs)**

- Conduct of voluntary health reviews to allow release back into the community – **DHHS Detention Hotels**
- Advise DoT and VicPol on numbers of passengers scheduled to exit quarantine – **DHHS Detention Hotels**
- Issuing of release documents and legal release of detainees from detention **DHHS Compliance (AOs).**

2.4.6 Communications including public communications

DHHS will manage communications according to the Operation Soteria Communication Plan.

2.5 Australian Federal Police (AFP)/Australian Border Force (ABF)

REDACTED

2.5.1 Airside operations

- Melbourne airport security and customs liaison
- Provide passengers with required information about Direction/requirements
- Collection of entry data (manifest)
- Marshall passengers in an area that is secure and be able to facilitate health screening
- Establish arrivals area for transport
- Marshall Passengers for boarding
- Assist boarding of passengers onto bus transport airside
- Escort bus transports to accommodation

2.6 AFP

- Escort bus transports to assigned accommodation
- Transfer manifest to VicPol on arrival at accommodation

2.7 Department of Foreign Affairs and Trade

The Department of Home Affairs (DFAT) assesses and approves all applications for returning Australians.

2.8 Department of Transport (DoT)

- The transport provider Skybus has been engaged to transport passengers (who do not have any immediate health needs requiring hospitalisation) to quarantine accommodation.
- Provision of transport to passengers to airport or approved transit location.
- Skybus and other DoT solutions tasked in accordance with projected arrivals and exits from quarantine accommodation
- Ensure transport of passengers (who do not have any immediate health needs requiring hospitalisation) between point of entry, to quarantine accommodation and returning to approved transit location following exit from quarantine accommodation

2.9 Ambulance Victoria

AV has responsibility for pre-hospital care and transport of passengers where required.

2.10 Victoria Police (VicPol)

Victoria Police provide support to AFP, DHHS and DJPR for enforcement and compliance issues.

- Provision of support to private security as required

REDACTED

- Security and management of passenger disembarkation from transport to accommodation
- Marshalling and security of incoming passengers
- Receive manifest and passengers from AFP on arrival at accommodation

2.11 Department of Jobs, Precincts & Regions (DJPR)

DJPR has responsibility for sourcing appropriate accommodation contracts (including food, concierge and security) to support mandatory passenger isolation and providing ongoing support to passengers for these needs.

- Manage accommodation contracts
- Manage transport arrangements/contracts for deliveries (ie: Commercial Passenger Vehicles)
- Manage private security contracts to enforce quarantine requirements at accommodation
- Reception parties established to coordinate movement of passengers from transport into accommodation- with DHHS Accommodation
- Reception parties established and coordinated at identified accommodation –with DHHS Accommodation
- Prepare for incoming passenger accommodation registration –with DHHS Accommodation
- Passenger data reconciled with airside entry data
- Detailed identification of, capture and management of welfare needs- with DHHS Accommodation
- Detailed identification of, capture and management of special/social needs (with DHHS)
- Management of services for all passengers including food, amenities and transport for deliveries.

3 Detention Authorisation

Section approver: Enforcement and Compliance Commander.

Last review date: 8 May 2020

3.1 Purpose

The purpose of this Detention Authorisation section is to:

- assist and guide departmental Authorised Officers (AOs) to undertake compliance and enforcement functions and procedures for the direction and detention notice issued under the *Public Health and Wellbeing Act 2008* (PHWA).
- provide clarity about the role and function of AOs.

3.2 Processes may be subject to change

It is acknowledged that the COVID-19 response is a rapidly evolving situation and matters are subject to fluidity and change. This is particularly the case for the direction and detention notice and the use of hotels to facilitate this direction.

To this end, this document will not cover every situation and will be subject to change. For example, the process for collecting data and signed direction and detention notices may change.

This document aims to describe key responsibilities and provide a decision-making framework for AOs. AOs are encouraged to speak to compliance leads for further advice and guidance.

3.3 Enforcement and Compliance Command for Mandatory Quarantine

Deliverables of the enforcement and compliance function

Enforcement and Compliance Command is responsible for:

- overall public health control of the detention of people in mandatory quarantine
- oversight and control of authorised officers administering detention
- administration of decisions to detain and decision to grant leave from detention.

Authorised officer* and Chief Health Officer obligations

Sections 200(1)(a) and 200(2) – (8) of the *Public Health and Wellbeing Act 2008* (PHWA) set out several emergency powers including detaining any person or group of persons in the emergency area for the period reasonably necessary to eliminate or reduce a serious risk to health.

Departmental staff that are authorised to exercise powers under the PHWA may or may not also be authorised to exercise the public health risk powers and emergency powers given under s.199 of the PHWA by the Chief Health Officer (CHO). This authorisation under s.199 has an applicable end date; relevant authorised officers (AOs) must be aware of this date. The CHO has not authorised council Environmental Health Officers to exercise emergency powers.

3.4 Direction and detention notices

An initial notice was issued on 27 March 2020, which ordered the detention of all persons who arrive into Victoria from overseas on or after midnight on 28 March 2020, requiring they be detained in a hotel for a period of 14 days. A second notice (No 2) was issued on 13 April 2020 that requires the detention of all

person who arrived into Victoria from overseas on or after midnight on 13 April 2020, requiring they be detained in a hotel for a period of 14 days.

The directions are displayed on the department's website at https://www.dhhs.vic.gov.au/state-emergency and were made by the Deputy Chief Health Officer or Chief Health Officer:

More information can be obtained from:

https://www.dhhs.vic.gov.au/information-overseas-travellers-coronavirus-disease-covid-19

3.5 Exemptions and exceptional circumstances

Detainees may seek to be exempt from detention or have alternative arrangements for detention. The ECC will consider these where exceptional circumstances exist and where the health and wellbeing of the individual is unable to be met within the hotel environment. These are approved under the authorised approvals outlined in the policy in **Annex 1.**

3.6 Obligations under the Charter of Human Rights and Responsibilities Act 2006

Department AOs are public officials under the Charter of Human Rights. This means that, in providing services and performing functions in relation to persons subject to the Direction and Detention Notice, department AOs must, at all times: act compatibly with human rights; and give 'proper consideration' to the human rights of any person(s) affected by a department AO's decisions. This is outlined in the Charter of Human Rights obligations document.

3.7 Processes and Procedures

To assist the delivery of operations a set of Standard Operating Procedures (SOP) has been developed which outlines the powers, authority and responsibilities of the Authorised officer to provide safe, efficient and effective activities at Ports of Entry and Quarantine Hotels. This set of SOPs is designed to be a 'one stop shop' for Authorised Officers for the provision of duties and activities and services.

The document containing the SOPs will also contain hyperlinks to more detailed procedures and processes. The document is contained at:

Annex 1: Operation Soteria – Authorised Officer Standard Operating Procedures

4 Operations

Section approver: DHHS Commander COVID-19 Accommodation

Last review date: 1 June 2020

4.1 Purpose

This set of guidelines outlines the activities and actions required to provide safe, efficient and effective hotel operations for those persons arriving in Australia via Victoria requiring mandatory quarantine, in accordance with the Standards contained in Annex 2. These guidelines are also designed as a one stop shop for the Team Leaders at ports of entry (both air and sea) and hotel operations as well as the broader team members. This will enable the efficient and effective provision of day to day services and activities required to operationally deliver Operation Soteria.

4.2 Method

This plan will outline the operational (including basic health and welfare) arrangements for people in mandatory quarantine as part of Operation Soteria, in the following phases:

- **Preliminary planning** to identify and develop the organisational structures, physical resources and systems required to enact the operation efficiently and effectively.
- **Reception** of passengers entering Australia via Victorian international air or marine ports. Passengers transit customs, are issued a Detention Order, are medically assessed and are transferred via bus from their port of entry to a quarantine hotel.
- **Accommodation** begins when the passengers disembark from the bus at their allotted quarantine hotel to begin their 14-day isolation period. Passenger data is reconciled with air/sea-port arrival data, and they are screened for special/social/welfare/medical/pharmaceutical/food needs. Passengers are allocated accommodation and checked in to the hotel. Passengers are provided with daily health checks and regular welfare calls to identify special needs. Mandatory detention is enforced by DHHS via Authorised Officers.
- **Return to the Community** begins when the guest is reviewed for exit (14 days is elapsed), and involves assessment of whether passengers are safe to enter the Victorian community. Passengers released are briefed, exit quarantine and are transported to an approved transit location, which can include transferring passengers back to the airport for onward air movement.

To oversee these operations, an Emergency Control Centre (EOC) has been established. The role of the is to ensure appropriate and timely coordination and resourcing of the international Ports of Entry into Victoria, and the Mandatory Quarantine Hotels.

An organisational structure of the EOC and hotels on-site structure is attached at **Appendix 3**. The EOC is located at 145 Smith Street Fitzroy.

The EOC will also coordinate the de-escalation of Operation Soteria.

4.3 Processes and Procedures

To assist the delivery of operations a set of Operational Guidelines has been developed which outlines the activities, actions and forms required to provide safe, efficient and effective Port of Entry and quarantine hotel operations.

The document containing the guidelines will also contain hyperlinks to more detailed procedures and processes. The document is contained at:

Annex 3: Operation Soteria – Operational Guidelines for Mandatory Quarantine

5 Health and Welfare

Section approver: Public Health Commander.

Last review date: 1 June 2020

5.1 Purpose

The health and welfare of persons in detention is the highest priority under Operation Soteria.

The Health and Welfare arrangements are based on a set of Public Health Standards for care of returned travellers in mandatory quarantine and a Policy for managing COVID-19 in this setting.

Clinical governance framework

The clinical governance framework for Operation Soteria will ensure that returned passengers in mandatory quarantine receive safe, effective and high-quality care that is consistent with best practice.

This framework integrates existing public health and operational oversight of the nursing, welfare, medical and mental health care provided to people in mandatory quarantine.

The framework ensures that risk from quarantine for individuals, families and the entirety of the passenger group in mandatory quarantine is proactively identified and managed. Information from welfare, nursing, mental health and medical providers will be provided in a secure digital tool which protects passengers' confidentiality and privacy.

This information will be available in real-time to Public Health Command and to Operational Command. Additionally, a daily clinical governance report will identify compliance with Health and Welfare Standards. The daily clinical governance report will also identify and address individual health and welfare issues to ensure that passengers are receiving the right care in the right place at the right time, and that health and welfare staff are able to work safely and effectively to deliver care.

5.2 Standards

The Public Health Standards for care of returned travellers in mandatory quarantine have been developed to ensure that ADEQUATE, APPROPRIATE and TIMELY measures are established and delivered to care for the health and welfare of quarantined persons.

Each standard is composed of a series of criteria to underpin the care of quarantined persons and a suite of indicators to monitor and evaluate the delivery of services. These standards, in **Annex 2**, include:

Standard 1. Rights of people in mandatory quarantine

Criterion 1.1 Charter of Human Rights and Responsibilities

Criterion 1.2 Diverse groups

Criterion 1.3 Use of interpreters

Criterion 1.4 Feedback and complaints process

Standard 2. Screening and follow up of health and welfare risk factors

Criterion 2.1 Health and welfare risk factors

Criterion 2.2 Schedule for screening

Criterion 2.3 Methods of screening

5.3 Public Health Policy for COVID-19 in Mandatory Quarantine

This document outlines the Department of Health and Human Services (DHHS) public health policy for COVID-19 in mandatory quarantine (Operation Soteria).
Identification and management of COVID-19 is undertaken in two scenarios – diagnostic testing of symptomatic individuals and routine testing by invitation to all persons in mandatory quarantine on Day 3 and Day 11 of the quarantine period.

5.4 Operational Guidelines

The **Operational Guidelines for mandatory quarantine, see Annex 3,** have been developed to ensure that public health management principles and processes , and appropriate procedures are applied for each stage of the mandatory quarantine process to ensure the health, wellbeing and safety of detainees.. They have been written to follow the path of a returned traveller entering mandatory quarantine.

They are intended for use by DHHS staff, healthcare workers and other departments involved in the care of individuals detained in mandatory quarantine. They will be updated as internal processes change.

Annex 3 contains the Operational Guidelines for managing mandatory quarantine, as per the following heading links.

6 Information and Data Management

6.1 Information management systems

The number of secure databases used for the storage and handling of confidential data on people in detention is minimised to prevent fragmentation of records management and to reduce the risk of critical information not being available to DHHS, health or welfare staff providing for the health and welfare needs of people in detention.

The following information management systems are authorised for use in this operation:

- The Public Health Event Surveillance System (PHESS);
- The healthcare and wellbeing database for mandatory quarantine (Dynamic CRM Database);
- Best Practice general practice software (see 3.3);
- Paper records (where necessary).

6.2 Data access, storage and security

The State Controller - Health, DHHS Commander COVID-19 Accommodation (or delegate) and Public Health Commander (or delegate) are authorised to access any record within these systems to enable oversight of the health and welfare of people in detention.

Information on people arriving internationally is shared with DHHS by DJPR to enable the operational functions under sections 3-5. While multiple applications/systems may be used during the operation, all information will be uploaded to PHESS, which will then hold the complete medical and compliance records for a person who was in detention in Victoria as part of this operation.

6.2.1 Privacy

Respecting the privacy of individuals who are detained under this operation is an important consideration, as information collected contains personal details and other sensitive information.

DHHS staff must comply with the Department of Health and Human Services privacy policy whenever personal and/or health information about passengers/detainees, staff or others is collected, stored, transmitted, shared, used or disclosed.

The privacy policy is an integrated policy, which supports the sensitive protection and management of personal information and seeks to meet the legislative requirements of the *Privacy and Data Protection Act 2014* and *Health Records Act 2001*. Information relating to privacy is available at intranet.dhhs.vic.gov.au/privacy.

6.2.2 Sending information by email

For communication within the department, there are risks to privacy in sending information by email. These include misdirection due to errors in typing the address and the ease of copying, forwarding, amending or disclosing emailed information to others. Care should be taken with the list of addressees, and the title of the email should not contain any identifying information.

6.2.3 Electronic security of passenger/detainee information

In addition to email, passenger/detainee information is stored, accessed and transmitted using systems and devices such as computers, laptops, and smartphones. These systems and devices must be as carefully protected as the passenger/detainee information itself.

An 'information security incident' occurs when the security of the information, system or device is compromised. Some examples of these incidents are:

- the details of a passenger is accidentally sent to the wrong email address
- a case worker's smartphone is lost or stolen and there was information about a passenger/detainee stored on it
- a virus infects a computer that stores or accesses passenger/detainee information.

Information security incidents must be reported to the Emergency Operations Centre who, in turn, will report it to the IT Service Centre.

6.3 Medical records

Medi7 is currently implementing a Best Practice medical record system for record-keeping. This will be uploaded to the DHHS Dynamic CRM Database.

6.3.1 Requirement for accessible medical records

Each quarantined individual must have a medical record accessible to all health care providers who require access to it and who are providing care. This record captures the person's significant medical history, current medications, allergies and any other significant components of the medical history, where these have been revealed by the person in detention or discussed as part of medical care provided to the person during detention. Each time health care is requested **and** provided it must be documented in this record.

6.3.2 Confidentiality and access to medical records

Any medical record created or held by DHHS for a person in detention is confidential and must only be accessed by persons coordinating and providing care for the person. The records will belong to DHHS and can be required to be provided at any time by the medical service contractor to DHHS for review, from the Best Practice software.

These records should be stored securely and should not be accessed by anyone not providing care for the person. Specifically, these medical records must only be accessed or viewed by an AHPRA-registered health practitioner employed by DHHS to provide services to people in detention, an authorised officer, or the Public Health Commander, State Controller - Health, DHHS Commander COVID-19 Accommodation or their named delegate. Other persons involved in Operation Soteria should not access a medical record for an individual unless authorised on a named basis by the Public Health Commander (or delegate) or the State Controller - Health (or delegate).

Accurate and comprehensive medical record keeping is essential for the health and safety of all individuals in mandatory quarantine and will ensure continuity of care for healthcare providers in subsequent shifts. If medical notes are recorded on paper, these should be stored securely and uploaded to the information management system as soon as is practicable and within 72 hours at most. If a doctor completes an assessment, they must provide a written record of this to the nursing staff, either on paper or via email, if an electronic medical record system is not available.

Any medical records documents that are potentially contaminated with COVID-19 (SARS-CoV-2) should be safely placed in plastic pockets to reduce the risk of infection transmission.

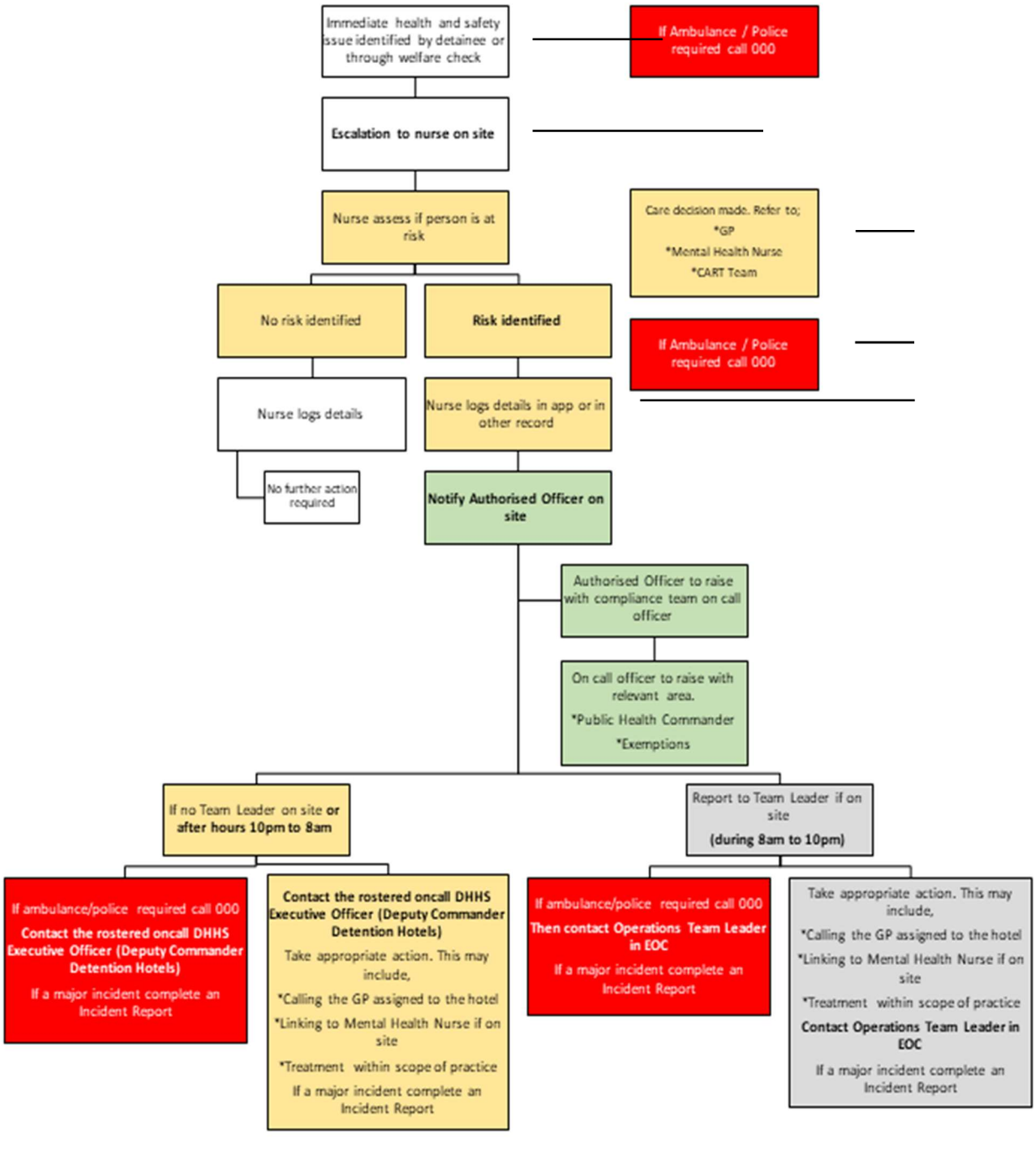
7 Issues escalation and incident reporting

The safety of staff, passengers/detainees and the Victorian community is a key priority of this operation.

All staff undertaking roles under Operation Soteria are responsible for timely and appropriate management and escalation of issues arising under the operation. All risks and incidents must be reported to the Department of Health and Human Services, via the on site Authorised Officer or relevant Commander.

7.1 Hotel escalation process

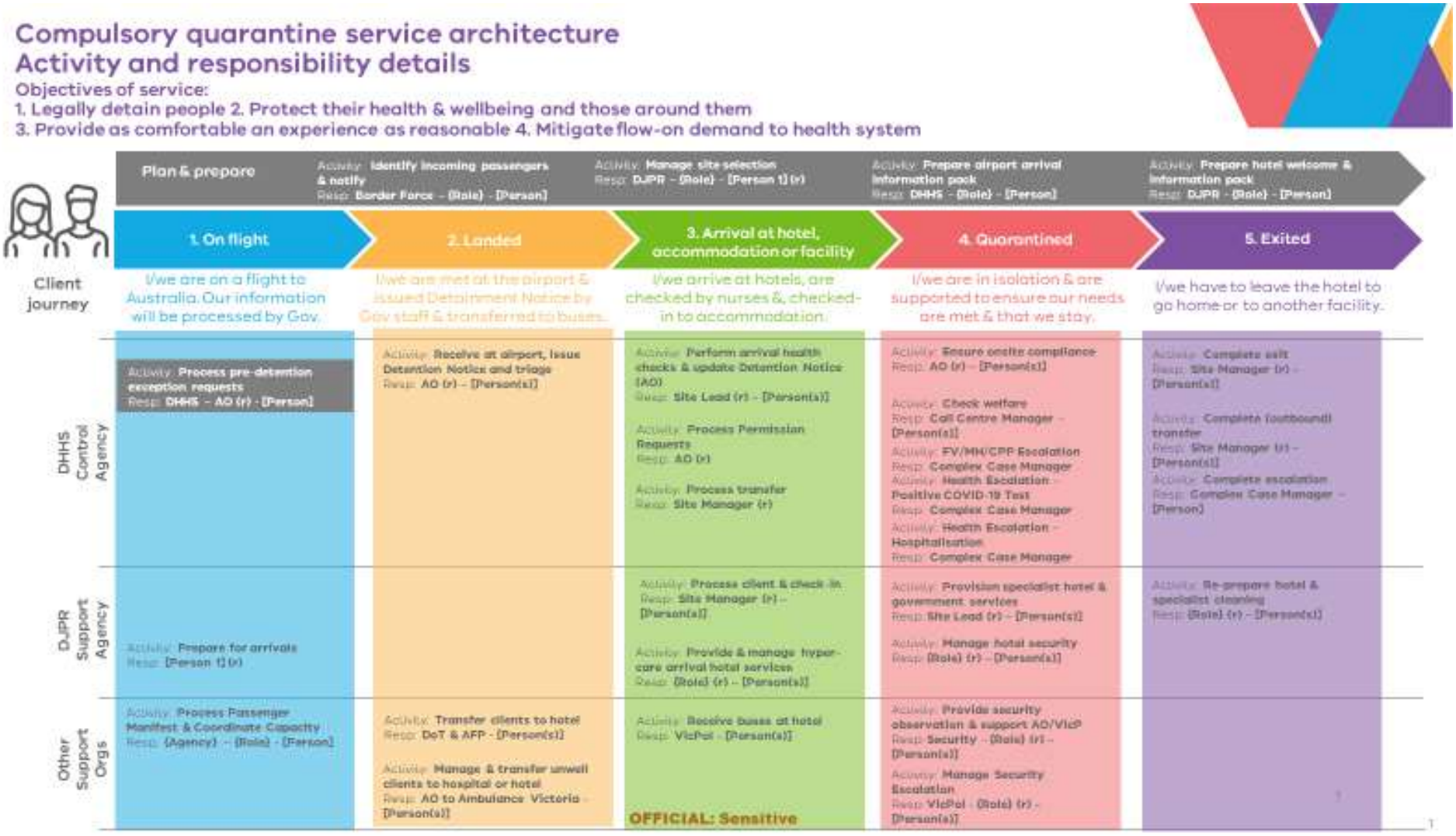
The escalation process in Figure 2 below must be followed for all health and medical risks arising in quarantine hotels.



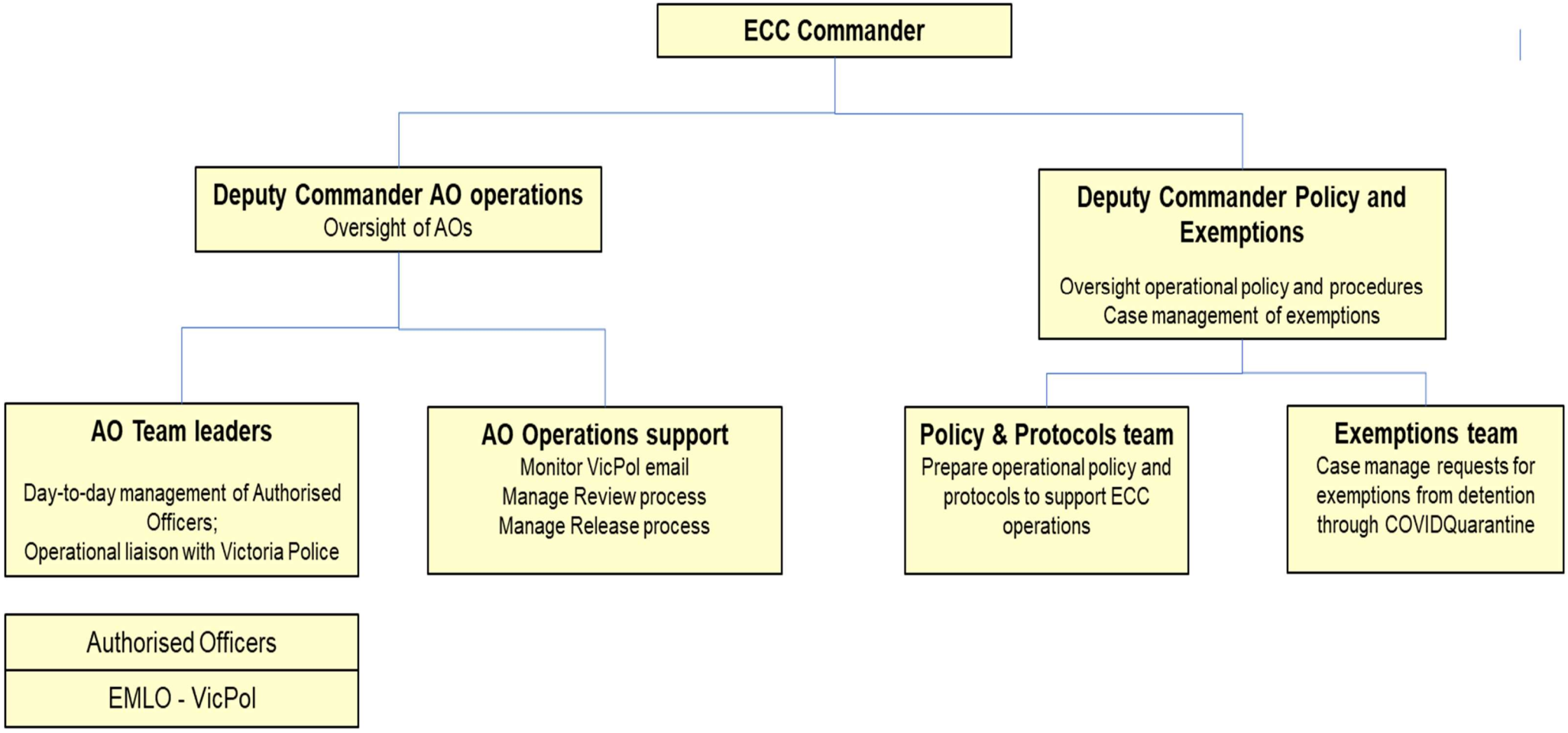
7.2 Incident reporting

The incident reporting process in **Appendix 4** outlines the Department of Health and Human Services management requirements for major incidents or alleged major incidents that involve or impact significantly upon passengers/detainees during airport reception, hotel quarantine, and other users or staff during provision of accommodation services during the COVID-19 emergency. Examples include injury, death, sustaining/diagnosis of a life threatening or serious illness, and assault/crime.

Appendix 1 - Operation Soteria process phases

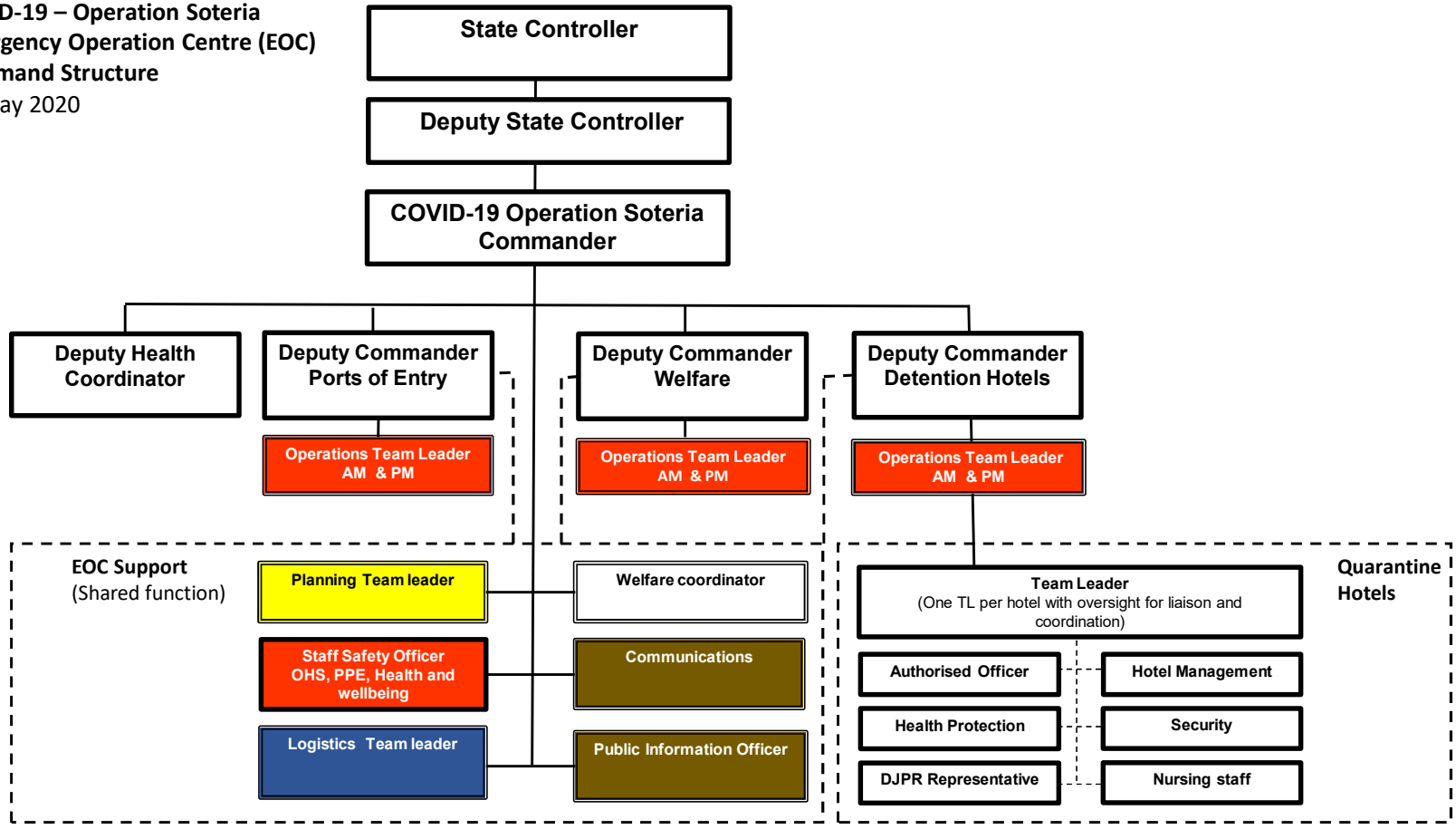


Appendix 2 - Enforcement and Compliance Command structure

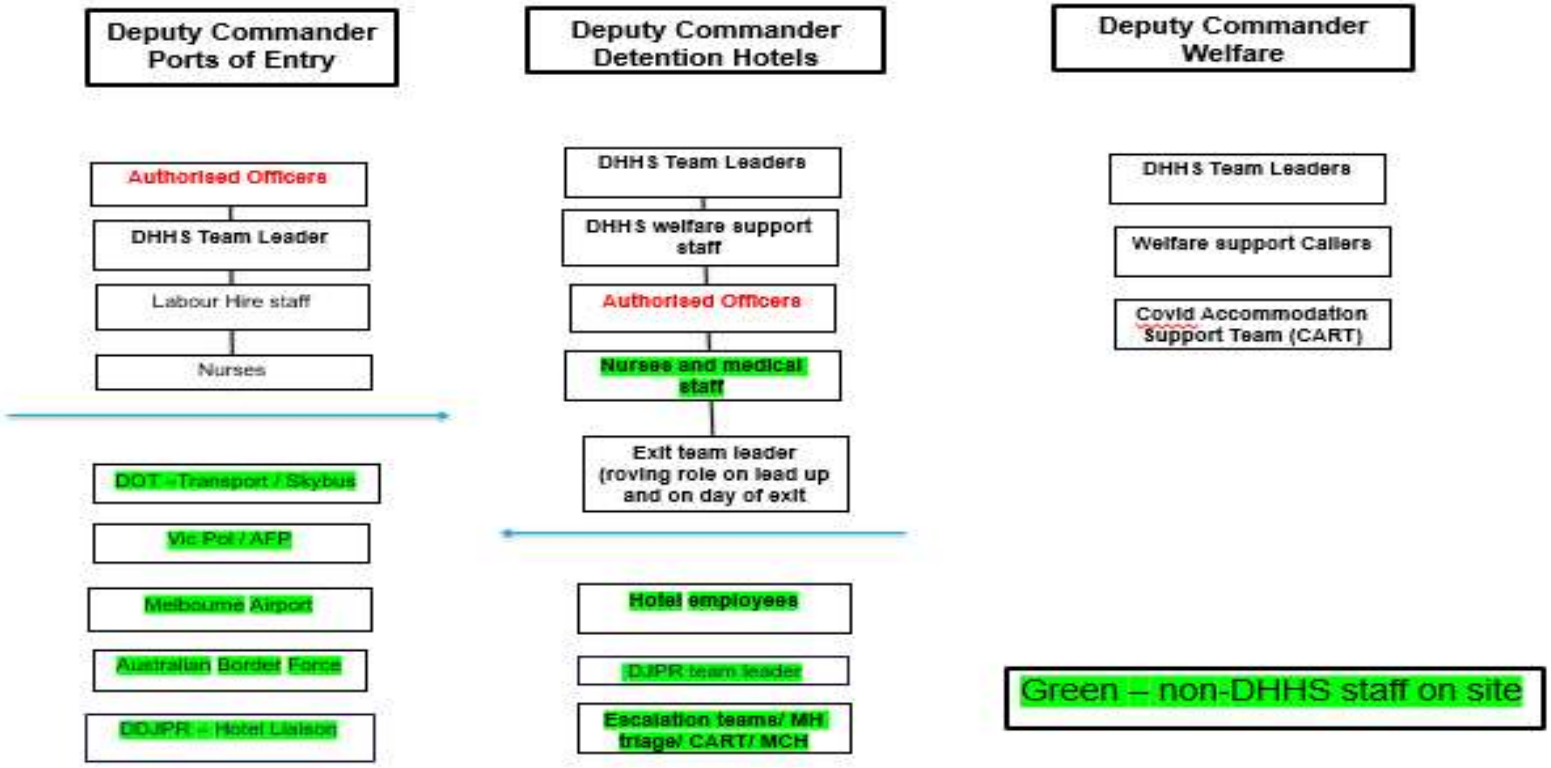


Appendix 3 Emergency Operations Centre Structure

COVID-19 – Operation Soteria
Emergency Operation Centre (EOC)
Command Structure
06 May 2020



Operation Soteria – on site teams



Appendix 4 - DHHS COVID-19 Quarantine – incident reporting

1. Introduction

This document outlines the Department of Health and Human Services 'the department' management requirements for major incidents or alleged major incidents that involve or impact significantly upon passengers/detainees during airport reception, hotel quarantine, and other users or staff during provision of accommodation services during the COVID-19 emergency. Examples include injury, death, sustaining/diagnosis of a life threatening or serious illness, and assault/crime.

The primary audience for this document is departmental staff on site and senior officers who are involved in reviewing, endorsing, processing, recording and analysing incident reports after Parts 1–6 of the incident report have been completed at the service delivery level supported by the appropriate Deputy Commander.

This document was last reviewed on 29 April 2020.

2. Reviewing and endorsing incident reports

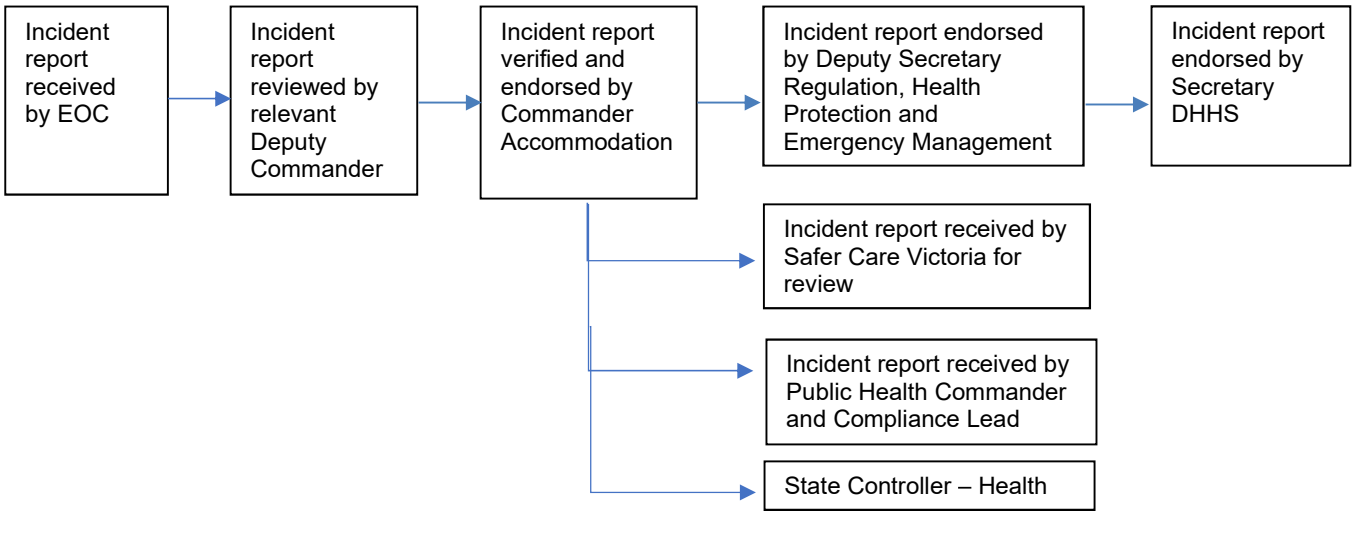
This section outlines the steps required for reviewing and endorsing incident reports, once provided to the DHHS Commander Accommodation via dhhsopsoteriaeoc@dhhs.vic.gov.au following verbal report from the relevant Deputy Commander. Figure 1 below provides an overview of the process.

2.1. Overview

Incident reports (Parts 1–6) are completed by the most senior departmental staff immediately involved in the management of the incident onsite, with support of the relevant Deputy Commander. In the case of any incident, the first priority is making sure passengers/detainees and staff are safe, and in hotels, appropriate care provided (see escalation process for hotel detention). After that, an incident report must be completed and sent to the Commander COVID-19 Accommodation via dhhsopsoteriaeoc@dhhs.vic.gov.au following verbal report. The report includes immediate actions that have been taken and planned follow-up actions.

The specified department officers review the incident report, and complete parts 7-9. The Commander Accommodation is also responsible for sending the report to Safer Care Victoria, the Public Health Commander, State Controller – Health and the Compliance Lead.

Figure 1: High Level flowchart for reviewing and endorsing an incident report



The incident report form is available from the Operation Soteria Emergency Operations Centre (EOC), dhhsopsoteriaeoc@dhhs.vic.gov.au or relevant Deputy Commander. All reports must be legible and presented in the specified report format.

2.2. Deputy Commander receives an incident report

When an incident report is forwarded to the DHHS EOC, the report is registered in the EOC's electronic file system, TRIM, and allocated a reference number. It is then forwarded to the relevant Deputy Commander as soon as possible (within 1 hour). The staff completing the report will contact the relevant Deputy Commander to advise of the incident.

2.2.1. Reports about passengers/detainees who are also clients

If a passenger/detainee is a client of other service types, service providers or government departments, information regarding a major incident may be disclosed to other agencies or departments to lessen or prevent a serious or imminent threat to a client's life, health, safety or welfare; and/or with the intent of preventing similar incidents from occurring in the future. The Commander Accommodation is responsible for notifying within the department and/or other organisations where the passenger/detainee is known to be a client, with the lead division will inform any community service organisations involved in providing services if applicable.

2.3. Review of the incident report

The relevant Deputy Commander endorses the incident report by completing Part 6 of the incident report (refer to attachment 1).

They must review the incident report and:

- check that the immediate needs of the passenger/detainee(s) have been addressed
- check that appropriate immediate actions have been taken in response to the incident and that any planned further actions are appropriate
- if a particular requirement has not been undertaken, the reasons why are documented
- ensure that the passenger/detainee and location details have been recorded and are accurate
- ensure all sections of the incident report are completed
- record any additional or required follow-up action (if any).

2.4. Verify and endorse the incident category

The Commander Accommodation verifies and endorses the incident report.

The Commander Accommodation is responsible for escalating an incident report to the Deputy Secretary Regulation, Health Protection and Emergency Management to endorse, and sending the report to the Public Health Commander, the Compliance Lead and Safer Care Victoria via irtreviews@safercare.vic.gov.au for review.

The Deputy Secretary Regulation, Health Protection and Emergency Management is responsible to escalate the incident report to the Secretary Department of Health and Human Services for endorsement.

2.5. File the completed incident report

After Parts 7-9 have been completed and endorsed, the incident report is returned to the Emergency Operations Centre for records management. This constitutes the final completed report.

The final completed report must be placed in a TRIM record must be updated in accordance with the department's record management policy.

Where allegations are made against a staff member, the incident report and any subsequent reports are to be retained in the staff file.

2.6. Incident report records management and privacy

Incident reports (paper versions and related electronic data) must be stored securely and only accessed by staff that have a business purpose for doing so. Paper reports are discouraged, and if required, should be stored in locked filing cabinets. Access to electronic data should be limited to appropriate staff only.

2.7. Local investigation and causal analysis

The Commander Accommodation will ensure that the incident is subject to an appropriate level of local investigation and causal analysis and that, where relevant, an improvement strategy is prepared.

Incident investigations should:

- identify reasons for the incident occurring
- identify opportunities for improvement in management systems or service delivery practice
- make local recommendations and implement improvement strategies in order to prevent or minimise recurrences. These strategies should be actionable and measurable and include an assessment of their effectiveness in delivering improvement
- satisfy mandatory reporting or review requirements (for example, notifying the Coroner or WorkSafe).

3. Privacy

Respecting the privacy of individuals who are involved in or witness to an incident is an important consideration in dealing with incident reports, which often contain personal details and other sensitive information.

Departmental staff must comply with the Department of Health and Human Services privacy policy whenever personal and/or health information about passengers/detainees, staff or others is collected, stored, transmitted, shared, used or disclosed.

The privacy policy is an integrated policy, which supports the sensitive protection and management of personal information and seeks to meet the legislative requirements of the *Privacy and Data Protection Act 2014* and *Health Records Act 2001*. Information relating to privacy is available at intranet.dhhs.vic.gov.au/privacy.

3.1. Sending information by email

For communication within the department, there are risks to privacy in sending information by email. These include misdirection due to errors in typing the address and the ease of copying, forwarding, amending or disclosing emailed information to others. Care should be taken with the list of addressees, and the subject line of the email should not contain any identifying information.

3.2. Electronic security of passenger/detainee information

In addition to email, passenger/detainee information is stored, accessed and transmitted using emergency management systems and devices (including computers, laptops, and smartphones). These systems and devices must be as carefully protected as the passenger/detainee information itself.

An 'information security incident' occurs when the security of the information, system or device is compromised. Some examples of these incidents are:

- the details of a passenger is accidentally sent to the wrong email address
- a case worker's smartphone is lost or stolen and there was information about a passenger/detainee stored on it
- a virus infects a computer that stores or accesses passenger/detainee information.

Information security incidents must be reported to the Emergency Operations Centre who, in turn, will report it to the IT Service Centre.

DHHS Quarantine – incident reporting template

Reference number	
Impact (Major only) *e.g. injury, death, sustaining/diagnosing life threatening condition, assault/crime*	

1. Service provider details

Reporting organisation	
Address of service delivery	
DHHS Service Area *(e.g. Emergency Management)*	
Service type	

2. Incident dates

Date of incident	
Date accuracy (exact/approximate)	
Time of incident	
Time accuracy (exact/approximate)	
Date incident disclosed	
Time incident disclosed	

3. Incident description

Location of incident	
Detailed incident description	

4. Individual details – Passenger/detainee 1 [duplicate for each person involved]

Passenger/detainee's full name	
Passenger/detainee incident impact	
Sex	
Indigenous status	
Date of birth	
Passenger/detainee address	
Passenger/detainee unique identifier number *(if applicable)*	
Incident type	
Involvement in the incident (victim, witness, subject of abuse allegation, participant)	
Passenger/detainee's immediate safety needs met (Yes/No)	
Medical attention provided (Yes/No)	
Passenger/detainee debriefing or counselling (Yes/No	
Referral to support services (Yes/No)	
Change passenger/detainee care (support plan) (Yes/No)	
Notified next of kin, guardian or key support person (Yes/No)	

5. Other/s involved in incident [duplicate for each other person involved]

Person's full name	
Date of birth	
Person's job title or relationship to passenger/detainee (carer, paid staff, other)	
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	

6. Service provider response details

Brief summary of incident	
Reported to police (Yes/No)	
Name of officer and date reported to police	
Police investigation initiated (Yes/No)	
Staff member stood down/removed (Yes/No)	
Manager's full name	
Manager's job title	

Date incident report reviewed	
Manager telephone number	
Manager email	
Immediate actions taken by the organisation in response to the incident	
Deputy Commander full name and signature	
Deputy Commander job title	
Date incident report approved	
Comments	

7. Incident report authorisation – EOC Command

Delegated authority full name and signature	
Delegated authority job title	Commander COVID-19 Accommodation
Date incident report approved	
Delegated authority phone number	
Delegated authority email address	
Comments	

8. Incident report authorisation – Deputy Secretary

Delegated authority full name and signature	
Delegated authority job title	
Date incident report endorsed	
Delegated authority phone number	
Delegated authority email address	
Comments (optional)	

9. Incident report authorisation - Secretary

Delegated authority full name	
Delegated authority job title	
Date incident report endorsed	

Annex 1 – Detention Compliance and Enforcement

Annex approver: DHHS Commander Enforcement and Compliance

Last version date: v2.0 1 June 2020

1. Purpose and background

1.1 Purpose

The purpose of this annex is to outline the compliance and enforcement policy and procedures to ensure compliance and enforcement functions and procedures for the direction and detention direction issued under the *Public Health and Wellbeing Act 2008* (PHWA).

1.2 Background

A mandatory quarantine (detention) approach was introduced by the Victorian Government, consistent with the Commonwealth Government (Department of Health Information for International Travellers) through a policy that a detention order would be used for all people arriving from overseas into Victoria.

An initial notice was issued on 27 March 2020, which ordered the detention of all persons who arrive into Victoria from overseas on or after midnight on 28 March 2020, requiring they be detained in a hotel for a period of 14 days. A second notice (No 2) was issued on 13 April 2020 that requires the detention of all person who arrived into Victoria from overseas on or after midnight on 13 April 2020, requiring they be detained in a hotel for a period of 14 days.

The policy is given effect through a direction and detention notice under the *Public Health and Wellbeing Act 2008.* The directions are displayed on the department's website at https://www.dhhs.vic.gov.au/state-emergency and were made by the Deputy Chief Health Officer or Chief Health Officer:

- The objectives of the approach for people returning from overseas to Victoria are:
- To identify any instance of illness in returned travellers in order to detect any instance of infection
- To ensure effective isolation of cases should illness occur in a returned traveller
- To provide for the healthcare and welfare needs of returned travellers who are well or shown to be COVID-19 negative but are required to remain in quarantine for the required 14 days.
- To implement the direction of the Deputy Chief Health Officer through meeting:
    - A requirement to detain anyone arriving from overseas for a period of 14 days at a hotel in a specific room for a specified period unless an individual determination is made that no detention is required
    - A requirement to record provision of a detention notice showing that the order was served and to manage access to information on who is in detention using a secure database
    - A requirement to undertake checks every 24 hours by a department Compliance Lead during the period of detention
    - A requirement to fairly and reasonably assess any request for permission to leave the hotel room / detention. This may be undertaken as part of a holistic approach involving Authorised Officers (AOs), DHHS welfare staff, medical practitioners, nurses and other specialist areas if needed.

2. Authorised officers and powers

2.1 Key points

- Only AO's additionally authorised for the purposes of the public health risk and emergency powers can undertake administration and enforcement of the direction and detention notice.
- AOs must undertake several obligations before exercising powers.

2.2 Authorisation under the PHWA for the purposes of the emergency order

Only VPS employees and council environmental health officers that are AOs under the PHWA and also authorised by the Chief Health Officer under section 199(2)(a) of the PHWA can exercise public health risk and emergency powers.

This authorisation under s.199 has an applicable end date; relevant authorised officers (AOs) must be aware of this date.

Note: Any AO who is unsure as to whether they have been authorised under s. 199 should contact the AO Operations support team prior to enforcing compliance with the Direction and Detention Notices.

While exercising their powers and monitoring compliance, AOs should be cognisant that persons subject to detention may be tired and stressed. AOs may need to use conflict negotiation, mediation skills and compassion to help persons settle into the new environment.

2.3 Authorised officer[1] and Chief Health Officer obligations

Sections 200(1)(a) and 200(2) – (8) of the PHWA set out several emergency powers including detaining any person or group of persons in the emergency area for the period reasonably necessary to eliminate or reduce a serious risk to health.

.1.1.1 Mandatory obligations for AOs

AOs have mandatory obligations that must be followed when carrying out functions. The table below summarises mandatory obligations.

Table 1: Mandatory obligations of AOs

Legislation	Obligations
Emergency powers and general powers in the *Public Health and Wellbeing Act 2008*	• AO must show ID card before carrying out actions/exercising powers
	• AO must explain to the person the reason why it is necessary to detain them – if not practicable, it must be done as soon as practicable
	• AO must warn the person that refusal or failure to comply without reasonable excuse, is an offence before carrying out actions/exercising powers
	• AO must facilitate a reasonable request for communication
	• AO must review every 24 hours, whether continued detention of the person is reasonably necessary to eliminate or reduce a serious risk to health (undertaken by AO Deputy Command with support from Operations Support Team)
	• AO must give written notice to the Chief Health Officer that detention has been made and if it is reasonably necessary to continue detention to eliminate or reduce the serious risk to public health.[1]
In addition, AOs must comply with the Charter of Human Rights	• AO must act compatibly with human rights
	• AO must give 'proper consideration' to the human rights of any person(s) affected by a department AO's decision.

Note:

The notice to the Chief Health Officer must include:

- the name of the person being detained
- statement as to the reason why the person is being, or continues to be, subject to detention.

Following receipt of a notice, the Chief Health Officer must inform the Minister as soon as reasonably practicable.

[1] *And Authorised Officer under the PHWA that has been authorised for the purposes of the emergency order*

General powers and obligations under the PHWA

The general powers of Authorised Officers are outlined under Part 9 of the PHWA (Authorised Officers). The following is an overview of powers and obligations. It does not reference all powers and obligations.

AOs are encouraged to read Part 9 and seek advice from the Deputy Commander AO Operations if they are unsure about the administration of their powers.

Produce your identity card - s166

- **Before** exercising powers provided to you under the PHWA:
- At any time during the exercise of powers, if you are asked to show your ID card
- As part of good practice, you should produce your identity card when introducing yourself to occupiers or members of the public when attending complaints or compliance inspections.

Inform people of their rights and obligations

- You may request a person to provide information if you believe it is necessary to investigate whether there is a risk to public health or to manage or control a risk to public health.
- Before exercising any emergency powers, you must, unless it is not practicable to do so, warn the person that a refusal or failure to comply without a reasonable excuse, is an offence.

3 AO responsibilities at airport

AOs are responsible for issuing Direction and Detention notices to people arriving in Victoria (airports and seaports)[2] from overseas and for advising them they must go into immediate compulsory quarantine for 14 days. This is because international arrivals present a high-risk of further transmission of the COVID-19 and detention is necessary to reduce or eliminate the serious risks to public health associated with the virus.

All passengers will be transported free of change to a designated hotel accommodation, where they must undertake a strict 14-day quarantine period.

The airport is the first point of contact for an AO, who must undertake several obligations to administer the direction and detention notice issued under the PHWA.

3.1 Key points

- AO must fulfil mandatory obligations (e.g. show ID card and explain reason for detention, etc).
- AO must check that a direction and detention notice is filled in properly.
- AO must provide factsheet and privacy collection notice to person.

3.2 Key responsibilities

Below provides an overview of the key authorised officer responsibilities at the airport, with further detail provided in **Table 2**.

Table 2: Key steps and AO roles and responsibilities at the airport

Step	AO roles and responsibilities	Mandatory obligation	Section (PHWA)
Note exemptions	1. Exemptions for flights will be provided by the Exemptions Team Leader to the AO rostered at the airport as well as Airport Operations Command prior to passenger disembarkation 2. Any queries in relation to the exemption should be directed to the Exemption team leader 3. AO to check exemption paperwork and identify passenger on manifest sheet 'exemption'		
Flight arrival	4. Inform flight crew of AO action and request translation of script3. 5. Declare you are an Authorised officer and show your identification card. 6. Read script, which: i. explains the reasons for detention ii. warns returning passengers that refusal or failure to comply without a reasonable excuse is an offence and that penalties may apply iii. reminds passengers they must keep their detention notice. 7. Repeat twice. 8. Request flight crew read script in all relevant	Yes	Sections 166, 200(2),200(4) and 202(1)

[2] Noting some exemptions apply for maritime crew – see exemptions section

	languages.		
Issue notice immediately after disembarkation	9. Serve the approved Direction and Detention Notice to each passenger (notification to parent/guardian may need to be conducted over the phone and interpretation services may be required). The approved notice is the general notice or the approved exemption notice. 10. If practicable at this time, provide the person with a copy of the department's privacy collection notice. If not practicable, this can be provided at the hotel.		
Facilitate request for communication	11. Facilitate any reasonable request for communication, such as a phone call or email and including if necessary, organising an interpreter to explain the reasons for detention (call Victorian Interpretation and translation service on 9280 1955; PIN code is REDACT.	Yes	Section 200(5)
Confirm details	12. Ensure each direction and detention notice: i. states the full name of the person being detained, date of birth and mobile phone number (if applicable) ii. contains the signature of the person being detained or their guardian as receipt of the notice iii. states the name and signature of the AO iv. contains the hotel name at which the person will be detained v. contains the date of commencement of detention.		
Record issue of receipt	13. Take a photo of direction and detention notice and record issue and receipt of the notice in the COVID-19 Compliance and Welfare Application. You may be assisted by a non-AO in this task. 14. Request person subject to detention present to AO at hotel		
Check with welfare team	15. Liaise with AO Team Leader and health team if the Health Check has identified passengers that need to transfer to hospital. 16. Issue leave permissions where required (e.g. in circumstances where a person needs to go to hospital Refer to Section 6 (Permissions) for further detail. 17. Ensure the detainee understands they must return to the hospital listed on the detention notice immediately after medical release in the transport organised by DHHS. 18. See hospital information sheet developed to assist the hospital on required and contact details.		
Record	19. Record any actions taken in the COVID-19 Compliance and Welfare App, including the above mandatory obligations, use of an		

	interpreter and any associated issues.		

For noting - transfer of uncooperative person to be detained

There may be circumstances where a person refuses to be cooperative. DHHS Operations staff at the airport may elect to organise a separate mode of transport for in such circumstances, noting Victoria Police may be requested to escort such individuals.

4 AO responsibilities at hotels

As part of meeting mandatory detention requirements in the direction and detention notice, the Victorian Government has arranged accommodation in numerous locations, primarily in the Melbourne CBD area. The purpose of this is to restrict the movement of international arrivals to limit the spread of COVID-19.

4.1 Key points

- AO reiterates detention requirements, explains reasons for detention and the penalties for non-compliance.
- AO oversees and provides advice on compliance and works with security, hotel staff, and medical and other staff.
- AOs are responsible for detention release following the mandatory 14 day detention

4.2 Shift change over

This section outlines the process for changing shift.

Table 3: Key steps and AO roles and responsibilities during shift change over

Step	AO roles and responsibilities	Mandatory obligation	Section (PHWA)
Introduction	1. Introduce yourself to: • hotel/duty manager • head of security • DHHS Team Leader • DJPR site manager (if on site) • clinical staff.		
Handover	2. Obtain a handover from the previous AO (verbal and high-level information) to: • understand detainee issues, early releases, exemptions and permissions • ascertain location of records and forms • Any hotel operational issues (e.g. physical exercise space unavailable, changes to operational policies like food delivery) • ensure COVID-19 Compliance Application has been updated • exits list provided to Release AOs		

4.3 Hotel check-in

The purpose of hotel check-in is to:

- enable hotel staff to provide people being detained with a room number and key
- reiterate obligations for those being detained.

Table 4: Key steps and AO roles and responsibilities – hotel check-in

Step	AO roles and responsibilities	Mandatory obligation	Section (PHWA)
Check-in	1. Ensure person to be detained provides Direction and Detention Notice to hotel staff; hotel staff to write on the notice: i. room number ii. the date that the person will be detained until (14 days after arrival at place of detention).		
Check and reiterate Direction and detention notice	2. Show identification and introduce yourself 3. Check completed Direction and Detention Notice to confirm that the following details have been correctly recorded on the notice and in the compliance app: • the hotel name • hotel room number and arrival date and time • the date that the person will be detained until (14 days after arrival at place of detention). 4. Return the notice to the person being detained (note that this must occur). AO's should reiterate: • the reason for detention • warn the person that refusal or failure to comply without a reasonable excuse is an offence and that penalties may apply • facilitate any reasonable request for communication.		Sections 166, 200(2), 200(4) and 203(1)
Liaise with medical and welfare staff	5. Liaise with nurses to identify persons that might require permissions for temporary leave (e.g. for medical treatments).		

4.4 Monitoring compliance

The AO will provide oversight and ensure compliance with the direction and detention notice

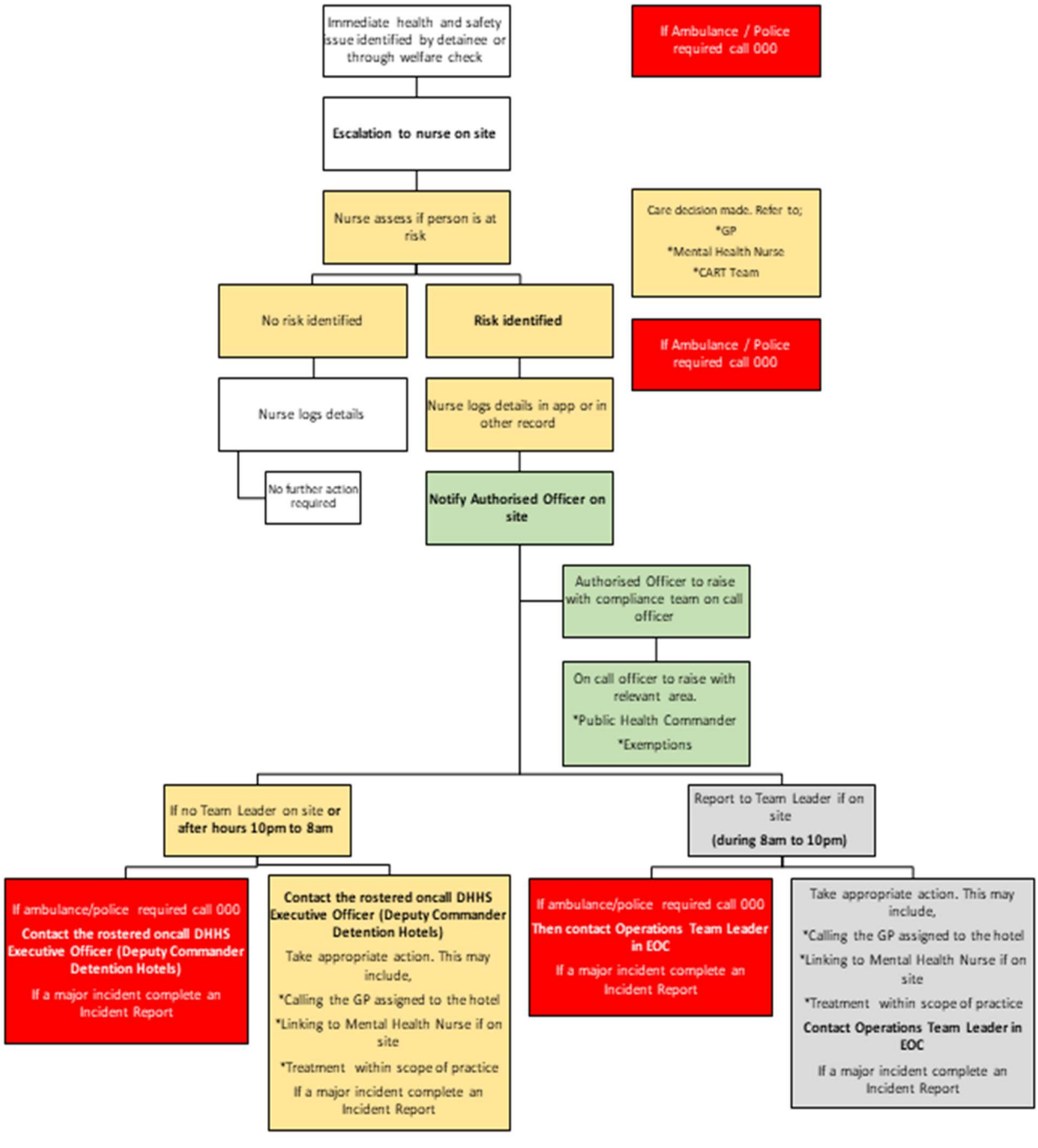
Table 5: Key steps and AO roles and responsibilities – monitoring compliance

Step	AO roles and responsibilities	Mandatory obligation	Section (PHWA)
Liaise with security	1. Check that security personnel are undertaking floor walks to encourage compliance and deter non-compliance.		
Oversee compliance	2. Oversee and provide advice on compliance-related issues such as: • a person refusing to comply and a person demanding to be removed from detention • reminding a person of the reason for the detention, their obligations under the detention and direction notice and the penalties if they do not comply • responding to requests from security to address compliance • answering questions from hotel staff, security and police as to what persons may be permitted or not permitted to do • seeking assistance from security or Victoria police to support compliance efforts • facilitating any reasonable requests for communication. For translation, call Victorian Interpretation and translation service on 9280 1955. PIN code is REDACT		203(1)
Permissions	3. See Section 6 (Permissions). 4. Raise requests for permission to leave with AO Team Leader if there is not an authorised area for the detainee to exercise the permission or there is complexity in applying the transition (e.g. requires leaving the hotel site). All requests by detainees to leave the hotel site must be escalated to Deputy Command AO operations if not already approved. 5. Administer permission to leave and monitor compliance.		203(1)
Exemptions	6. See Section 5 (Exemptions). 7. Raise any exemption requests with AO Team Leader in the first instance. The AO Team Leader may then refer exemption requests to covidquarantine@dhhs.vic.gov.au,[or may request the AO to do so] for decision. 8. Issue Direction and Detention Notices for detention in alternate locations if ECC Commander approves an exemption request. In this case, a case manager from the Exemptions Team will contact the AO with details.		200(2),200(4) and 202(1)
Records	9. Make notes of compliance related issues and actions. The means of recording notes are dependent of the availability and use of		

	technology and could include the COVID Compliance Application. 10. Record all permissions in the permissions register and COVID-19 Compliance App 11. Upload photos of all amended direction notices issued while at the hotel to the COVID-19 Compliance Application.		
Other issues	12. Inform nurse, medical practitioner, welfare staff or DHHS concierge staff of other matters you become aware of.		

4.5 Emergency health and welfare incidents

Where there is an immediate health and welfare issue identified at the hotel, the following process is to be followed.



4.6 Clarity about role of AO

AOs should be aware that their role and scope is related to administration of, and compliance with, the direction and detention notice under the PHWA. Activities outside the scope of the role of the AO include:

- transport - this is the responsibility of the DHHS Team Leader on-site. If a DHHS Team Leader is not on-site, please refer to the Emergency Operations Command at DHHSOpSoteriaEOC@dhhs.vic.gov.au and title the email “Referral to organise transport”
- physically moving COVID-19 patients. Please see procedure under ‘Occupational Health and safety”
- retrieving luggage
- food quality

- inspecting care packs, removing items from care packs such as perishables and alcohol and ordering food such as Uber eats
- monitoring or ordering PPE or other supplies.

If an AO becomes aware of these or other non-compliance related issues in a hotel, they should refer them to the DHHS Team Leader on-site for follow up. For medical and welfare issues, the AO should inform on-site medical and nursing staff in accordance with section 4.5 above.

4.7 Daily review and reporting by the AO Review Team

The daily review is a mandatory obligation to determine whether continued detention of a person is reasonably necessary to eliminate or reduce a serious risk to health. There are mandatory obligations for the AO to inform the Chief Health Officer (CHO) and the CHO to inform the Minister. This is the responsibility of the Deputy Commander AO Operations who will be aided by the AO operations support team in fulfilling this task.

Table 6: Key steps and AO Review Team roles and responsibilities – daily review

Step	AO Review Team roles and responsibilities	Mandatory obligation	Section (PHWA)
Daily review	1. AO operations support Team will – at least once every 24 hours – review whether the continued detention of the person is reasonably necessary to protect public health.	Yes	S 200(6)
Review checks	2. Undertake an electronic review of detainment arrangements by viewing the COVID-19 Compliance Application. This includes: ○ reviewing the date and time of the previous review (to ensure it occurs at least once every 24 hours) ○ reviewing the number of detainees present at the hotel ○ reviewing the duration each detainee has been in detention for, to ensure that the 14-day detention period is adhered to ○ noting individuals who have been tested and cleared of COVID-19 by Public Health Command while in detention 3. Determine whether continued detention of each detainee is reasonably necessary to eliminate or reduce a serious risk to health 4. Consider the human rights being impacted – refer to 'Charter of Human Rights' obligations in Appendix 11 5. Consider any other issues that have arisen.		
Review considerations	6. Consider that the person is a returned overseas traveller who is subject to a notice and that they are obliged to comply with detainment. 7. Consider that detainment is based on expert medical advice that overseas travellers are of an increased risk of COVID-19 and form most COVID-19 cases in Victoria. 8. Consider any other relevant compliance and welfare issues, such as:		

	○ The person's health and wellbeing ○ any breaches of self-isolation requirement ○ issues raised during welfare checks (risk of self-harm, mental health issues) ○ actions taken to address issues ○ a person having been tested and cleared of COVID-19 while in detention ○ any other material risks to the person.		
Possible release from detention	9. Review could identify that detention may no longer be required. These matters will be provided to the Deputy Commander Policy and Exemptions for further consideration.		
Record	10. Record the outcomes of their review (high level notes) (for each 24-hour period) in the **COVID-19 Compliance Application**. This allows ongoing assessment of each detainee and consideration of their entire detention history.		
Prepare brief (Minister)	11. Prepare brief from CHO to Minister to advise of notice received about detention and review. The brief will serve as a written notice that: ○ a person has been made subject to detention ○ following a review, whether continued detention is reasonably necessary to eliminate or reduce the serious risk to public health. 12. The notice to the CHO must include: ○ the name of the person being detained ○ statement as to the reason why the person is being, or continues to be, subject to detention. 13. Deputy Commander AO operations to review and approve the Review and Brief 14. Report to be sent to Public Health Commander, cc to ECC Commander and Deputy Commander Policy and Exemptions		Sections 200(7) and (8) Section 200(9)

4.8 Departure – release from mandatory detention

The purpose is to ensure and confirm the person being detained:

i. has completed their period of detention under the Direction and Detention notice
ii. is released in a timely and orderly manner.

Pre-check out

Prior to release of a person being detained, DHHS (with the help of hotel security) will provide each person being detained with either:

1. an End of Detention Notice, **Appendix 7;**
2. an End of Detention Notice (confirmed case or respiratory illness symptoms), **Appendix 8** or
3. an End of Detention Notice for close contacts (to be supplied).

The notice provides information about the discharge process and the obligations of the detainees until they are discharged.

Health check

Health checks will be undertaken by clinical staff on the second last day prior to the 14-day period ending to make an assessment of whether each person being detained is well, symptomatic or positive.

Everyone will be offered a voluntary temperature and symptom check by a nurse around 24 hours before release.

If people being detained have a temperature or other symptoms of coronavirus before leaving or at the health check, this will not affect the completion of their detention. They will not be detained for longer than the 14-day quarantine period, even if they have symptoms consistent with coronavirus. However, if they do have symptoms at the health check, when they are released, they will need to seek medical care and will be required to self-isolate (as is required as of all members of the community).

Day of release

Security will provide detainees approximately 1 hour notice of their exit time. Security will then bring detainees down at their scheduled exit time.

Check-out process overview (compliance check-out)

The release process will consist of an organised check-out procedure (the compliance check-out). This means people being detained will be released in stages throughout a set time period on the day of release.

Security will bring travelling parties down to reception in stages to complete the check-out process. People being detained will also need to settle any monies owing to the hotel for additional meals and drinks if they have not already done so. Physical distancing must be maintained throughout this process.

Table 7: Key steps, roles and responsibilities at check-out (AO role unless specified)

Step	Roles and responsibilities	Mandatory obligation	Section (PHWA)
Notification of COVID-19 cases of close contacts	1. ECC Operations Support Team, to inform AO of those who are confirmed cases of COVID-19 (cleared or not yet cleared, suspected cases ofCOVID-19 or close contacts. Public health will have contacted each detainee in these categories to discuss arrangements post detention. 2. AO to note and to inform security that COVID-19 cases will need separate check-out time and implement extra precautionary measures.		
Check-out	3. Request to see identification (passport) and the End of Detention notice from each person 4. Cross check the person's identification details and room number with information on exit sheet 5. Sign the End of Detention notice and provide back to the person 6. Confirm the period of detention and explain detention period has ceased 7. Confirm self-isolation requirements for all confirmed COVID cases. 8. Detainee to sign discharge exit sheet as evidence they have received a notice and have been discharged		
Record	9. Provide exit list to a translator team member on site for updating in the COVID-19 Compliance Application (note this may be a data entry update after the process has been completed). 10. All exit sheets are to be returned to the Operational Support team as soon as possible		

Where a person has been COVID-19 cleared, their detention release must be accompanied with a COIVD-19 Clearance letter provided by Public Health Command. This will be included in the release pack prepared by the AO Operations Support team.

5 Exemption requests

5.1 Key points

- AOs must be aware of how requests for exemption from detention are escalated.
- DHHS case manager from the Exemptions Team will liaise with AO Team Leader regarding approved exemption request.

5.2 Exemption requests – overview

In limited circumstances, approval may be sought to undertake detention in another location, transit to another state/country or for early release. **Generally, exemptions are not granted.**

Requests for exemption from mandatory hotel detention may be considered before a person commences detention or while in detention. The Public Health Commander is responsible for approving and granting approvals to alter the way in which mandatory quarantine applies. The Public Health Commander may delegate approvals to the ECC Commander in accordance with *Guidance Note — Exceptions to the General Quarantine Policy,* see **Appendix 9.**

While each exemption request must be considered on its own merits, the following circumstances have been identified as open for consideration of early release or change of detention location. These include:

- Unaccompanied minors in transit to another state
- Unaccompanied minors where a parent or guardian does not agree to come into the hotel
- Foreign diplomats coming into the country
- ADF staff travelling for essential work
- People with a terminal illness
- People whose health and welfare cannot be accommodated in a hotel environment (e.g. mental health or requirements for in-facility health treatment)
- People who are transiting directly to another country (and who do not need to travel domestically first)
- Air crew
- Maritime workers who have come off a boat and will be leaving by boat
- Maritime workers who have come off a plane and will be leaving by boat within the quarantine period.

Any approval must consider the public health risk and must ensure the individual is not showing symptoms of COVID-19 or may be released into an environment where a highly vulnerable person may be a close contact.

There is no blanket exemption approval.

Table 8: Key steps, roles and responsibilities for exemptions prior to commencing, and during, detention

Step	Roles and responsibilities	Mandatory obligation	Section (PHWA)
Request	1. covidquarantine@dhhs.vic.gov.au receives a request for exemption[4] 2. Person confirms flight details and arrival information before the matter is assessed.		
Assessment and decisions	3. Exemptions Team will consider the request and refer to the ECC Commander for decision 4. Exemptions case manager to: • inform the Deputy Commander AO operations if an exemption is granted so that relevant AO Airport Team Leader and AOs are informed (including correspondence) • Inform the EOC to arrange transport • Inform the CART team if required • arrange for compliance oversight with Victoria police • contact other jurisdictions (if transiting through Victoria) • Record all actions and supporting paperwork in the case management tool		
AO to issue Notice of Direction and Detention	5. The exemption team will provide guidance to the AO about issuing the exemption paperwork 6. AO will: • issue a Notice of Direction and Detention for those permitted to undertake detention at an alternative location • permit international transit for those issued a letter • record details in COVID-19 Compliance Application		200(2) and (4) 202(1)
International transit passenger process	7. To facilitate an exemption given to a person for international transit, the AO Team Leader will notify Airport AO and Australian Border Force (ABF) prior to their arrival at the airport via a specific email with a specific subject title to: • "map.border.clearance@abf.gov.au" with a cc to "NorthandWest.EOC@dhhs.vic.gov.au". A template email is below. • Email to be titled *Transit Passenger from Quarantine Hotel (DHHS)* and request assistance to collect released detainee for connecting transit flight to XXX. Email should include:		

[4] An onsite nurse or welfare staff can recommend the exemption for a person via covidquarantine email and outline why they believe an exemption should be considered. Unless impracticable the person on whose behalf the request has been made should be consulted

	○ full name (as per passport) ○ passport number ○ flight departure time ○ flight number ○ arrival time at T2 international departure.		

5.3 Unaccompanied minors

Unaccompanied minors will be considered on a case-by-case basis. If an unaccompanied minor is detained in a hotel without a parent or guardian, a specific process must apply.

There are three options:

i. Unaccompanied minor to undertake detention at an alternate location with parent or guardian
ii. Unaccompanied minor to undertake detention in hotel with parent. The parent or guardian will be required to agree to the mandatory detention arrangements
iii. Unaccompanied minor to undertake detention in hotel with welfare support provided by DHHS.

In general, there is a presumption that there are no exemptions granted to mandatory quarantine. The issues associated with mandatory quarantine of unaccompanied minors include:

1. where this occurs, and
2. with what adult supervision.

The State can issue a detention order to a person under 18 years who is unaccompanied outside the home (a person in the care of the state) if certain conditions are met. However, this is not preferred because of the intensive obligations imposed.

There is guidance for AOs on how to comply with the Charter of Human Rights in relation to unaccompanied minors at Appendix 5.

Table 9: Key steps, roles and responsibilities for managing unaccompanied minors

Step	Roles and responsibilities	Mandatory obligation	Section (PHWA)
When an unaccompanied minor normally resides outside Victoria			
AO to request approval if not already sought	1. If Exemptions team has not granted approval, AO to escalate to the Deputy Commander Policy and Exemptions and cc covidquarantine		
Assessment and decision	2. Exemptions case manager to: ○ inform the AO Operation Lead and AO Airport Team Leader of approval or rejection ○ contact other jurisdictions (if transiting to a location outside Victoria) ○ Advise requesting party of the risk management obligations on a domestic flight out of Victoria and seek confirmation it can be achieved.		
AO to issue Notice of Direction and Detention	3. AO will: ○ issue a Notice of Direction and Detention to undertake detention at an alternative location in Victoria in accordance with the instructions and templates provided by the Exemptions case manager		200(2),(4) and 202(1)

	○ permit transit to another state if minor normally resides outside Victoria ○ record details in COVID-19 Compliance Application.		
When minor resides in Victoria			
AO to request approval if not already sought	4. If Exemptions team has not granted approval, AO to escalate to Deputy Commander Policy and Exemptions and cc covidquarantine		
Assessment and decision	5. Exemptions case manager to: ○ inform the AO Operation Lead and AO Airport Team Leader of approval ○ arrange transport ○ arrange for compliance oversight with Victoria Police.		
AO to issue Notice of Direction and Detention	6. AO to issue direction and detention notice to child through their guardian for: ○ alternate location (home and / or parts of the home); or ○ Provide advice on minimising risk of transmission to others in the home where the minor is detained (equivalent to advice provided to close contacts in quarantine).		200(2), (4) and 202(1)

Escalation of issues

Should an AO become aware of any concern about a child, the AO must:

- contact the department's welfare teams immediately. Child Protection contact details for each Division are available from: https://services.dhhs.vic.gov.au/child-protection-contacts. West Division Intake covers the City of Melbourne LGA: REDACTED
- if it is after hours, contact the after-hours child protection team on 13 12 78 if the AO thinks a child may be harmed, and Victoria Police on 000 if the immediate safety of a child is at risk.

6 Permissions

6.1 Key points

- AOs can make decisions in consultation with their AO Team Leader or Deputy Commander AO Operations for simple requests.
- AO must complete a permission for temporary leave form and enter details in COVID-19 Compliance Application.

There are four circumstances under the Direction and Detention Notice in which permission to leave the room may be granted:

- for the purpose of attending a medical facility to receive medical care
- where it is reasonably necessary for physical or mental health
- on compassionate grounds
- emergency situations.

AOs should refer to the 'Permission for Temporary Leave from Detention' guide at **Appendix 3.**

6.2 AO to make decisions on certain permission requests on case-by-case basis

An AO in consultation with their AO Team Leader or Deputy Commander AO Operations can make certain straightforward decisions about the following scenarios on a case-by-case basis:

- attendance at a funeral
- medical treatment
- seeing family members who have a terminal illness
- smoke breaks where people are suffering extreme anxiety and where it is safe to do so from a public health/infection control perspective
- exercise breaks where it is safe to do so.

Not all leave requests can be accommodated and may be site and resource dependent. Any arrangement for leave would need to meet public health and human rights requirements and balance the needs of the person.

It is expected that those with medical needs, seeking to attend a funeral or with family members who are about to pass away are granted leave. The AO should confirm appropriate details before issuing permission to leave (refer to Table 10 for further details).

If medical care is deemed urgent by an on-site nurse or medical practitioner or attending AV paramedic, the AO should prioritise and approve leave immediately.

AOs are not responsible for transport arrangements. This is the responsibility of the DHHS Team Leader on-site. If a DHHS Team Leader is not on-site, please refer to EOC – DHHSOPSoteriaEOC@dhss.vic.gov.au and title the email "Referral to organise transport".

Table 10: Key steps, roles and responsibilities for temporary leave

Step	Roles and responsibilities	Mandatory obligation	Section (PHWA)
Assess site for suitability	1. AO Team Leader to assess site for suitability of exercise and fresh air breaks 2. AO to consider safety and security and obtain agreement from Security and DHHS Team Leader on suitable site 3. Site Map to be put on the Team Sharepoint site and attached as an attachment to this protocol following Deputy Commander AO Operations		

	approval.		
Request for temporary leave	4. Person may seek permission directly from the AO or may email covidquarantine@dhhs.vic.gov.au and explain the grounds for leave		
Referral to AO	5. Exemptions team to triage and forward to AO for decision 6. Exemptions team to assess complex cases and inform AO		
AO assessment and decision	7. AO to make decision and consider: • those that require exercise or fresh air break or those who may be at risk without these breaks (this is the most important consideration for fresh air and exercise breaks) • willingness and availability of security to oversee and facilitate exercise or other fresh air break (the number security will determine how many people can undertake temporary leave, as well as the ability to ensure small groups by room are distanced accordingly) • site layout, safety and capability to ensure persons are in a cordoned off area • maintaining infection control, such as ensuring persons do not touch door handles or lift buttons • adherence to exercise and smoking procedures 8. In considering a request for a person to visit a terminally ill family member in hospital, the AO will need to first check whether the medical facility will accept the person.		
Issue permission for temporary leave	9. AOs to: • instruct security on the dates and times permitted for leave • provide procedural guidance to security and the person in detention, such as exercising in a cordoned off area not accessed by members of the public • request the medical facility or hospital inform the AO prior to return (for medical temporary leave) • prepare a Permission for Temporary Leave from Detention form (see Appendix 2), and issue to the detainee and explain the leave obligations. For example: - a person attending a funeral must not attend the wake, must practice physical distancing and return immediately within stipulated timeframes - an exercise break is for a certain time and the person must return to their room following exercise or fresh air break • warn the person that failure to comply with these		s.203(1)

	directions is an offence • ensure the person checks back into the hotel at specified time • seek feedback on implementation of temporary leave and note any issued raised		
Record	10. If AO approves leave, the AO: • must keep original copies of the Permission for Temporary Leave from Detention form for the person, Appendix 2 and the Register of permissions granted under 4(1) of the Directions and Detention Notice, **Appendix 12**, and • enter details in COVID-19 Compliance Application.		

6.3 Emergency situations

Table : Key steps, roles and responsibilities for emergency leave

Step	Roles and responsibilities	Mandatory obligation	Section (PHWA)
Determine risk	1. AOs and Victoria Police officers may need to determine the severity of any emergency (such as a building fire, flood, natural disaster etc) and the health risk they pose to persons in detention.		
Evacuation	2. Assist with immediate evacuation to common assembly point 3. Contact Victoria police, emergency services and Deputy Commander AO Operations to support 4. Promote infection prevention and control and physical distancing principles if possible 5. Account for all persons being detained at the assembly point by way of the register of persons in detention		

6.4 Procedure for a person in detention / resident to leave their room for exercise or smoking

A person must be compliant and must not have symptoms before they could be allowed to have supervised exercise or a smoking break. Only well residents from the same room should be able to go out to exercise at the same time.

6.5 Guidance for safe movement associated with permissions

Guidance for person in detention

The steps that must be taken by the person in detention are:

- Confirm to the person who will escort them that they are well.
- Confirm to the person who will escort them that they have washed their hands immediately prior to leaving the room.

- Don a single-use facemask (surgical mask), to be supplied by the security escort prior to leaving the room.
- Perform hand hygiene with alcohol-based hand rub as they leave, this will require hand rub to be in the corridor in multiple locations.
- Be reminded to – and then not touch any surfaces or people within the hotel on the way out, and then not actually do it.
- Return immediately to their hotel room following the break.

Guidance for security escort

Security escort should:

- Don a single-use facemask (surgical mask) if a distance of >1.5 metres cannot be maintained when escorting the person;
- Perform hand hygiene with an alcohol-based hand rub or wash hands in soapy water before each break;
- Remind the person they are escorting to not touch any surfaces or people within the hotel on the way out or when coming back in
- Be the person who touches all surfaces if required such as the lift button or door handles (where possible using security passes and elbows rather than hands);
- Wherever possible, maintain a distance (1.5 metres or greater) from the person;
- Perform hand hygiene with an alcohol-based hand rub or wash hands in soapy water at the end of each break and when they go home
- Ensure exercise is only undertaken in a cordoned off area with no public access or interaction.

Infection control considerations

Points to remember when using a single-use facemask (surgical mask):

- Always perform hand hygiene before donning the mask.
- Mould the metal clip over the bridge of the nose and ensure the bottom of the mask fits snuggly under the chin.
- Avoid touching or adjusting the mask once it has been donned.
- Unless damp or soiled, masks may be worn for the duration of a shift for up to four hours.
- Masks must be removed and disposed of for breaks and then replaced if needed.
- Masks must never be partially removed (for example, top tie undone and left dangling around the neck) and then re-worn.
- Perform hand hygiene immediately before and after removal of the mask.

There is no requirement to wear gloves and this is not recommended, as many people forget to take them off and then contaminate surfaces. Hand hygiene is one of the most effective ways to prevent the spread of infection and gloves should not be seen as a substitute for hand hygiene. If gloves are worn, remove the gloves immediately after the person is back in their room and then wash your hands.

In addition:

Family groups may be taken out in a group provided it is only 2 adults and less than 5 in total.

They can be taken to an outside area with sunlight, for up to 15 minutes outside of the hotel.

Smokers can take up to 2 breaks per day if staffing permits.

Rostering to be initiated by the departmental staff/AO present.

7 Compliance

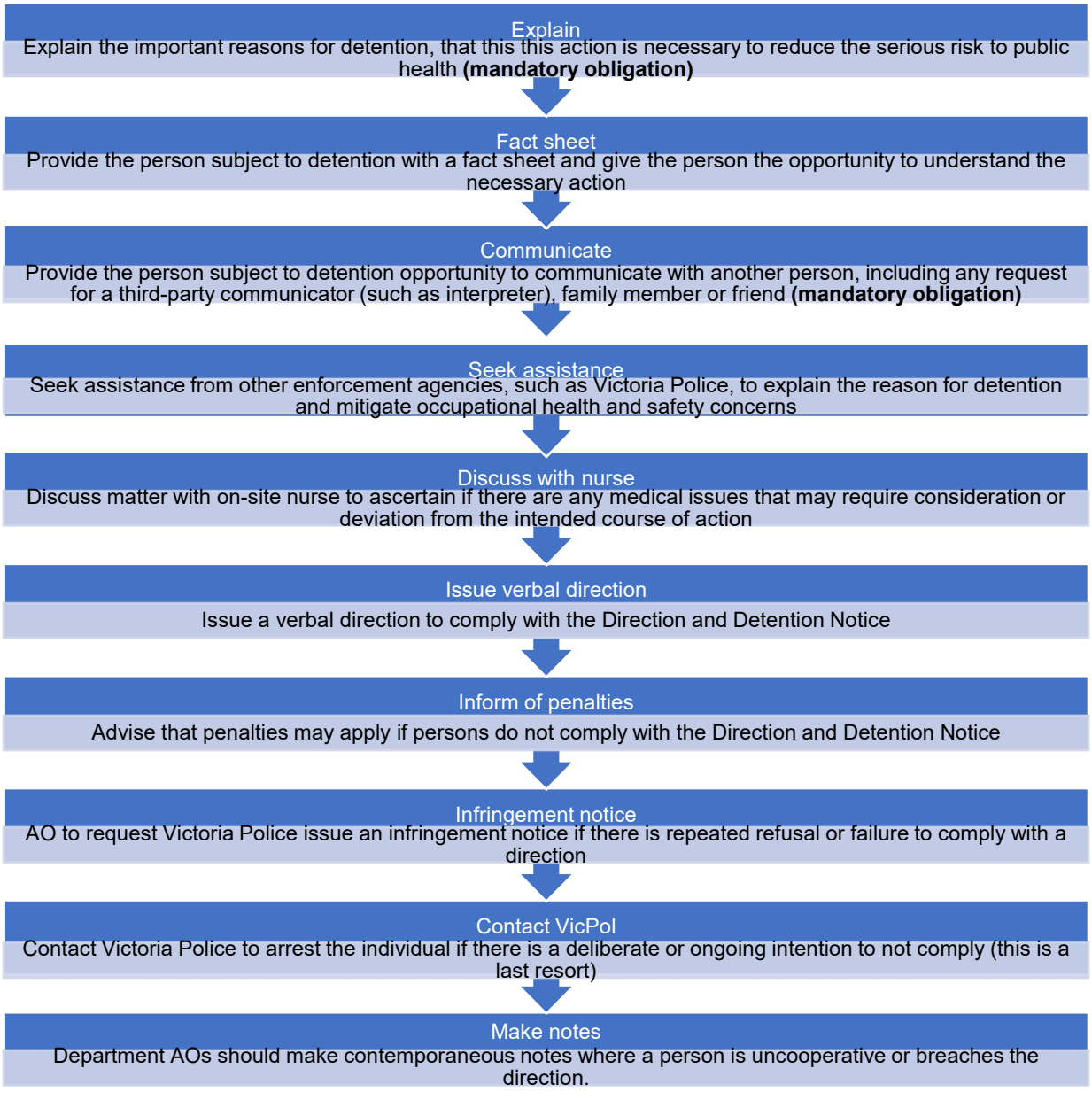
7.1 Key points

- AOs to apply a graduated approach to compliance.

7.2 Options to facilitate compliance

AOs should make every effort to inform the person of their obligations, facilitate communication if requested and explain the important rationale for the direction. Non-compliance could take the form of a person refusing to comply with the direction at the airport or hotel.

The following graduated approach should guide AOs:



7.2 Unauthorised departure from accommodation

Table 12: Key steps, roles and responsibilities for managing unauthorised departure from accommodation

Step	Roles and responsibilities	Mandatory obligation	Section (PHWA)
Notify and search	1. AO to notify AO Team Leader, on-site security and hotel management and request search.		
Contact Victoria police	2. AO to seek police assistance and notify the Deputy Commander AO operations if the person is not found.		
Identification and compliance	3. If the person is located, AO to: • seek security or Victoria Police assistance if it is determined the person poses a risk of trying to leave • provide an opportunity for the person to explain the reason why they left their room • assess the nature and extent of the breach, for example: - a walk to obtain fresh air - a deliberate intention to leave the hotel - mental health issues - escaping emotional or physical violence. • consider issuing an official warning or infringement through Victoria Police • reassess security arrangements.		s.203(1)

7.3 Infringements

There are four infringement offences applicable to detention arrangements. These are:

Table 13: List of infringements

Section (PHWA)	Description	Amount
s.183	Hinder or obstruct an authorised officer exercising a power without reasonable excuse (5 penalty units).	5 penalty units (PU)
s.188(2)	Refuse or fail to comply with a direction by CHO to provide information made under s.188(10 penalty units for a natural person and 30 penalty units for a body corporate without a reasonable excuse).	10 PU natural person, 30 PU body corporate
s.193(1)	Refuse or fail to comply with a direction given to, or a requirement made or, a person in the exercise of a public health risk powers (10 penalty units for natural person and 60 penalty units for body corporate).	10 PU natural person, 30 PU body corporate
s.203(1)	Refuse or fail to comply with a direction given to, or a requirement made or, a person in the exercise of a public health risk powers (10 penalty units for natural person and 60 penalty units for body corporate).	10 PU natural person, 30 PU body corporate

8 Occupational health and safety (OHS) for Authorised Officers

The purpose of this section is to provide an occupational health and safety procedure for AOs when attending off site locations during the current State of Emergency.

8.1 Key points

OHS is a shared responsibility of both the employer and the employee. AOs must raise hazards, concerns and incidents with the AO Team Leader of the Deputy Commander AO Operations.

AOs must take steps to protect themselves from transmission of COVID-19 and adhere to physical distancing protocols wherever possible

8.2 Health Emergency

Coronaviruses are a large family of viruses that cause respiratory infections. These can range from the common cold to more serious diseases. COVID-19 is the disease caused by a new coronavirus. It was first reported in December 2019 in Wuhan City in China.

Symptoms of COVID-19 can range from mild illness to pneumonia. Some people will recover easily, and others may get very sick very quickly which in some cases can COVID-19 can cause death.

8.3 OHS

OHS is a shared responsibility of both the employer and the employee. Officers must raise hazards, concerns and incidents with the rostered AO Team Leader.

One of the foremost issues associated with site attendance is the 'uncontrolled environment' that exists. AOs can be exposed to infectious diseases (such as COVID-19), confrontational and/or aggressive members of the public who may be drug affected, mentally ill or intellectually impaired. The very nature of this work is likely to be perceived as invasive and can provoke a defensive response.

Risks can be minimised by maintaining routine safe work practices and proper planning. Prior to any site visit, risks and hazards should be identified and assessed.

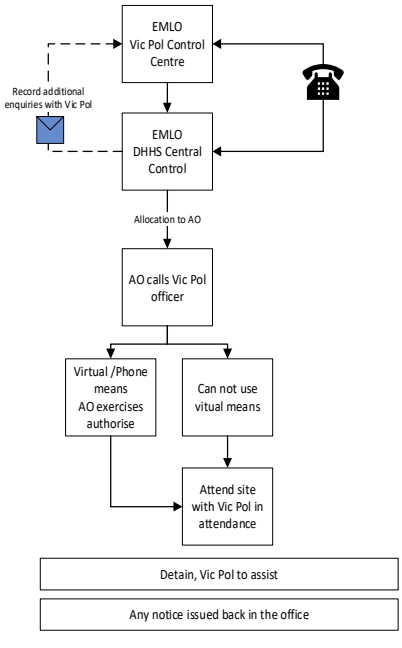
Officers and managers both have a shared responsibility for occupational health and safety. All employees have a responsibility to report and discuss hazards or perceived hazards, by bringing this to the managers attention.

8.4 Fatigue

AOs will be rostered on a rotating basis, with the aim of mitigating the risk of fatigue. Fatigue may impede decision making capability and when driving a motor vehicle to a location. When fatigue is identified please make this known to your AO Team Leader.

To mitigate the risk of fatigue, AOs should be aware of any fatigue they may have. A good tool to use to help officers identify their level of fatigue is to use the following calculator: http://www.vgate.net.au/fatigue.php

AOs are required to hold a valid motor vehicle licence and are required to adhere to the requirements of the department's driving policy. Information about this policy can be found on the DHHS intranet site.



8.5 Risk assessment before attendance | Personal Protection

In the first instance, officers are required to use technology (i.e: mobile phone, Facetime, Skype) to exercise their authority. This aims to protect officers from attending an uncontrolled environment, where the risk of harm is increased.

Before attending a site, whether an airport or a hotel, the officer should make themselves familiar with the recommendations produced by the Australian Government and the Department of Health and Human Services, in the protection against COVID-19.

Interventions are known as 'transmission reduction, or 'physical distancing' measures. Officers can take the following personal measures to reduce their risk of exposure to COVID-19. Officers with pre-existing medical conditions that put

them more at risk of COVID-19, should discuss this with their medical practitioner and manager.

8.6 Personal measures to reduce the risk of exposure to COVID-19

General

AOs must take steps to protect themselves from transmission of COVID-19 and adhere to physical distancing protocols wherever possible. For example,:

- Stay healthy with good nutrition, regular exercise, sensible drinking, sleep well, and if you are a smoker, quit.
- Wash your hands often with soap and water for at least 20 seconds, especially after you have been in a public place, or after blowing your nose, coughing, sneezing, or using the toilet. If soap and water are not readily available, use a hand sanitiser that contains at least 60 per cent alcohol.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Cover your nose and mouth with a tissue when you cough or sneeze. If you don't have a tissue, cough or sneeze into your upper sleeve or elbow.
- Stop shaking hands, hugging or kissing as a greeting.
- Ensure a **distance of 1.5 metres** is kept between yourself and others.
- Get vaccinated for flu (influenza) as soon as available. This could help reduce the risk of further problems. *Note: the department covers expenses for vaccines, speak to your manager for more details.*
- Clean and disinfect high touch surfaces regularly, for example: telephones, keyboards, door handles, light switches and, bench tops.

When an officer is called to attend the airport or a hotel to exercise powers in relation to the Direction and Detention notice they should take a **risk-based approach** and assess the most suitable way to reduce harm to themselves. Before attending, the officer must obtain information such as:

- Is the person being detained a positive case of COVID-19?
- Has the person being detained been recently in close contact with a positive case of COVID-19?

Officers are required to use their discretion and take into account their own personal safety. The Department of Health and Human Services has provided the following PPE:

- Single-use surgical mask
- Gloves
- Hand sanitizer.

AOs going onto floors of hotel

AOs going onto hotel floors with persons subject to detention must wear a surgical mask. There will be surgical masks for AO's at the hotels.

AO's should not enter the room in which a person is being detained. Communication should be from the corridor or outside the room.

Relocating COVID-19 positive person

While this process is led by the nurses/medical staff it must be authorised by the AO.

Before the person is moved, the AO must issue a new detention notice with the amended details. This must be served by the AO in PPE as advised by the health staff. The detention notice must clearly state it replaces the previous detention notice dated XXX. The AO is then to very briefly state that the patient was in room(x) and will be moved to room(y) as a result of their positive result. The AO WILL THEN LEAVE IN A SEAPARATE LIFT TO THE SECURITY/NURSING STAFF.

The room or location change must be recorded in the COVID-19 compliance app by the AO

Measures and guides to enhance occupational health and safety

PPE/measure	Guide
Single-use face mask (surgical mask)	When there is known case of COVID-19, or a person subject to detention has been recently exposed to COVID-19 and a distance of at least 1.5 metres cannot be maintained.
Gloves	If contact with the person or blood or body fluids is anticipated.
Hand hygiene / Hand Sanitizer Soap and water	Always
Physical distancing of at least 1.5 meters	Always

Known risks and hazards

Hazard	Risk	Mitigate
COVID-19 infection	Serious illness / death	Follow personal protective measures
Fatigue	Impaired decisions / driving to site	In the first instance use virtual technology to perform duties Use fatigue calculator http://www.vgate.net.au/fatigue.php
Physical Injury	Low / Medium	Only attend a site with Victoria Police or with security.
Other infectious agents		Follow personal protective measures

Appendix 1 – Script for plane/arrival

Required script before issuing a direction and detention notice

My Name is XXXX, I work for the Department of Health and Human Services Victoria and I am an Authorised Officer under the Public Health and Wellbeing Act. I am also authorised for the purposes of the emergency and public health risk powers in Victoria's current State of Emergency.

Because you have arrived in Victoria from overseas, when you disembark off this plane you will be issued with a direction and detention notice, which requires you to quarantine for a 14-day period at the hotel nominated on the notice.

Many of Victoria's cases of covid-19 originate from overseas and international travellers so this action is necessary to ensure we reduce the serious risk to public health posed by COVID 19.

Refusal or failure to comply without reasonable excuse is an offence. There are penalties for not complying with the notice.

Once you have been issued with the notice, please keep it with you at all times.

We greatly appreciate your co-operation and assistance in these challenging times. Thank you again.

Appendix 2 - Permission for temporary leave from detention

PERMISSION FOR TEMPORARY LEAVE FROM DETENTION

Public Health and Wellbeing Act 2008 (Vic)

Section 200

An Authorised Officer has granted you permission to leave your room based on one of the grounds set out below. This is temporary. You will be supervised when you leave your room. You must ensure you comply with all the conditions in this permission and any directions an Authorised Officer gives you. You must return to your room at the time specified to finish your detention. Speak to your supervising Authorised Officer if you require more information.

Temporary leave

(1) You have arrived in Victoria from overseas, on or after midnight [on 28 March 2020 or 13 April 2020] and have been placed in detention, pursuant to a Direction and Detention Notice that you were provided on your arrival in Victoria (**Notice**).

(2) This Permission for Temporary Leave From Detention (**Permission**) is made under paragraph 4(1) of the Notice.

Reason/s for, and terms of, permission granting temporary leave

(3) Permission for temporary leave has been granted to: _____ _____ [insert name] for the following reason/s [tick applicable]:

☐ (a) for the purpose of attending a medical facility to receive medical care:

Name of facility: _____

Time of admission/appointment:_____

Reason for medical appointment:_____

☐ (b) where it is reasonably necessary for physical or mental health:

Reason leave is necessary:_____

Proposed activity/solution:_____

☐ (c) on compassionate grounds:

Detail grounds:_____

(4) The temporary leave starts on _____

and ends on _____ [insert date and time].

_____ **Signature of Authorised Officer**

Name of Authorised Officer: _____

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

Conditions

(5) You must be supervised **at all times**/may be supervised *[delete as appropriate]* while you are out of your room. You are not permitted to leave your hotel room, even for the purpose contained in this Permission, unless you are accompanied by an Authorised Officer.

(6) While you are outside your room you must practice social distancing, and as far as possible, maintain a distance of 1.5 metres from all other people, including the Authorised Officer escorting you.

(7) When you are outside your room you must refrain from touching communal surfaces, as far as possible, such as door knobs, handrails, lift buttons etc.

(8) When you are outside your room you must, at all times, wear appropriate protective equipment to prevent the spread of COVID-19, if directed by the Authorised Officer escorting you.

(9) When you are outside your room you must, at all times, comply with any direction given to you by the Authorised Officer escorting you.

(10) At the end of your temporary leave, you will be escorted back to your room by the Authorised Officer escorting you. You must return to your room and remain there to complete the requirements under the Notice.

(11) Once you return to the hotel, you must proceed immediately to the room you have been allocated above in accordance with any instructions given to you.

(12) You must comply with any other conditions or directions the Authorised Officer considers appropriate.

(Insert additional conditions, if any, at Annexure 1)

Specific details

(13) Temporary leave is only permitted in limited circumstances, to the extent provided for in this Permission, and is subject to the strict conditions outlined at paragraph 3. You must comply with these conditions at all times while you are on temporary leave. These conditions are reasonably necessary to protect public health, in accordance with section 200(1)(d) of the Public Health and Wellbeing Act 2008 (Vic).

(14) Permission is only granted to the extent necessary to achieve the purpose of, and for the period of time noted at paragraph 2 of this Permission.

(15) Nothing in this Permission, invalidates, revokes or varies the circumstances, or period, of your detention, as contained in the Notice. The Notice continues to be in force during the period for which you are granted permission for temporary leave from detention. The Notice continues to be in force until it expires.

Offences and penalties

(16) It is an offence under section 203 of the Act if you refuse or fail to comply with the conditions set out in this Permission, unless you have a reasonable excuse for refusing or failing to comply.

(17) The current penalty for an individual is $19,826.40.

Appendix 3 Guidance Note: Permission for Temporary Leave from Detention

How do you issue a Permission for Temporary Leave from Detention?

It is recommended that Authorised Officers take the following steps when issuing a Permission for Temporary Leave from Detention:

Before you provide the Permission for Temporary Leave from Detention

Carefully consider the request for permission and consider the grounds available under paragraph 4(1) of the Direction and Detention Notice – which include:

- for the purposes of attending a medical facility to receive medical care; or
- where it is reasonably necessary for the person's physical or mental health; or
- on compassionate grounds.

Complete all sections of the Permission, including clearly documenting the reasons for the Permission, date and time when the temporary leave is granted from and to, and whether the person will be supervised by the authorised officer during the temporary leave

Ensure the reference number is completed.

When you provide the Permission for Temporary Leave from Detention

You must warn the person that refusal or failure to comply without reasonable excuse, is an offence, and:

- explain the reason why it is necessary to provide the Permission and the conditions which apply to the temporary leave (including that the person is still subject to completing the remainder of the detention once the temporary leave expires, and the Permission is necessary to protect public health);
- provide a copy of the Permission to the person, provide them with time to read the Permission and keep the completed original for the department's records.

NB If it is not practicable to explain the reason why it is necessary to give the Permission, please do so as soon as practicable after Permission has been exercised.

What are the requirements when you are granting a permission to a person under the age of 18?

The same requirements set out above apply when issuing a Permission to an unaccompanied minor. However, the supervising Authorised Officer must have a Working With Children Check, have regard to the special conditions in the Direction and Detention Notice as well as the person's status as a child.

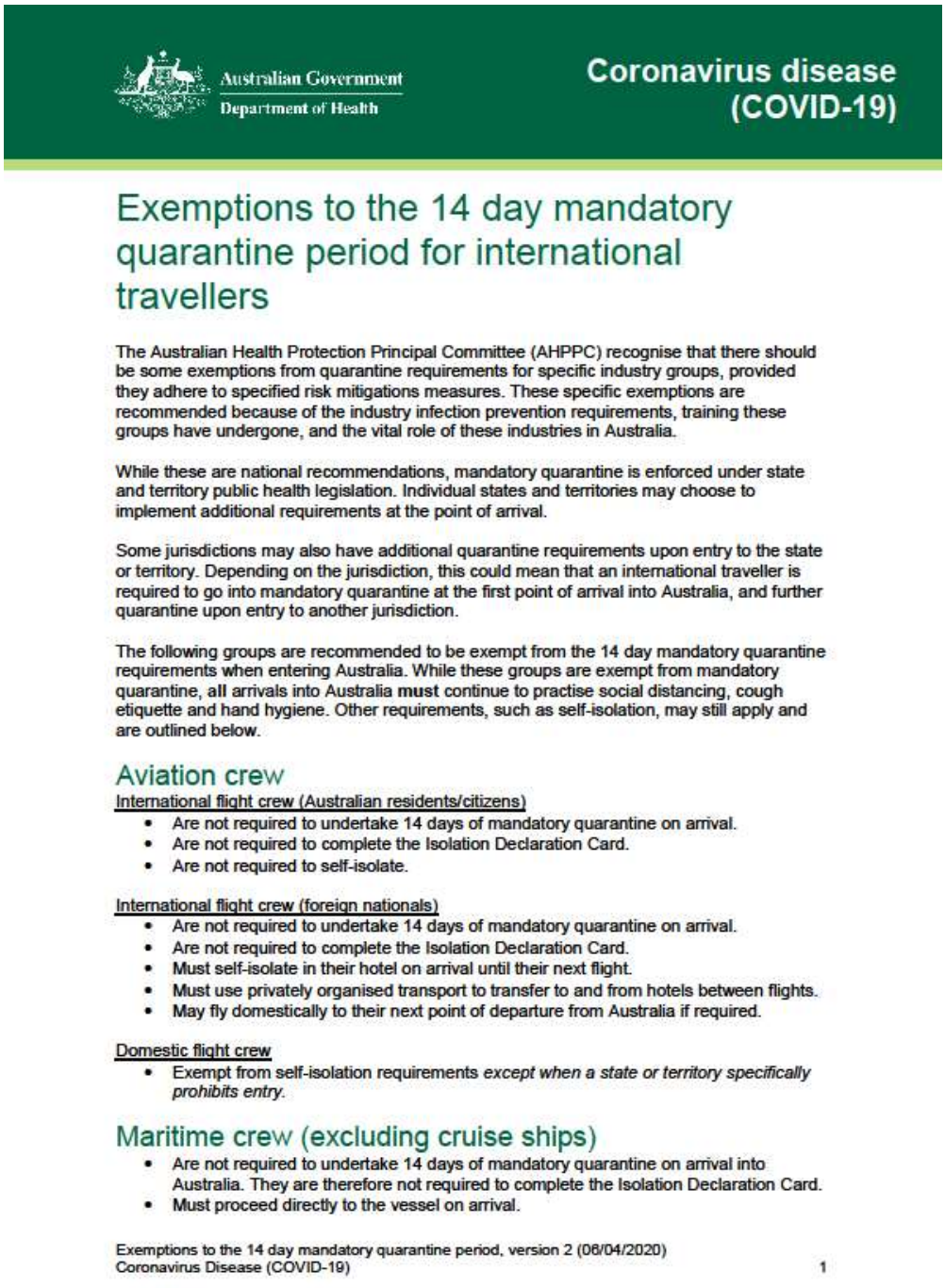
What other directions can you give?

Section 200(1)(d) of the PHWA sets out an emergency power that allows an authorised officer to give any other direction that the authorised officer considers is reasonably necessary to protect public health.

What are your obligations when you require compliance with a direction?

Exercising this power imposes several obligations on departmental authorised officers including that an authorised officer must, before exercising any emergency powers, warn the person that refusal or failure to comply without reasonable excuse, is an offence.

Appendix 4 Guidance: Exemptions under Commonwealth law



Australian Government
Department of Health

Coronavirus disease (COVID-19)

Exemptions to the 14 day mandatory quarantine period for international travellers

The Australian Health Protection Principal Committee (AHPPC) recognise that there should be some exemptions from quarantine requirements for specific industry groups, provided they adhere to specified risk mitigations measures. These specific exemptions are recommended because of the industry infection prevention requirements, training these groups have undergone, and the vital role of these industries in Australia.

While these are national recommendations, mandatory quarantine is enforced under state and territory public health legislation. Individual states and territories may choose to implement additional requirements at the point of arrival.

Some jurisdictions may also have additional quarantine requirements upon entry to the state or territory. Depending on the jurisdiction, this could mean that an international traveller is required to go into mandatory quarantine at the first point of arrival into Australia, and further quarantine upon entry to another jurisdiction.

The following groups are recommended to be exempt from the 14 day mandatory quarantine requirements when entering Australia. While these groups are exempt from mandatory quarantine, **all** arrivals into Australia **must** continue to practise social distancing, cough etiquette and hand hygiene. Other requirements, such as self-isolation, may still apply and are outlined below.

Aviation crew

International flight crew (Australian residents/citizens)

- Are not required to undertake 14 days of mandatory quarantine on arrival.
- Are not required to complete the Isolation Declaration Card.
- Are not required to self-isolate.

International flight crew (foreign nationals)

- Are not required to undertake 14 days of mandatory quarantine on arrival.
- Are not required to complete the Isolation Declaration Card.
- Must self-isolate in their hotel on arrival until their next flight.
- Must use privately organised transport to transfer to and from hotels between flights.
- May fly domestically to their next point of departure from Australia if required.

Domestic flight crew

- Exempt from self-isolation requirements *except when a state or territory specifically prohibits entry.*

Maritime crew (excluding cruise ships)

- Are not required to undertake 14 days of mandatory quarantine on arrival into Australia. They are therefore not required to complete the Isolation Declaration Card.
- Must proceed directly to the vessel on arrival.

Exemptions to the 14 day mandatory quarantine period, version 2 (06/04/2020)
Coronavirus Disease (COVID-19) 1

- If access to the vessel is not immediate, crew must self-isolate at their accommodation during any lay-over period.
- May travel domestically and/or take a domestic flight to meet their vessel at the next point of departure if required.
- At the completion of their shifts, they are not required to go into mandatory 14 days quarantine, but must undertake 14 days self-isolation.
- Time at sea counts towards the 14 days of self-isolation if no illness has been reported on-board. Therefore crew signing off commercial vessels that have spent greater than 14 days at sea, with no know illness on-board, do not need to self-isolate on arrival.

Unaccompanied minors

Unaccompanied minors will be allowed to travel domestically after entering Australia to self-quarantine with a parent or guardian at their home.

Transit passengers

- International transit passengers arriving into Australia are able to depart on another international flight if the following conditions are met:
  - If the individual has up to 8 hours until the departing international flight, they must remain at the airport and be permitted to onward travel, maintaining social distancing and hand hygiene.
  - If 8-72 hours before the departing flight, they must go to mandatory quarantine at the state designated facility until the time of the departing flight.
- No domestic onward travel is allowed, even if this is to meet a departing international flight. These people should go into mandatory quarantine at the state designated facility at the first point of arrival.

Diplomats

- Australia has legal obligations under the Vienna Convention to ensure diplomats freedom of movement and travel, and protection from detention. Diplomats are not required to undertake 14 days of mandatory quarantine on arrival into Australia. They are therefore not required to complete the Isolation Declaration Card.
- Diplomats should self-isolate at their mission or in their usual place of residence on arrival for 14 days.
- Diplomats must continue to practise social distancing, cough etiquette and hand hygiene.

Compassionate or medical grounds

Applications on medical or compassionate grounds should be submitted to the relevant state or territory who will consider requests on a case-by-case basis.

Contact details for state or territory public health agencies are available at www.health.gov.au/state-territory-contacts.

Where can I get more information?

For the latest advice, information and resources, go to www.health.gov.au.

Call the National Coronavirus Helpline on 1800 020 080. This line operates 24 hours a day, seven days a week. If you require translating or interpreting services, call 131 450.

Appendix 5 - Guidance note: Ensuring physical and mental welfare of international arrivals in individual detention (unaccompanied minors)

Introduction

You are an officer authorised by the Chief Health Officer under section 199(2)(a) of the *Public Health and Wellbeing Act 2008* (Vic) to exercise certain powers under that Act. You also have duties under the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**Charter**).

These Guidelines have been prepared to assist you to carry out your functions in relation to Victorian unaccompanied minors who have arrived in Victoria and are subject to detention notices, requiring them to self-quarantine in a designated hotel room for 14 days in order to limit the spread of Novel Coronavirus 2019 (**2019-nCoV**) where no parent, guardian or other carer (**parent**) has elected to join them in quarantine (a **Solo Child Detention Notice**).

As part of your functions, you will be required to make decisions as to whether a person who is subject to a Solo Child Detention Notice should be granted permission to leave their room:

- for the purposes of attending a medical facility to receive medical care; or
- where it is reasonably necessary for their physical or mental health; or
- on compassionate grounds.

Authorised Officers are also required to review the circumstances of each detained person at least once every 24 hours, in order to determine whether their detention continues to be reasonably necessary to eliminate or reduce a serious risk to public health.

Your obligations under the Charter of Human Rights and Responsibilities Act 2006

You are a public officer under the Charter. This means that, in providing services and performing functions in relation to persons subject to a Detention Notice you must, at all times:

- act compatibly with human rights; and
- give 'proper consideration' to the human rights of any person(s) affected by your decisions.

How to give 'proper consideration' to human rights

'Proper consideration' requires you to:

1. **first**, understand in general terms which human rights will be affected by your decisions (these rights are set out below under 'relevant human rights');
2. **second**, seriously turn your mind to the possible impact of your decisions on the relevant individual's human rights, and the implications for that person;
3. **third**, identify the countervailing interests (e.g. the important public objectives such as preventing the further spread of 2019-nCoV, which may weigh against a person's full enjoyment of their human rights for a period of time); and
4. **fourth**, balance the competing private and public interests to assess whether restricting a person's human rights (e.g. denying a person's request to leave their room) is justified in the circumstances.

Relevant human rights

The following human rights protected by the Charter are likely to be relevant to your functions when conducting daily wellbeing visits and when assessing what is reasonably necessary for the physical and mental health of children who are subject to Solo Child Detention Notices:

The right of children to such protection as is in their best interests (s 17(2)). As the Solo Child Detention Notices detain children in circumstances where no parent has elected to join them in quarantine, greater protection must be provided to these children in light of the vulnerability that this creates. Where possible the following additional protection should be provided:

You should undertake two hourly welfare checks while the child is awake and once overnight. You should ask the child to contact you when they wake each morning and let you know when they go to sleep so that this can be done.

You should ask the child if they have any concerns that they would like to raise with you at least once per day.

You should contact the child's parents once per day to identify whether the parent is having contact with the child and whether the parent or child have any concerns.

You should ensure that where the child does not already have the necessary equipment with them to do so (and their parent is not able to provide the necessary equipment) the child is provided with the use of equipment by the department to facilitate telephone and video calls with their parents. A child must not be detained without an adequate means of regularly communicating with their parents.

You should ensure that where the child does not already have the necessary equipment with them to do so (and their parent is not able to provide the necessary equipment) the child is provided with the use of equipment by the department to participate in remote education if that is occurring at the school they are attending. Within the confines of the quarantine you should obtain reasonable assistance for the child in setting up that computer equipment for use in remote education.

You should allow the child's parents to bring them lawful and safe items for recreation, study, amusement, sleep or exercise for their use during their detention. This should be allowed to occur at any time within business hours, and as many times as desired, during the detention.

The rights to liberty (s 21) and freedom of movement (s 12), and the right to humane treatment when deprived of liberty (s 22). As the Solo Child Detention Notices deprive children of liberty and restrict their movement, it is important that measures are put in place to ensure that the accommodation and conditions in which children are detained meet certain minimum standards (such as enabling parents to provide detained children with food, necessary medical care, and other necessities of living). It is also important that children are not detained for longer than is reasonably necessary.

Freedom of religion (s 14) and cultural rights (s 19). Solo Child Detention Notices may temporarily affect the ability of people who are detained to exercise their religious or cultural rights or perform cultural duties; however, they do not prevent detained persons form holding a religious belief, nor do they restrict engaging in their cultural or religious practices in other ways (for example, through private prayer, online tools or engaging in religious or cultural practices with other persons with whom they are co-isolated). Requests by children for additional items or means to exercise their religious or cultural practices will need to be considered and accommodated if reasonably practicable in all the circumstances.

The rights to recognition and equality before the law, and to enjoy human rights without discrimination (s 8). These rights will be relevant where the conditions of detention have a disproportionate impact on detained children who have a protected attribute (such as race or disability). Special measures may need to be taken in order to address the particular needs and vulnerabilities of, for example Aboriginal persons, or persons with a disability (including physical and mental conditions or disorders).

The rights to privacy, family and home (s 13), freedom of peaceful assembly and association (s 16) and the protection of families (s 17). Solo Child Detention Notices are likely to temporarily restrict the rights of persons to develop and maintain social relations, to freely assemble and associate, and will prohibit physical family unification for those with family members in Victoria. Children's rights may be particularly

affected, to the extent that a Solo Child Detention Notice results in the interference with a child's care and the broader family environment. It is important, therefore, to ensure children subject to Solo Child Detention Notices are not restricted from non-physical forms of communication with relatives and friends (such as by telephone or video call). Requests for additional items or services to facilitate such communication (e.g. internet access) will need to be considered and accommodated if reasonably practicable in all the circumstances.

Whether, following 'proper consideration', your decisions are compatible with each these human rights, will depend on whether they are reasonable and proportionate in all the circumstances (including whether you assessed any reasonably available alternatives).

General welfare considerations

All persons who are deprived of liberty must be treated with humanity and respect, and decisions made in respect of their welfare must take account of their circumstances and the particular impact that being detained will have on them. Mandatory isolation may, for some people, cause greater hardship than for others – when performing welfare visits you will need to be alert to whether that is the case for any particular person.

In particular, anxieties over the outbreak of 2019-nCoV in conjunction with being isolated may result in the emergence or exacerbation of mental health conditions amongst persons who are subject to Detention Notices.

If you have any concerns about the mental health of a detained person, you should immediately request an assessment of mental health be conducted and ensure appropriate support is facilitated. Hotel rooms are not normally used or designed for detention, so you should be aware that a person who is detained in a hotel room could have greater opportunity to harm themselves than would be the case in a normal place of detention.

Additional welfare considerations for children

Children differ from adults in their physical and psychological development, and in their emotional and educational needs. For these reasons, children who are subject to Solo Child Detention Notices may require different treatment or special measures.

In performing functions and making decisions with respect to a detained person who is a child, the best interests of the child should be a primary consideration. Children should be given the opportunity to conduct some form of physical exercise through daily indoor and outdoor recreational activities. They should also be provided with the ability to engage in age-appropriate activities tailored to their needs.

Each child's needs must be assessed on a case-by-case basis. Requests for items or services to meet the needs of individual children will need to be considered and accommodated if reasonably practicable in all the circumstances.

Where available, primary school age children should be allocated rooms that have an outside area where it is safe for active physical play to occur (not a balcony) and consideration should be given to allowing small children access to any larger outdoor areas that are available within the hotel, where possible within relevant transmission guidelines. Although each child’s needs must be assessed daily and individually, it can be assumed that it will have a negative effect on a child’s mental health to be kept in the same room or rooms for two weeks without access to an adequate outdoor area in which to play.

Balancing competing interests

However, the best interests of children and the rights of anyone who is subject to a Solo Child Detention Notice will need to be balanced against other demonstrably justifiable ends; for example, lawful, reasonable and proportionate measures taken to reduce the further spread of 2019-nCoV.

It is your role to undertake this balance in your welfare checks, based on the information and advice that you have from the department and on the information provided to you by the children that you are assessing.

Appendix 6 Direction and Detention Notice – Solo Children

DIRECTION AND DETENTION NOTICE

SOLO CHILDREN

Public Health and Wellbeing Act 2008 (Vic)
Section 200

Reason for this Notice

You have arrived in Victoria from overseas, on or after midnight on 28 March 2020.

A state of emergency has been declared under section 198 of the *Public Health and Wellbeing Act 2008* (Vic) (the **Act**), because of the serious risk to public health posed by COVID-19.

In particular, there is a serious risk to public health as a result of people travelling to Victoria from overseas. People who have been overseas are at the highest risk of infection and are one of the biggest contributors to the spread of COVID-19 throughout Victoria.

You will be detained at the hotel specified in clause 2 below, in the room specified in clause 2 below, for a period of 14 days, because that is reasonably necessary for the purpose of eliminating or reducing a serious risk to public health, in accordance with section 200(1)(a) of the Act.

Having regard to the medical advice, 14 days is the period reasonably required to ensure that you have not contracted COVID-19 as a result of your overseas travel.

You must comply with the directions below because they are reasonably necessary to protect public health, in accordance with section 200(1)(d) of the Act.

The Chief Health Officer will be notified that you have been detained. The Chief Health Officer must advise the Minister for Health of your detention.

Note: These steps are required by sections 200(7) and (9) of the Act.

Place and time of detention

You will be detained at:

Hotel: _____ *(to be completed at place of arrival)*

Room No: _____ *(to be completed on arrival at hotel)*

You will be detained until: _____ on ____of _____2020.

Directions — transport to hotel

You must **proceed immediately to the vehicle** that has been provided to take you to the hotel, in accordance with any instructions given to you.

Once you arrive at the hotel, **you must proceed immediately to the room** you have been allocated above in accordance with any instructions given to you.

Conditions of your detention

You must not leave the room in any circumstances, unless:

you have been granted permission to do so:

for the purposes of attending a medical facility to receive medical care; or

where it is reasonably necessary for your physical or mental health; or

on compassionate grounds; or

there is an emergency situation.

You must not permit any other person to enter your room, unless the person is authorised to be there for a specific purpose (for example, providing food or for medical reasons).

Except for authorised people, the only other people allowed in your room are people who are being detained in the same room as you.

You are permitted to communicate with people who are not staying with you in your room, either by phone or other electronic means.

Note: An authorised officer must facilitate any reasonable request for communication made by you, in accordance with section 200(5) of the Act.

(18) If you are under 18 years of age your parent or guardian is permitted to stay with you, but only if they agree to submit to the same conditions of detention for the period that you are detained.

Review of your detention

Your detention will be reviewed at least once every 24 hours for the period that you are in detention, in order to determine whether your detention continues to be reasonably necessary to eliminate or reduce a serious risk to public health.

Note: This review is required by section 200(6) of the Act.

Special conditions because you are a solo child

Because your parent or guardian is not with you in detention the following additional protections apply to you:

We will check on your welfare throughout the day and overnight.

We will ensure you get adequate food, either from your parents or elsewhere.

We will make sure you can communicate with your parents regularly.

We will try to facilitate remote education where it is being provided by your school.

We will communicate with your parents once a day.

Offence and penalty

It is an offence under section 203 of the Act if you refuse or fail to comply with the directions and requirements set out in this Notice, unless you have a reasonable excuse for refusing or failing to comply.

The current penalty for an individual is $19,826.40.

_____

Name of Authorised Officer: _____

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

Appendix 7: End of Detention Notice

Public Health and Wellbeing Act 2008 (Vic)

Section 200

Subject to the conditions below, this Notice is evidence that this detainee has completed their period of detention under a *Direction and Detention Notice* issued to reduce or eliminate the serious public health risk posed by COVID-19.

9 Detention Notice

You have arrived in Victoria from overseas, on or after midnight on 28 March 2020 or on or after midnight on 13 April 2020 and have been placed in detention, pursuant to a Direction and Detention Notice that you were provided on your arrival in Victoria (**Notice**).

10 Details of Detention Notice

Name of Detainee: **<<FIRST NAME>> <<LAST NAME>>**

Date of Detainment and Detention Notice: <<DETENTION START DATE>>

Place of Detention: <<HOTEL>> <<ROOM>>

11 End of Detention Notice

In accordance with section 200(6) of the *Public Health and Wellbeing Act 2008,* I have reviewed your continued detention.

On review of the Notice, I have made the following findings:

you will have served the required detention period by <<DETENTION END DATE>>; and

you have not started exhibiting any symptoms of COVID-19.

In consideration of the above circumstances, I have decided that your continued detention is not reasonably necessary to eliminate or reduce a serious risk to public health.

I advise that your detention pursuant to section 200(1)(a) of the *Public Health and Wellbeing Act 2008* (Vic) and the Notice will end on <<**DETENTION END DATE**>> at _____after you have been discharged by an Authorised Officer and have commenced transportation to your ordinary residence.

Although you are no longer to be detained pursuant to the Notice, you are required to comply with all directions currently in force in Victoria. This includes the Stay at Home Directions (No 4) (**Direction**), as amended from time to time. Pursuant to the Direction, if you live in Victoria you are required to travel directly to the premises where you ordinarily reside, and remain there unless you are leaving for one of the reasons listed in the Direction.

If you are a resident of another state arrangements will be made for you to return home. While you remain in the State of Victoria, you are required to comply with all Directions in operation in Victoria. Once you have returned home, you are required to comply with the Directions and/or Orders in place in your home jurisdiction, including any directions that may require you to isolate for a further 14 day period.

In the event that you start to experience symptoms of COVID-19, it is important that you self-isolate and, if necessary, contact your General Practitioner or local Public Health Unit.

12 End of Detention Instructions

You must not leave your hotel room until you have been collected by Security at which time you are permitted to travel to the hotel lobby to meet an Authorised Officer who will **sight your identification** and discharge you from detention. **Security will give you approximately an hour notice of when they will collect you.**

Your detention **does not end** until the time stated in paragraph 0 of this notice which will be filled in by an authorised officer when you are discharged from detention. Until that time you must continue to abide by the requirements of your detention, as contained in the Notice.

When leaving detention you **must** adhere to the following safeguards:

if provided to you, you **must** wear personal protective equipment;

you **must** refrain, as far as possible, from touching communal surfaces, such as handrails, elevator buttons and door handles;

you **must** where possible, engage in social distancing, maintaining a distance of 1.5 metres from other people; and

upon leaving your hotel room, you **must** go straight to the foyer for discharge and then immediately after travel to your transportation and travel directly to your ordinary residence.

These steps are to ensure your protection, and reduce the risk of you becoming infected with COVID-19 by any persons detained in the hotel, or in the community, who may have COVID-19.

Until your detention has concluded, you must follow instructions from Authorised Officer/s and any other conditions set out.

2 Offence and penalty

(1) It is an offence under section 203 of the Act if you refuse or fail to comply with the directions set out in this notice, unless you have a reasonable excuse for refusing or failing to comply.

(2) The current penalty for an individual is $19,826.40.

_____ **Signature of Authorised Officer**

Name of Authorised Officer: _____

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

Appendix 8: End of Detention Notice (confirmed case or respiratory illness symptoms)

Public Health and Wellbeing Act 2008 (Vic)

Section 200

An Authorised Officer has decided to end your Direction and Detention Notice. This decision has been made following the mandatory review of your Direction and Detention Notice because you [*have returned a positive test for COVID-19*] *or* [*have started displaying symptoms of respiratory illness*].

1. Detention Notice

You have arrived in Victoria from overseas, on or after midnight on 28 March 2020 or on or after midnight on 13 April 2020 and have been placed in detention, pursuant to a Direction and Detention Notice that you were provided on your arrival in Victoria (**Notice**).

2. Details of End of Detention Notice

Name of Detainee:_____

Date Notice Made:_____

Date Notice Expires:_____

Place of Detention:_____

Medical Facility:_____
(if medical care is required)

COVID-19 Status or respiratory illness symptoms [tick applicable]:

COVID-19 confirmed*:* _____ *[insert date of test]*	☐	coughing	☐
fever or temperature in excess of 37.5 degrees	☐	sore throat	☐
congestion, in either the nasal sinuses or lungs	☐	body aches	☐
runny nose	☐	fatigue	☐

3. End of Detention Notice

In accordance with section 200(6) of the Public Health and Wellbeing Act 2008, I have reviewed your continued detention.

On review of the Notice, I have noticed that you [have been diagnosed with COVID-19] or [have exhibited the symptoms of respiratory illness, as outlined above at paragraph 2(8) *[delete as applicable*].

In consideration of the above, I do not believe that continued detention is reasonably necessary to eliminate or reduce a serious risk to public health because:

a) [*if applicable*] You have been confirmed to have COVID-19 and will be required to self-isolate in accordance with the Isolation (Diagnosis) Direction, in a premises that is

suitable for you to reside in, or a medical facility, until such a time you are notified that you no longer need to self-isolate and a clearance from isolation (self-isolation) is given;

b) [*if applicable*] You are showing symptoms of respiratory illness and will be required to self-isolate in accordance with the Stay at Home Direction (4) currently in force in Victoria and will need travel directly to your ordinary residence once you leave detention, and remain there unless you are permitted to leave for a reason specified in the Stay at Home Direction (4); and

c) You are ordinarily a resident in Victoria.

Compliance with Directions made by the Deputy Chief Health Officer is required to reduce or eliminate the serious risk to public health posed by COVID-19. It is essential that you [self-isolate in accordance with the Isolation (Diagnosis) Direction until such time as you are notified that you no longer need to self-isolate and a clearance from self-isolation is given] OR [return to your ordinary residence and remain there unless you are permitted to leave for a reason specified in the Stay at Home Direction (4). Please monitor your symptoms and seek appropriate medical care if required]. *[delete as applicable*].

The Notice is ended subject to the directions below under paragraph 4. Non-compliance with these directions is an offence.

4. Conditions

- You will be transited from the hotel where you have been detained to your ordinary residence / Premises for Isolation pursuant to Isolation (Diagnosis) Direction / medical facility [*delete as appropriate*] by an Authorised Officer. You may / will [*delete as appropriate*] be supervised during transit.
- While you are transiting to your ordinary residence / Premises for Isolation pursuant to Isolation (Diagnosis) Direction / medical facility [*delete as appropriate*], you must refrain from touching communal surfaces, as far as possible, such as door knobs, handrails, lift buttons etc.
- When you are transiting to your ordinary residence / Premises for Isolation pursuant to Isolation (Diagnosis) Direction / medical facility [*delete as appropriate*], you must, **at all times**, wear appropriate protective equipment to prevent the spread of COVID-19, if directed by the Authorised Officer.
- You must practice social distancing, and as far as possible, maintain a distance of 1.5 metres from all other people, including any Authorised Officer escorting you.
- When you are transiting to your ordinary residence / Premises for Isolation pursuant to Isolation (Diagnosis) Direction / medical facility [*delete as appropriate*], you must, **at all times**, comply with any direction given to you by any Authorised Officer escorting you.

5. Offence and penalty

It is an offence under section 203 of the Act if you refuse or fail to comply with the directions and requirements set out in this notice and/or the Isolation (Diagnosis) Direction *[if applicable*], unless you have a reasonable excuse for refusing or failing to comply.

The current penalty for an individual is $19,826.40.

_____ **Signature of Authorised Officer**

Name of Authorised Officer: _____

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

Appendix 9: Guidance Note – End of Detention

How to conclude a person's detainment under a *Direction and Detainment Notice* if they have served the required period of detainment, become a confirmed case of COVID-19 or have symptoms of respiratory illness

What do you have to do before you issue an End of Detention Notice?

If the person has served 14 days of detention you must decide how to administer the completion of that person's detention arrangements:

a) selecting a time for the person to attend a foyer after the 14 day period has concluded - it is recommended that this occur in small groups of people who are practicing appropriate social distancing and with sufficient time between groups to avoid crowds. This will ensure Authorised Officers can safely discharge each detainee

b) collecting a person from their hotel room after the 14 day period has concluded – this approach should be carefully administered to ensure Authorised Officers can safely discharge each person

c) if a person's detainment is concluding because they have a confirmed case of COVID-19 or symptoms of respiratory illness they must be discharged when it is safe to do so – e.g. when other detained people are in their rooms, under full supervision etc.

d) complete all sections of the Notice, including clearly documenting the reasons for the end of detention and the details recorded on the Direction and Detention Notice

e) update all the registers and relevant records about the person's detainment arrangements ensure the reference number is completed.

When should you issue an End of Detention Notice?

It is preferable that an End of Detention Notice be issued the day before a person's detainment is set to conclude – this will give the person adequate time to prepare (e.g. to pack their belongings) and ensure the orderly discharge of large groups of people.

A notice may be provided earlier but it creates a risk that a person may develop COVID-19 symptoms before the day the detainment period must end.

What do you have to do when you issue an End of Detention Notice?

When you issue an End of Detention Notice you must:

a) explain the reason why detention has ceased and is no longer necessary to eliminate or reduce a serious risk to public health

b) advise that person of the arrangements being made for their discharge from detention (e.g. at an allocated time at the foyer; when they are escorted from their room etc)

c) notify they person that although they are no longer subject to detention when they are discharged and leave the premises of their detention, they are still subject to the directions which are in force in Victoria, including

d) if they are ordinarily resident in Victoria, they are required to return immediately to their ordinary residence, where they must remain, in accordance with the Stay at Home Directions (No 2)

e) if they have a confirmed case of COVID-19, they must isolate at home in accordance with the Isolation (Diagnosis) Direction

Appendix 10 - Guidance Note — Exceptions to the General Quarantine Policy

Summary

You are [an officer authorised by the Chief Health Officer under section 199(2)(a) of the *Public Health and Wellbeing Act 2008* (Vic) (**PHW Act**) to exercise certain powers under that Act] [or a delegate of the Chief Health Officer under section 22 of the PHW Act] [**Note: however, only registered medical practitioners can be delegates under s 22**]. You also have duties under the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**Charter**).

This guidance note has been prepared to assist you to carry out your functions in determining whether individual persons arriving in Victoria from overseas should be exempt from being made subject to a detention notice requiring them to self-quarantine in a designated hotel room for 14 days in order to limit the spread of Novel Coronavirus 2019 (**2019-nCoV**) (the **general quarantine policy**). This policy is in place because people returning from overseas are at increased risk of infection from 2019-nCoV and may inadvertently transmit it to others upon their return and because the earlier requirement to isolate at home was not uniformly complied with.

As part of your functions, you are required to make decisions as to whether an exception to the general quarantine policy is warranted in particular cases that have been escalated to you by authorised officers. If you decide that an exception applies, you must subsequently decide whether the person in question should be:

released from quarantine in Victoria (because they are medically cleared or will be subject to another jurisdiction's regime); or

required to complete their quarantine in another location in Victoria (at home or in another facility), in which case they would be subject to the same conditions that apply to other international arrivals under the standard direction and detention notice, including monitoring and penalties for non-compliance.

This guidance note sets out the following **six categories of exceptions** to the general quarantine policy and provides a checklist of relevant factors to be considered when determining whether each exception applies:

1. International transit (for example, transit in Victoria from New Zealand en route to Europe or vice versa).

Interstate transit (with the approval of the receiving jurisdiction, usually for compassionate reasons or as an unaccompanied minor).

Unaccompanied minors whose legal guardians are unable to reside with them at the hotel (for example, due to other caring responsibilities).

Compassionate or medical grounds (for example, if the person suffers from anaphylaxis).

Previous confirmed cases with medical clearance who no longer require quarantine.

Key workers.

It also provides guidance on how to fulfil your obligations under the Charter for each exception. Those obligations are to act compatibly with human rights and to give 'proper consideration' to the relevant human rights of any person(s) affected by your decisions. The relevant factors and human rights considerations will differ depending on the applicable exception.

We note that, although it is important that the exceptions are reasonably transparent and communicated clearly to people arriving in Victoria from overseas, this must be balanced against the need to ensure that the categories of exceptions are appropriately circumscribed so as not to undermine the general quarantine policy. Further, although this guidance note has been developed in the interests of ensuring consistency and clarity in the application of the exceptions, you must determine each request on a case-by-case basis.

Your obligations under the Charter

You are a public officer under the Charter. This means that, in deciding whether an exception to the general quarantine policy is warranted in any particular case, you must give 'proper consideration' to the human rights of *any person* affected by the decision, including the person who would otherwise be subject to the detention notice, the person(s) who they may quarantine with if they were to quarantine at home, and members of the community.

'Proper consideration' requires you to:

- **first**, understand in general terms which human rights will be affected by your decision (these rights are set out below and differ depending on the exception);
- **second**, seriously turn your mind to the possible impact of your decision on the relevant individual's human rights, and the implications for that person;
- **third**, identify the countervailing interests (e.g. the important public objectives such as preventing the further spread of 2019-nCoV, which may weigh against a person's full enjoyment of their human rights for a period of time); and
- **fourth**, balance the competing private and public interests to assess whether restricting a person's human rights is justified in the circumstances.

Exceptions [*Ensure consistency with Australian Government policy re exceptions to mandatory quarantine*]

1. International transit

Description of category

Ref page 65

Relevant factors

[DHHS to please provide]

Relevant human rights

Ref page 67

2. Interstate transit

Description of category

[*Refer to letter to diplomat re exception to travel to Canberra*]

Relevant factors

[DHHS to please provide]

Relevant human rights

3. Unaccompanied minors whose legal guardians are unable to reside with them at the hotel

Description of category

Ref page 71

Relevant factors

[DHHS to please provide]

Relevant human rights

4. Compassionate or medical grounds

Description of category

[*Refer to previous assessments fo* REDACTED

Relevant factors

[DHHS to please provide]

Relevant human rights

5. Previous confirmed cases with medical clearance who no longer require quarantine

Description of category

Relevant factors

[DHHS to please provide]

Relevant human rights

6. Key workers

Description of category

[*Refer to letter from Minister Hunt re exception for key workers*]

Relevant factors

[DHHS to please provide]

Relevant human rights

[Note: do we possibly need a 'miscellaneous' / catch-all category, to capture cases that may warrant an exception but do not fall squarely into one of the above categories?]

Appendix 11: Charter of Human Rights obligations

Key points

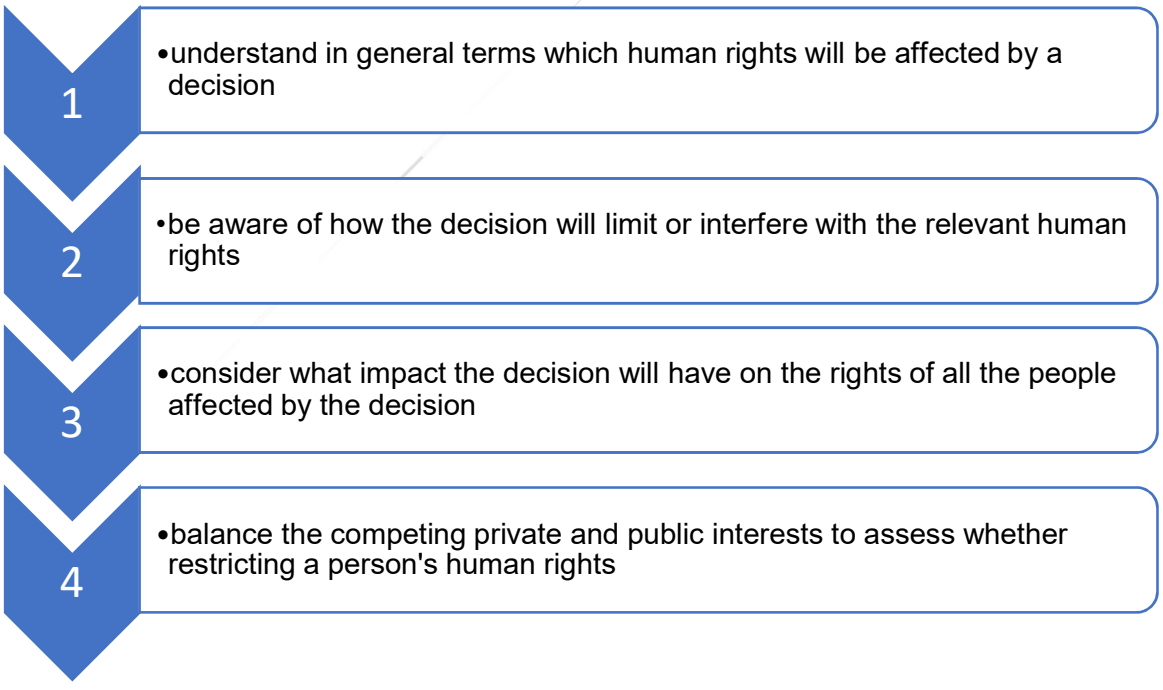
- AO must act compatibly with human rights.
- AO must give 'proper consideration' to the human rights of any person(s) affected by an AO's decision.

Department of Human Health and Services AO obligations under the *Charter of Human Rights and Responsibilities Act 2006*

Department AOs are public officials under the Charter of Human Rights. This means that, in providing services and performing functions in relation to persons subject to the Direction and Detention Notice, department AOs must, at all times:

- act compatibly with human rights; and
- give 'proper consideration' to the human rights of any person(s) affected by a department AO's decisions.

How to give 'proper consideration' to human rights



The relevant Charter Human Rights that departmental AOs need to be aware of that may be affected by a decision:

Charter Right	Obligation

Charter Right	Obligation
Right to life	This includes a duty to take appropriate steps to protect the right to life and steps to ensure that the person in detention is in a safe environment and has access to services that protect their right to life
Right to protection from torture and cruel, inhuman or degrading treatment	This includes protecting persons in detentions from humiliation and not subjecting persons in detention to medical treatments without their consent
Right to freedom of movement	while detention limits this right, it is done to minimise the serious risk to public health as a result of people travelling to Victoria from overseas
Right to privacy and reputation	this includes protecting the personal information of persons in detention and storing it securely
Right to protection of families and children	this includes taking steps to protect families and children and providing supports services to parents, children and those with a disability
Property Rights	this includes ensuring the property of a person in detention is protected
Right to liberty and security of person	this includes only be detained in accordance with the PHWA and ensuring steps are taken to ensure physical safety of people, such as threats from violence
Rights to humane treatment when deprived of liberty	this includes treating persons in detention humanely.

Appendix 12 Register of permissions granted under 4(1) of the *Direction and Detention Notice*

Authorised officer:_____

Ref No.	Date	Name of detained person	Reason	Time-Out	Time-In

Appendix 13 - Enforcement and Compliance roles and responsibilities

Enforcement and Compliance Command

Role	Responsibilities
Enforcement and Compliance Commander	• Lead and provide oversight to compliance matters under all Public Health Directions • Provide advice and input into complex compliance matters. • Provide advice and support to the Chief Health Officer and their delegate on compliance • Approves exemptions
Deputy Command – AO Operations	• Executive oversight of Authorised officer operations in the hotels. Ensures planning arrangements allow for safe operations of AO decisions and escalation point for complex AO decisions across all AO operations across the airport and hotel environments. Ensure AOs understand protocols and follow protocols to ensure detention arrangements are legal • Ensure VicPol have appropriate AO guidance and support.
AO Operation support	• Undertake rostering, recruiting and onboarding of AOs. (rostering transitioning to EOC) • Manage the release process for detention and 24 hour legal review process
AO Team Leader*	• Provide management oversight of AOs • First point of escalation of permissions • Report on daily review of people being detained. (Transition to Review and release team)

AO	• Primary responsible for:
	  ○ administration of, and ensuring compliance with, the Direction and Detention Notices (27 March 2020 and 13 April 2020)
	  ○ meeting obligations under the PHWA

Deputy Command Policy and Exemptions	• Executive oversight of development of operational protocols, exemptions and review process. Ensures connections with other relevant areas to ensure processes are connected and complex issues resolved.
Operational Policy and Protocols Leader	• Develop operational policy and protocols to support Directions • Coordinates the training of AOs

Exemptions Leader	• Manage the COVID Quarantine inbox[5].and case management process – ensure cases are allocated and resolved in a timely manner

Contacts for each role are as per daily roster.

Other non-ECC roles involved in compliance

Role	Responsibility
DHHS Hotel site lead	• Supports the health and well-being of staff • Liaises with airport command and staff from other departments and agencies represented at the hotel • Provides situational awareness and intelligence to inform transport providers, state-level emergency management arrangements and airport operations • Provides a point of reference to all site-staff to help resolve operations, logistics or site-related issues and / or escalations required • Ensures appropriate records management processes are in place.
DJPR	• Manage contracts with accommodation providers
Medical, Nursing and welfare staff	• Provide 24 hour on-call medical support subject to demand • Provide welfare to detainees through a daily welfare check — welfare officers email COVIDQuarantine@dhhs.vic.gov.au and phone the site AO individually to alert AO of medical and welfare issues • Capture client personal needs, e.g. dietary, medication, allergies, personal hygiene needs • Provide a satisfaction survey for residents to complete each week.
Department and hotel staff	• Deliver hyper-care (concierge) services onsite • Manage transport arrangements from the airport and other locations detainees may be permissioned to go • Manage material needs including food and drink.
Security	• To assist AOs in ensuring detainees comply with notices and permissions. This includes ensuring detainees do not leave hotel rooms, assisting with movement of detainees where they have permission to leave rooms, and assisting with release

[5] COVIDquarantine@dhhs.vic.gov.au

Annex 2 – Health & Wellbeing

Annex approver: Public Health Commander

Last version date: v2.0 1 June 2020

Standards for healthcare and welfare provision

Standard 1. Rights of people in mandatory quarantine

Criterion 1.1 Charter of Human Rights and Responsibilities

Policies and practices guiding decisions made about people in mandatory quarantine under Operation Soteria must consider the Victorian Charter of Human Rights and Responsibilities.

The Victorian Charter of Human Rights and Responsibilities Act 2006 (the Charter) contains twenty basic rights that promote and protect the values of freedom, respect, equality and dignity. The Charter requires the Victorian Government (state and local) to consider human rights when they make decisions about people. While some of these rights may be restricted for quarantined people, consideration of these rights must underlie all decisions made by Operation Soteria staff in relation to people in mandatory detention.

- Relevant Charter of Human Rights that must be considered by Operation Soteria staff when making decisions in relation to people in mandatory detention include:

  - Right to life
  - Right to protection from torture and cruel, inhumane or degrading treatment
  - Freedom from forced work
  - Right to freedom of movement
  - Right to privacy and reputation
  - Freedom of thought, conscience, religion and belief
  - Freedom of expression
  - Right to protection of families and children
  - Cultural rights
  - Property rights
  - Right to liberty and security of the person
  - Right to humane treatment when deprived of liberty

  Noting section 19(2) outlines the distinct cultural rights of Aboriginal persons.

- Quarantined persons should be provided with a notice of detention, information on the terms and nature of the mandatory quarantine period and opportunity to seek exemption or review of the current detention order

Criterion 1.2 Diverse groups

- All persons in mandatory quarantine should be treated with dignity and respect.
- Providers of health and welfare services must meet the care needs of quarantined persons on an individual basis.
- Consideration should be given to the special needs of Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse (CALD) backgrounds; lesbian, gay, bisexual, trans, gender diverse and intersex people; people with disabilities, and others.
- Quarantined persons should be screened on arrival to identify those persons who are of Aboriginal or Torres Strait Islander heritage

- The care provided to Aboriginal and Torres Strait Islander peoples should fulfil the six actions of the National Safety and Quality Health Service Standards that focus specifically on meeting the needs of Aboriginal and Torres Strait Islander people (for further details see https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Safety-and-Quality-Health-Service-Standards-User-Guide-for-Aboriginal-and-Torres-Strait-Islander-Health.pdf).
- Quarantined persons should be screened on arrival to identify those with physical, sensory, psychosocial or intellectual disabilities.
- Quarantined persons with a disability should be provided with the services and supports they require. Australia is a signatory to the United Nations Convention on the Rights of Persons with Disabilities, which sets out human rights for people with disabilities which include accessibility, personal mobility and access to healthcare.

Criterion 1.3 Use of interpreters

- Quarantined persons should be screened on arrival to identify those who require interpreters
- Interpreters must be used for quarantined persons where English is not their first language and translation would normally be required for interaction with the health or welfare systems
- Language requirements should be recorded in the quarantined person's record and hotel staff advised.

Criterion 1.4 Feedback and complaints process

A feedback and complaints process can provide unique information about quarantined persons needs and the quality of care provided by Operation Soteria. Openly discussing feedback and concerns helps staff to understand strengths in their service, potential problems, and how to make improvements.

- Processes for assessing satisfaction and receiving and addressing complaints should be established.

Potential indicators

Program delivery

- Number of people seeking exemptions from mandatory quarantine
- Number of Aboriginal and Torres Strait Islander peoples in quarantine
- Number of people with a disability in quarantine
- Number of people in quarantine requiring interpreter services
- Number of adverse events arising from failure to address the needs of a person with disability
- Nature of adverse events (de-identified) arising from failure to address the needs of a person with disability
- Number of adverse events arising from failure to use an interpreter
- Nature of adverse events (de-identified) arising from failure to use an interpreter
- Number of complaints related to detention, health and welfare services
- Nature of complaints (de-identified) related to detention, health and welfare services

Outcomes

- Number of people receiving exemptions from mandatory quarantine
- Reasons for exemptions granted (de-identified)
- Outcomes of adverse events (de-identified) arising from failure to use an interpreter
- Outcomes of adverse events (de-identified) arising from failure to address the needs of a person with disability
- Resolution of complaints related to on-site staff, mandatory detention processes and health and welfare services

Reporting frequency

- Significant adverse events (major incidents): as soon as possible after occurrence
- All other adverse events: daily
- Formal complaints: weekly

Standard 2. Screening and follow up of health and welfare risk factors

As part of the duty of care towards people in mandatory detention under Operation Soteria, it is essential that appropriately qualified staff screen quarantined individuals for health and welfare risk factors, so that appropriate services are made available to those who require them.

Criterion 2.1 Health and welfare risk factors

Returned travellers will be screened for risk factors related to the following:

- current or potential infection with COVID-19 including:
  - temperature
  - symptoms including fever, cough, shortness of breath, chills, body aches, sore throat, headache, runny nose, muscle pain or diarrhoea
- potential complications or adverse events arising from
  - current or previous physical health conditions
  - current or previous mental health conditions
  - current or previous disabilities
- allergies and food sensitivities, with particular note of anaphylaxis
- need for ongoing medication, contact with usual treating health professionals, and other support services
- family violence or child abuse
- drug and alcohol use and/or dependence
- current stressors or factors that will make quarantine particularly difficult, such as small children, bereavement, etc
- needs or fears expressed by the quarantined person
- vulnerability due to age (children or people over 65) or pregnancy

Criterion 2.2 Schedule for screening

- Returned travellers should be screened for COVID-19 at the following times:

  On arrival at airport: screening to include temperature and symptoms of COVID-19

  Day 3 and Day 11: voluntary routine testing
- Returned travellers will be screened for other health and welfare concerns at the following times:

  On day of arrival using the initial welfare self-reported survey XXX hyperlink to document

  Nurse health assessment within the first 24 hours, documented in the nurse health record

  Regularly throughout detention as determined by risk factors (Criterion 2.5), including welfare checks and checks by nurses or other appropriate staff.

Criterion 2.3 Methods of screening

- Screening tools (online or paper-based surveys, interview questions and prompts) that have been validated to assess health and welfare risk factors should be used where available.
- If appropriate validated tools are unavailable, any tools created for this purpose should be developed by professionals with expertise in survey development.
- It is essential that the initial screening assessment includes identification of Aboriginal and/or Torres Strait Islander status.

Criterion 2.4 Staff undertaking screening

- Staff undertaking health screening should have appropriate qualifications to conduct the tasks they are allocated, including understanding of Aboriginal cultural safety.
- Assessment of current or potential infection with COVID-19 should be undertaken by medical or nursing staff

- Assessment of all other risk factors should be undertaken by staff who have:
- an understanding of the issues likely to be raised and their implications
- knowledge of the circumstances that would require escalation or referral to health or mental health professionals
- training and experience in handling conversations:
    - on sensitive topics, such as family violence
    - with disturbed or fearful people
- It should be noted that health, education and other professional groups have mandatory requirements to report suspected child abuse. CART should be notified, and the individual practitioners are required to make a notification through child protection intake.
- Health or welfare phone calls to Aboriginal or Torres Strait Islander people should be undertaken by people who have undertaken Aboriginal cultural safety training.

Criterion 2.5 Risk assessment and follow up of persons 'at risk'

The self-screening survey and health assessment needs to identify any of the following risk factors to allocate an appropriate risk Tier. This must be completed in the first 24 hours and documented in the nurse health record and/or welfare application. Each quarantined person could be triaged into three tiers of risk based on identified risk factors as per the example table below.

Risk Tier	**Risk factors**	**Follow up by appropriate health or welfare professionals**
Tier 1	• Persons with suspected or confirmed COVID-19 • Families with children < 18 years • Persons aged > 65 years • Aboriginal and Torres Strait Islander peoples • Persons with underlying physical comorbidities (e.g. respiratory or cardiac conditions) • Persons with a disability • Persons with a history of mental illness • Allergies and food sensitivities, with particular note of anaphylaxis • History of family violence or child abuse • Drug and alcohol use and/or dependence • Current stressors or factors that will make quarantine particularly difficult, such as small children, bereavement, etc. • Those with needs or fears expressed by the quarantined person • Pregnant women	Phone call daily
Tier 2	• Persons who indicate they require a phone call but do not have any other risk factors. • Persons who are by themselves.	Phone call every second day
Tier 3	• Persons with none of the factors above	Tailored contact

- Relevant plans for follow up of identified risks should be developed

- Protocols for communicating follow up plans to relevant health and welfare staff should be documented
- At the discretion of the on-site clinical staff, quarantined persons with currently active physical or mental health issues should be:
    - managed on-site if within the capacity, capability and credentialing of attending medical and nursing staff
    - referred to the appropriate health services (e.g. mental health services, specialist medical services, hospital, etc) or other support services as required.

- Notification to the DHHS team leader and escalation to Emergency Operation Centre as appropriate.

Potential indicators

Program delivery

- Number of returning passengers arriving in Victoria
- Number and percentage of returning passengers screened for COVID-19 at the airport
- Reasons for COVID-19 screening not completed at the airport (e.g. passenger refused screening, insufficient staff, etc)
- Number and percentage of quarantined persons receiving health assessment (including risk assessment) in the first 24 hours of arrival
- Reasons for initial health assessment not completed on day of arrival (passenger refused screening, insufficient staff, etc)
- Number and percentage of quarantined persons receiving initial health assessment (including risk factors) after the first 24 hours (e.g. 20% on Day 2)
- Number and percentage of quarantined persons receiving subsequent screen for risk factors during detention period (i.e. screening survey or interview, follow up of identified risk factors)

Outcomes

- Number and percentage of screened passengers with known COVID-19 based on documentary evidence
- Number and percentage of screened passengers with known COVID-19 based on self-report
- Number and percentage of screened passengers with suspected COVID-19 based on signs and symptoms
- Number and percentage of quarantined persons with identified risk factors at initial health assessment
- Number and percentage of quarantined persons with identified risk factors at subsequent health assessment
- Nature of risk factors (de-identified)
- Number and percentage of quarantined persons referred to Operation Soteria health or support services by service (e.g. 10 [2%] referred to on-site doctor, 5 [1%] referred to NorthWestern Mental Health Services)
- Number and percentage of quarantined persons with identified risk factors referred to external services (e.g. one referred to Aboriginal community-controlled health services)

Reporting frequency

- All: Daily
- A daily report will be collated from the AO database, nurse health record and welfare application.

Standard 3. Provision of health and welfare services

The needs of quarantined individuals vary widely and Operation Soteria must have a flexible on-site system for the provision of health and welfare services that can accommodate urgent, non-urgent, complex, planned chronic care and preventive health needs.

Criterion 3.1 Meeting the needs of people in mandatory quarantine

The following principles should be followed in meeting the health and welfare needs of quarantined persons:

- All reasonable requests for medical care from quarantined persons should be facilitated within an appropriate timeframe depending on the acuity of the issue or request, and in a culturally appropriate manner.
- Provision of health or welfare services should not be deferred or delayed because a person is in quarantine.
- Any request for medical review should be carefully considered to determine whether telemedicine or in-person consultation is the most appropriate approach. Telemedicine should not be used if an in-person review or physical examination is clinically indicated. However, if an in-person review is not required, telemedicine is appropriate to reduce risk of infection to health providers and quarantined persons.
- Quarantined persons should be supported in accessing care through their usual general practitioner (GP), medical specialist, Aboriginal community-controlled health organisation, or other health professional via telehealth arrangements where possible. They should also be asked to request that the health professional consulted provides information regarding any ongoing health or welfare issues to the on-site clinical team if appropriate.

Criterion 3.2 Provision of on-site clinical services

- Safeguarding of the health and welfare of quarantined persons is paramount.
- Medical, nursing and other clinical services should be engaged at each hotel/facility to enable ADEQUATE, APPROPRIATE and TIMELY and culturally safe delivery of regular health assessment, acute clinical and support services. This should be determined by those commissioning/operating the health and welfare services in consultation with the Clinical Lead. It should correspond to the workload and burden of illness/needs of the population in mandatory quarantine at any time.
- Given the risk of mental health issues for people in isolation, mental health primary care services should also be available at a ratio proportionate to the burden of disease emerging from the quarantined cohort. Linking Aboriginal and Torres Strait Islander clients to culturally safe and trauma informed mental health and wellbeing services is essential.
- Medical, nursing and other clinical staff should practice within the requirements of their professional registrations, level of experience, codes of conduct and professional standards.
- Medical and nursing clinical practices, record-keeping and correspondence with other health professionals should meet the expectations and usual standards of high-quality primary care.
- Medical and nursing staff should have appropriate training, experience and credentials to:
    - identify physical and mental health emergencies
    - manage acute physical and mental health conditions by providing treatment or arranging appropriate referrals/ escalate care appropriately
    - provide support to quarantined persons who are distressed.
- Clinical governance arrangements should be in place to ensure that:
    - staff have appropriate training, experience and credentials
    - clinical practice is consistent with the best available evidence and follows applicable professional standards
    - clear and consistent escalation pathways are clearly communicated to all clinical staff
    - adequate, appropriate, well-maintained and calibrated clinical equipment is available to deliver primary care services
    - suitable arrangements are in place to enable comprehensive and secure medical record keeping.
- Provision should be made for both on-site in-person clinical consultations and telehealth consultations
- On-site clinical staff should be provided with mobile phones to facilitate rapid access by quarantined persons, operational and administrative staff, and external healthcare providers
- Processes for ensuring continuity of care through accurate and comprehensive medical record keeping and communication of medical information between providers engaged to provide on-site health care should be established.
- It is the responsibility of the doctor who orders any test (COVID-19 or otherwise) to follow up on the result and notify the patient in a timely manner. If they are not able to do so, they must handover this task to the next doctor on-call, inform the nurse, and record this in the medical record.

- Requests for medical care must be actioned in keeping with the acuity of the issue. Where staffing allows, the doctor may see patients before the nurse, particularly if the request is deemed urgent. An example of appropriate response times is included below.

Acuity of issue	Time frame for response
Emergency/life-threatening issue	Immediate – any person present to call 000 ASAP without waiting for nurse or doctor to attend
Urgent physical health concerns	Nurse to review ASAP (within 30 minutes) Doctor to review within 1 hour
Urgent mental health issue	Doctor or nurse to review within 1 hour
Urgent mental health issue accompanied by suicidal intent	Doctor to review ASAP (within 30 minutes)
Minor health issue (physical or mental) requiring review, non-urgent	Nurse to review within 4 hours Doctor to review (if required) within 12 hours
Prescription requests (urgent)	Doctor to action within 8 hours
Prescription requests (non-urgent)	Doctor to action within 24 hours

- At the discretion of the on-site clinical staff, quarantined persons with currently active physical or mental health issues should be:
    - managed on-site if within the capacity, capability and credentialing of attending medical and nursing staff
    - referred to the appropriate health services (e.g. mental health services, specialist medical services, hospital, Aboriginal community-controlled health organisation, etc.) or other support services as required.
- In the case of a physical health emergency in a quarantined person (e.g. heart attack, stroke, anaphylaxis, etc.) an ambulance should be called immediately by any person in attendance. There is no need to wait for attendance of medical or nursing staff in this situation, but they should be called for review as soon as practical after an ambulance has been called.
- In the case of a mental health emergency in a quarantined person (e.g. acute suicidal ideation, thoughts of self-harm, psychosis, etc.) the quarantined individual should be reviewed by the doctor on call as a matter of urgency, particularly if suicidal intent is present. The doctor should then determine if transfer to hospital via ambulance is required for urgent psychiatric assessment or if psychiatric advice or assessment can be appropriately obtained over the phone. If the quarantined individual is deemed as needing urgent psychiatric review and is not willing to be transferred for assessment, the doctor on call will need to decide if enacting provisions within the Mental Health Act 2014 is required.
- Documented protocols related to provision of on-site health services should include:

  Processes for follow up of physical and mental health risk factors identified through screening

  Clear instructions for:
    - quarantined persons on how to contact medical and nursing staff
    - clinical staff on responsibilities for first point of contact, triage, escalation and referral pathways
    - clinical staff on actions to be taken in response to acute physical and mental health emergencies
    - clinical staff on continuity of care and handover of outstanding tasks and concerns
    - agreed method of documentation of outstanding tasks/ physical or mental health issues needing follow up.
- Documentation should also include contact numbers for:
    - Hotels and other facilities being used for quarantine
    - Medical and nursing contacts at each facility

- Health service emergency departments, mental health services, Aboriginal community-controlled health services, liaison officers related to this operation (including Aboriginal hospital liaison officers)
- Other resources including, but not limited to, local health and welfare services, psychiatric triage team (1300 TRIAGE), Crisis Assessment and Treatment Teams (CATT), DHHS Complex Assessment and Referral Team (CART), telephone advice lines, online services, etc.
- Emergency operations centre and DHHS teams.

Prescribing benzodiazepines/anxiolytics

When considering initiating prescription of benzodiazepines for short term management of anxiety or other mental health issues (such as claustrophobia, panic attacks, PTSD etc) in mandatory detention, doctors should exercise a high degree of caution, and implement other strategies to manage these conditions where possible. Doctors initiating prescriptions for benzodiazepines, opioids, anxiolytics and antipsychotics should only do so after a careful history and risk assessment has been conducted. Psychiatric input should be sought where necessary. Care should be taken to ensure that benzodiazepines are not prescribed to individuals who are consuming alcohol, or who have other contraindications to these medications. Prescriptions should also be limited to small quantities of tablets at a time, with appropriate follow up review arranged to assess response and re-evaluate need for medication.

Initiation of sleeping tablets (including benzodiazepines, zolpidem, zopiclone etc.) in mandatory quarantine should only be considered after a thorough assessment by a healthcare professional. Those on sleeping tablets regularly should have their dose confirmed with their usual GP prior to prescriptions being provided in mandatory quarantine. Care should be taken to ensure sleeping tablets are not prescribed to individuals who are consuming alcohol, or who have other contraindications to these medications.

Further information on the safe keeping of prescription medications such as Benzodiazepines can be found at Annex 3, section 10 and through the Commander COVID-19 Accommodation.

- On-site doctors should be informed of these specific considerations for prescribing benzodiazepines and anxiolytics to quarantined persons.

Criterion 3.3 Provision of welfare services

- Safeguarding of the health and welfare of quarantined persons is paramount
- All quarantined persons should have access to communication services such as phone (local calls) internet and wi-fi so that they can stay in regular contact with family and friends.
- All quarantined persons should have access to entertainment and news services such as television and radio.
- Arrangements for quarantined persons to receive care packages of personal items from family and friends should be established.
- Appropriate professionals should be engaged at a ratio proportionate to the number of quarantined persons at each hotel/facility to enable ADEQUATE, APPROPRIATE, culturally safe and TIMELY delivery of welfare services. This should be determined by those commissioning/operating the health and welfare services. It should correspond to the workload and burden of illness/needs of the population in mandatory quarantine at any time.
- Welfare professionals should practice within the requirements of their professional registrations, level of experience, codes of conduct and professional standards.
- Welfare practices, record-keeping and correspondence with other health and welfare professionals should meet the expectations of high-quality welfare services.
- Welfare staff should have appropriate training, experience and credentials (including Aboriginal cultural safety) to:
    - identify and deal with significant welfare issues by providing advice or arranging appropriate referrals
    - provide support to quarantined persons who are distressed.
- Governance arrangements should be in place to ensure that welfare staff have appropriate training, experience and credentials.
- Provision should be made for both on-site in-person welfare consultations and telehealth consultations.

- Welfare staff should be provided with mobile phones to facilitate rapid access by quarantined persons, operational and administrative staff, and external healthcare providers.
- Regular welfare checks should be conducted, at a minimum, based on the three risk tiers noted above or more frequently to meet the needs of quarantined individuals as determined by clinical or welfare staff.
- Requests for welfare assistance from quarantined persons or clinical staff should be actioned in keeping with the urgency and significance of the issue (usually within 24 hours).
- Processes for managing, escalating and referring incidents of family violence or child abuse should be established, including provision of safe accommodation and referral to Victoria Police where appropriate.
- Processes for assessing satisfaction and receiving and addressing complaints should be established
- Documented protocols related to provision of welfare services should include, but not be limited to:

  Processes for follow up of risk factors related to welfare issues identified through screening

  Clear instructions for:
    - quarantined persons on how to contact welfare staff
    - quarantined persons on the arrangements for care packages
    - on-site clinical staff on how to contact welfare staff
    - welfare staff on responsibilities for first point of contact, triage, escalation and referral pathways
    - welfare staff on continuity of care and handover of outstanding tasks and concerns
    - welfare staff on management, escalation and referral of reports of family violence or child abuse

- Documentation should also include, but not be limited to contact numbers for:
    - Welfare staff
    - Welfare agencies for referral
    - Family violence and child abuse services
    - Services and programs for Aboriginal and/or Torres Strait Islander people
    - Appropriate Victoria Police departments

Criterion 3.4 Provision of pharmacy and pathology services

- Pharmacy services should be provided to allow for
    - prompt procurement of necessary medications (prescriptions or over-the-counter products) and equipment for quarantined persons
    - delivery to the relevant hotel/facility
    - prescriptions to be emailed to the pharmacy by the quarantined person's usual doctor or the on-site doctor
- Processes for COVID-19 swabs should follow the COVID 19 instructions for testing. (hyperlink) Pathology tests required by the treating clinician (on-site doctor or person's own GP) should be undertaken by the on-site medical or nursing staff. Equipment for taking bloods should be available at (or available to be transported to) the hotel/facility. These specimens should be labelled as per the protocol for labelling COVID-19 swabs (same requirement for identifiers)
- Routine pathology tests should be deferred until after the quarantine period if possible.

Criterion 3.5 Public health policy for COVID-19 in mandatory quarantine

- All staff should follow the COVID-19 policy for mandatory quarantine detailed in Annex 3 (hyperlink).

Potential indicators

Program delivery

- Number of quarantined persons followed up as per their risk screening follow up plan
- Number of Aboriginal and Torres Strait Islander people followed up as per their risk screening follow-up plan
- Number of referrals to external health and welfare providers
- Number of adverse events arising from absent or inadequate protocols for health and welfare or failure to follow relevant protocols
- Nature of adverse events (de-identified) arising from absent or inadequate protocols for health and welfare or failure to follow relevant protocols
- Number of serious physical or mental health incidents not related to protocols for health and welfare
- Nature of serious physical or mental health incidents (de-identified) not related to protocols for health and welfare
- Number of COVID-19 swabs
- Number of calls related to family violence or child abuse
- Number of emergencies requiring 000 calls
- Number of emergency transfers to hospital
- Number of non-emergency transfers to hospital
- Nature of emergency and non-emergency transfers to hospital (de-identified)

Outcomes

- Outcomes of adverse events (de-identified) arising from absent or inadequate protocols for health and welfare or failure to follow relevant protocols
- Outcomes of serious physical or mental health incidents (de-identified) not related to protocols for health and welfare
- Outcomes of emergency transfers to hospital
- Outcomes of non-emergency transfers to hospital
- Number of COVID-19 swabs with positive results
- Action taken as a result of positive COVID-19 swab
- Action taken as a result of response to calls related to family violence or child abuse

Reporting frequency

- Adverse events, serious incidents and COVID-19 positive swabs: as soon as possible after occurrence
- All others: daily

Standard 4. Health promotion and preventive care

While in mandatory quarantine, health promotion and preventative care should be made available to all quarantined individuals. This includes access to fresh air and promotion of exercise where possible.

Criterion 4.1 Smoking

- Smoking is not permitted in most hotels
- Quarantined persons who are smokers should be provided with information and actively encouraged to quit using validated methods such as:
    - Nicotine Replacement Therapy
    - Quitline telephone counselling (phone 13 78 48)
    - Contacting their regular GP via telehealth

- Where feasible, smoking breaks may be permitted in some circumstances for individuals who do not have access to a smoking area or balcony, where it can be safely and practically implemented at the hotel (weather permitting), taking into account infection control and physical distancing precautions.

Criterion 4.2 Fresh air

- Individuals in mandatory quarantine should have access to fresh air where possible.
- If the room has a balcony or windows that open, quarantined persons should be advised to use them for fresh air and ventilation.
- Individuals in mandatory quarantine should be allowed one hour of suitable exercise (or leisure time) in open air daily, where it can be safely and practically implemented at the hotel (weather permitting), taking into account infection control and physical distancing precautions.
- Only people who are well, and who are staying in the same room, should go outside to exercise at the same time.

Criterion 4.3 Exercise

- Exercise is important for physical and mental health, particularly in the mandatory quarantine environment
- In-room exercises should be encouraged and resources to support this should be facilitated if possible

Criterion 4.4 Alcohol and drugs

- Alcohol is permitted within hotels
- Excessive alcohol consumption should be discouraged.
- Alcohol should not be provided to persons under 18 years of age (including in the hotel room minibar)
- If there are concerns about potential alcohol or other substance abuse or withdrawal:
    - Request nurse or medical review.
    - Provide numbers for support services.
- If there are concerns about acute alcohol withdrawal, confusion, deteriorating mental state, or mental illness:

Escalate for urgent medical review

Consider calling 000

Potential indicators

- Number of incidents related to nicotine, alcohol or other drugs (withdrawal or intoxication)
- Number of people taking fresh air breaks

Standard 5. Infection control

Infection control procedures in the mandatory quarantine hotels are essential to protect on-site staff and quarantined individuals from COVID-19 and other pathogens. The foundation of good infection control is to assume everyone is potentially infectious, and therefore proper procedures have to be followed at all times.

Criterion 5.1 Personal protective equipment (PPE)

- Appropriate personal protective equipment (single-use face masks, P2/N95 masks, gowns and eye protection) should be available to all staff and quarantined individuals for use when indicated
- PPE stocks should be maintained at each hotel/facility, monitored through regular stocktake and a mechanism to rapidly obtain additional stock in place. Hotels should not run out of stock
- Biohazard bags for waste disposal, hand sanitizer, paper towels, and other necessities for hand hygiene stations should also be available in hotels
- PPE, hand hygiene stations, and waste disposal facilities should be situated at the donning/doffing areas in each hotel

- Appropriate PPE protocols (for droplet and contact precautions) should be available to all staff working in the hotels with clear instruction on what type of PPE to wear in what circumstances, how to don and doff it, and how to dispose of it (see the department's website for further information on PPE usage: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19#personal)
- Additional training and educational resources should be made available to staff who require it.

Criterion 5.2 Cleaning and waste disposal

- Quarantined individuals should have safe and clean rooms
- Housekeeping services should not be provided routinely in the interest of infection control
- Fresh linen, towels and additional amenities should be left outside rooms for quarantined individuals to collect
- Terminal cleaning is required on vacation of each room. This should follow the processes outlined in the DHHS document 'Cleaning and disinfecting to reduce COVID-19 transmission'
- Rooms that have been vacated should not be repurposed during the quarantine period
- Quarantined individuals may not be able to upkeep their rooms for various reasons, which may affect their physical and mental health. Efforts should be made to assist a quarantined person with cleaning their room if they are not capable of doing so themselves. Any persons for whom there is a concern about room hygiene and safety should be flagged to the team leader.

Criterion 5.3 Laundry

- Quarantined individuals should place dirty linen in biohazard bags which are left outside rooms for collection
- Hotel staff should wear appropriate PPE when handling dirty laundry
- Handling of dirty linen should be minimised; it should be put straight into the washing machines if possible
- Laundry should be washed on the highest possible temperature setting and thoroughly dried before use
- Staff should follow hand hygiene protocols after handling dirty linen.

Criterion 5.4 Isolation protocols

- All staff should follow the 'Public health policy for COVID-19 in mandatory quarantine' (bearing in mind a trauma informed approach is essential for Aboriginal people in isolation).
- Suspected cases of COVID-19 should be separated/isolated from people they share a room with as soon as they become symptomatic if consent is given.
- If this has not already occurred, confirmed cases should be isolated from people they share a room with as soon as the positive result is known. All people who are COVID-19 positive are to be moved the designated COVID-19 hotel unless due to exit mandatory quarantine within 24 hours in which the need for transfer may be assessed on a case by case basis. Appropriate signage, PPE and other consumables should be available at the entrance to this area of the hotel.
- Where there are large numbers of confirmed cases arriving on a flight, a COVID-19 hotel is a more appropriate arrangement. Where the infrastructure allows, suspected cases should also be moved to an area of the hotel away from well individuals.

Potential indicators

Program delivery

- Number of adverse events arising from absent or inadequate protocols for infection control or failure to follow relevant protocols
- Nature of adverse events (de-identified) arising from absent or inadequate protocols for infection control or failure to follow relevant protocols.

Outcomes

- Outcomes of adverse events (de-identified) arising from absent or inadequate protocols for infection control or failure to follow relevant protocols

Reporting frequency

- Significant adverse events: as soon as possible after occurrence
- All others: daily

Standard 6. Allergies and dietary requirements

As part of the duty of care towards people in mandatory detention, it is essential that appropriately qualified staff document and have processes for managing quarantined individuals' allergy and dietary requirements, as failure to do this can have life-threatening consequences.

- Information on allergies should be collected from all quarantined individuals.

  Allergen (e.g. name of medication, type of food, etc)

  Allergic reaction (e.g. rash, gastrointestinal disturbance, etc)

  History of severe allergic reactions or anaphylaxis

  Use of antihistamines, corticosteroids or EpiPens

  Clinical staff should ensure that quarantined persons have adequate supplies of allergy medications. If required, urgent prescriptions should be filled and delivered to the hotel/facility
- Mechanisms should be put in place to avoid/limit quarantined individual's contact with allergens
- Dietary requirements should be collected from all quarantined individuals

  Food allergy (as above, e.g. cow's milk allergy)

  Food intolerance (e.g. lactose intolerance)

  Clinical diet (e.g. low salt diet for kidney disease)
- Screening tools that have been validated to collect details of allergies and dietary requirements should be used. If appropriate validated tools are unavailable, any tools created for this purpose should be developed by professionals with methodological expertise in survey development and content knowledge of allergy and dietary requirements
- Clinical staff identifying allergies and dietary requirements should escalate this information to appropriate operations staff to ensure that details are provided to catering providers:
- An ambulance should be called for anyone who develops a severe allergy whilst in mandatory quarantine, without needing approval from clinical staff, authorised officers or hotel staff etc. On arrival, paramedics should be given clear access to the person for whom the ambulance was called
- Documented protocols related to provision of appropriate services to meet allergy and dietary requirements should include, but not be limited to:

  Processes for dealing with food allergies, intolerances and other requirements

  Clear instructions for:

  - clinical and operations staff on how to communicate allergy and dietary requirements to catering providers
  - catering providers on how to address allergy and dietary requirements
  - quarantined persons on how their allergy and dietary requirements will be met
- Documentation should also include, but not be limited to contact numbers for next of kin of the person with an allergy
- As a safeguard, some form of door marking or sign should be used to indicate that a person in the hotel room has a significant allergy or specific dietary requirements.

Potential indicators

Program delivery

- Number of adverse events arising from absent or inadequate protocols for allergies and dietary requirements or failure to follow relevant protocols

- Nature of adverse events (de-identified) arising from absent or inadequate protocols for allergies and dietary requirements or failure to follow relevant protocols.

Outcomes

- Outcomes of adverse events (de-identified) arising from absent or inadequate protocols for allergies and dietary requirements or failure to follow relevant protocols

Reporting frequency

- Significant adverse events: as soon as possible after occurrence
- All others: daily

Standard 7. Information and data management (including medical records)

Criterion 7.1 Confidentiality and privacy of personal information (including medical records)

Operation Soteria has a systematic approach to maintaining the confidentiality and privacy of a quarantined person's personal and health information.

The *Privacy Act 2001 (Cth)* states that a patient's personal health information includes a person's name, address, account details and any health information (including medical or personal opinion) about the person.

Medical, nursing, clinical and allied heath staff have requirements relating to confidentiality in their professional registration and codes of conduct.

- Quarantined persons should be informed that their health information will be treated as private and confidential and will only be released to third parties with their consent or in compelling circumstances (e.g. concern for the patient's safety or the safety of others) as required by law
- Mechanisms should be in place to ensure that information is shared between on-site staff when necessary but within the bounds of the law. Any transfer of information to a third party without the consent of the quarantined person needs to be documented in their medical record
- Patient information in hotels/facilities should not be stored or left visible in areas where non-health services staff have unrestricted access, or where constant staff supervision is not easily provided
- Devices used to access the information management systems are only accessible to authorised clinical staff
- Screensavers or other automated privacy protection devices are enabled
- Documented protocols related to the confidentiality and privacy of personal and health information of quarantined persons should include, but not be limited to:

  Informing newly quarantined people about the information collected about them, the use of that information, the range of people (e.g. doctors, nurses, psychologists) who may have access to their medical records and the scope of that access, privacy arrangements and how they can gain access to their personal and health information

  Gaining consent from quarantined people before disclosing personal and health information to third parties

  Providing health information to another health professional if requested by the quarantined person

  Maintaining the security of information held at the hotel/facility, on private external servers or on government servers

  Retaining medical records as required by law.

- Documentation should also include, but not be limited to:

the type of personal health information that may need to be relayed to DHHS when assessing special needs of a quarantined person

how confidentiality can be maximised if a third party is present in the consultation without the consent of on-site clinical staff or patient.

Criterion 7.2 Information security (including medical records)

It is paramount that the security of confidential data on quarantined persons is maintained.

- The security of patient information (including medical records) in electronic or paper formats should be maintained through the use of secure-access information management systems
- A minimum number of secure databases should be used to prevent fragmentation of records management and reduce the risk of critical information not being available to DHHS, health or welfare staff providing for the health and welfare needs of quarantined persons
- Different staff members should have different levels of access to quarantined person's information (for example, administrative staff should not have access to the patient's medical records). In relation to medical records, the principles of patient confidentiality should be maintained unless required by law
- These records should not be accessed by anyone not providing care for the person. Specifically, these medical records must only be accessed or viewed by an AHPRA-registered health practitioner employed by DHHS to provide services to people in detention.
- On-site staff have personal passwords to authorise appropriate levels of access to health or other personal information.
- If medical notes are recorded on paper, these should be stored securely and uploaded to the information management system as soon as is practicable and within 72 hours at most
- If an on-site doctor completes an assessment, they must provide a written record of this to the on-site nursing staff, either on paper or via email, if an electronic medical record system is not available. This must be securely stored as soon as possible
- Inactive records must also be also be kept and stored securely. An inactive record is generally considered to be a record of a person who is no longer detained in mandatory detention
- An information disaster recovery plan for use in an emergency such as device failure or power failure should be established.

Back-ups of electronic information are performed at an appropriate frequency

Back-ups of electronic information are stored in a secure offsite environment

Antivirus software is installed and updated

- All internet connected devices have firewalls installed
- Documented protocols related to information security should include, but not be limited to processes for:

Collection, storage and transfer to electronic storage

Back-up and recovery of digital information

- Documentation should also include, but not be limited to:

Record of which staff are authorised to access different levels of information about a quarantined person (e.g. Personal details, contact details, medical record, COVID-19 status, etc).

Criterion 7.3 Transfer of personal information (including medical records)

On request from a quarantined individual, in an emergency, or to support a referral for health or welfare reasons, a summary or a copy of personal information (including the patient health record) may be transferred to the patient, another medical practitioner, health service provider or health service.

- Transfer of patient information in these situations should be facilitated

- Consent of the quarantined person should be obtained before transferring information, except in an emergency when they are unable to give consent and failure to transfer the information will prevent optimal care. Consent may be given for the release of some information beyond an individual consultation
- On-site staff record any requests by quarantined individuals or other reasons for transfer of health information in the medical record. This note should include details of where the information was sent and who authorised the transfer
- Any electronic data transmission of patient information over a public network must be encrypted.

Criterion 7.4 Retention of personal information (including medical records)

The *Privacy Act 1988 (Cth)* requires personal health information to be destroyed or permanently de-identified once it is no longer needed for any authorised use or for disclosure under the legislation.

The *Health Records Act 2001 (Vic)* recommends that individual patient health records be retained for a minimum of 7 years from the date of last contact, or until the patient has reached the age of 25 years, whichever is the longer. In the case of patient health information collected for the purpose of providing medical advice or treatment, it may be appropriate to retain this information indefinitely so that it is available, if necessary, to assist with the patient's future diagnosis and treatment.

- A protocol for the retention and destruction of personal health information for people in mandatory quarantine consistent with the *Privacy Act 1988 (Cth)* and *Health Records Act 2001 (Vic)* should be established and communicated to all relevant staff

Potential indicators

Program delivery

- Incidents of breach of privacy related to medical information
- Incidents related to failure to maintain adequate medical records

Outcomes

- Adverse events arising from breach of privacy or failure to maintain adequate medical records

Reporting frequency

- Significant adverse events: as soon as possible after occurrence
- All others: daily

Standard 8. Health and welfare reporting to the Public Health Commander

A series of potential indicators to measure program delivery and outcomes are presented for each Standard and a suggested reporting frequency is provided. These indicators were developed systematically to address all the issues contained within these Standards. However, it may not be feasible, or even desirable, to collect and report on them all. They remain as a comprehensive list in this document to inform current decision-making for Operation Soteria and potential measures that may be taken to address future public health emergencies.

- Final decisions on the reporting structure; content, format and frequency of reports; and methods of data collection and analysis should be determined through deliberations with all stakeholders including, but not limited to, Public Health, Compliance, Intelligence and Operations.
- Decision-making criteria should include, but not be limited to:
    - information priorities of each stakeholder group
    - risk assessment and mitigation strategies
    - program monitoring and evaluation questions

    - feasibility of, and resources required for, data collection, analysis and reporting
- Data should be assessed for accuracy (reliability and validity) and completeness. Appropriate measures should be instigated to enable and facilitate easy and accurate capture, entry and transmission of data.
- Minimum datasets for urgent, daily and weekly reporting should be established.

Public Health Policy for COVID-19 in Mandatory Quarantine

Summary

This document outlines the Department of Health and Human Services (DHHS) public health policy for COVID-19 in mandatory quarantine (Operation Soteria).

Identification and management of COVID-19 is undertaken in two scenarios – diagnostic testing of symptomatic individuals and routine testing by invitation to all persons in mandatory quarantine on Day 3 and Day 11 of the quarantine period.

Policy quick reference guide

Table 1. Management based on outcomes of diagnostic testing or Day 3 routine testing

Negative result	Asymptomatic	• Must complete 14 days of mandatory quarantine • Should still be offered testing on Day 11 and if they become symptomatic
	Symptomatic	• Remain in current location to complete 14 days of mandatory quarantine • May require repeat testing if symptoms do not improve (repeat testing should be directed by the on-site GP) • If requiring transport, they should go by Non-Emergency Patient Transport (NEPT) and should wear personal protective equipment (PPE) while in transit
Positive result	All cases	• Transfer to the COVID-19 hotel for the remainder of the quarantine period • Transport of positive cases (to home or to the COVID-19 hotel) should be by NEPT and cases should wear PPE while in transit • Close contacts sharing a room with positive cases should be encouraged to move to a separate room • When the 14-day mandatory quarantine period is complete individuals who have not yet met the department's criteria for release from isolation of a confirmed case should be managed as per confirmed cases from Day 11 testing (see box below)
	Asymptomatic	• If a person is currently asymptomatic and has no history of symptoms in the past 14 days, then the test date will be taken as a proxy for a symptom onset date (Day 0) and they will be required to isolate for 10 days from this date
	Symptomatic	• If a person is symptomatic, the isolation period will be determined as per the department's criteria for release from isolation of a confirmed case • Release from isolation will be actively considered when **ALL** the following criteria are met: – the person has been afebrile for the previous 72 hours, **AND** – at least **10 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
Not tested	Asymptomatic	• Must complete 14 days of mandatory quarantine • Should still be offered testing on Day 11 and if they become symptomatic

(declined testing or other reason)	Symptomatic	• Remain in current location to complete 14 days of mandatory quarantine • Strongly advise to be tested • Document that they are symptomatic, and that they have been offered and refused testing • If requiring transport, they should go by NEPT and should wear PPE while in transit

Table 2. Management based on outcomes of Day 11 routine testing

		Staying in Victoria on exit	**Leaving Victoria on exit (interstate or international)**
Negative result	Asymptomatic	• **Subject to the Stay at Home Directions** • Issue End of Detention Notice (standard) • Allow to exit detention	• **Subject to the Stay at Home Directions until they leave Victoria** • Issue End of Detention Notice (standard) • Allow to exit detention
	Symptomatic	• **Subject to the Stay at Home Directions** • Issue End of Detention Notice (standard) • Allow to exit detention • Advise to stay at home until symptoms have resolved for 72 hours	• **Subject to the Stay at Home Directions until they leave Victoria** • Allow to exit detention • Issue End of Detention Notice (standard) • Allow to travel interstate • Advise to stay at home until symptoms have resolved for 72 hours
Positive result	All cases	• **Subject to the Diagnosed Persons and Close Contacts Direction** • Issue End of Detention Notice (confirmed case) • If the person has more than 24 hours left in mandatory quarantine before they are due to exit, they should be transferred to the COVID-19 hotel for the remainder of the quarantine period • If the person is due to exit to home within 24 hours of receiving the positive test result, the decision to transfer to the COVID-19 hotel should be made on a case-by-case basis, and exiting from their current hotel to home on Day 14 may be the more appropriate arrangement. • When the 14-day mandatory quarantine period is complete: – Victorians who are still infectious (who have not yet met the department's criteria for release from isolation of a confirmed case) are permitted to isolate at home, if they	• **Subject to the Diagnosed Persons and Close Contacts Direction** • Issue End of Detention Notice (confirmed case) • **Must not travel interstate** • When the 14-day mandatory quarantine period is complete: – Individuals from interstate who are still infectious (who have not yet met the department's criteria for release from isolation of a confirmed case) are permitted to isolate at an identified residence in Victoria, if they can do so safely and appropriately – Individuals from interstate who cannot safely isolate at an alternative residence in Victoria may continue to isolate at the COVID-19 hotel until they meet the department's criteria for release from isolation of a

		can do so safely and appropriately – Victorians who cannot safely isolate at home may continue to isolate at the COVID-19 hotel until they meet the department's criteria for release from isolation of a confirmed case • Transport of positive cases (to home or to the COVID-19 hotel) should be by Non-Emergency Patient Transport (NEPT) • Positive cases should wear PPE while in transit	confirmed case • Transport of positive cases (to the COVID-19 hotel or to other appropriate accommodation in Victoria) should be by NEPT • Positive cases should wear PPE while in transit • If there are concerns that the person will not safely isolate in Victoria, a further Direction and Detention Notice should be considered, in consultation with the Public Health Commander and DHHS Legal
	Asymptomatic	• If a person is currently asymptomatic and has no history of symptoms in the past 14 days, then the test date will be taken as a proxy for a symptom onset date (day 0) and they will be required to isolate for 10 days from this date.	• If a person is currently asymptomatic and has no history of symptoms in the past 14 days, then the test date will be taken as a proxy for a symptom onset date (day 0) and they will be required to isolate for 10 days from this date.
	Symptomatic	• If a person is symptomatic, the isolation period will be determined as per the department's criteria for release from isolation of a confirmed case • Release from isolation will be actively considered when **ALL** 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	• If a person is symptomatic, the isolation period will be determined as per the department's criteria for release from isolation of a confirmed case • Release from isolation will be actively considered when **ALL** 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
Results pending	Asymptomatic	• **Subject to the Stay at Home Directions** • Issue End of Detention Notice (standard) • Allow to exit detention • All persons exiting mandatory quarantine who have COVID-19 test results pending should be advised to isolate until the test result is known • DHHS should ensure the test result, positive or negative, is provided to the person	• **Subject to the Stay at Home Directions until they leave Victoria** • Issue End of Detention Notice (standard) • Allow to exit detention • All persons exiting mandatory quarantine who have COVID-19 test results pending should be advised to isolate until the test result is known • DHHS should ensure the test result, positive or negative, is provided to the person and, if positive, to the relevant

			state/territory public health department
	Symptomatic	• **Subject to the Stay at Home Directions** • Issue End of Detention Notice (respiratory symptoms) • Allow to exit detention • Victorians who can safely isolate at home must do so until the test result is known • Transport by NEPT, should wear PPE while in transit • Victorians who cannot safely isolate at home or other appropriate accommodation may continue to isolate at the quarantine hotel until the test result is known • DHHS should ensure the test result, positive or negative, is provided to the person	• **Subject to the Stay at Home Directions until they leave Victoria** • Issue End of Detention Notice (respiratory symptoms) • **Must not travel interstate**, must stay in Victoria until test result is known • If there is concern that they will not follow this advice, a further Direction and Detention Notice may be issued in consultation with the Public Health Commander and DHHS Legal • DHHS will accommodate in quarantine hotel until test result is known, if they have no other appropriate/safe accommodation to isolate in Victoria • If required, transport by NEPT and wear PPE while in transit • DHHS should ensure the test result, positive or negative, is provided to the person and, if positive, to the relevant state/territory public health department
Newly symptomatic after Day 11 test		• Where a person develops symptoms after the Day 11 testing, and the Day 11 test result is negative, repeat testing should be undertaken • Management should be as per the relevant category described above	• Where a person develops symptoms after the Day 11 testing, and the Day 11 test result is negative, repeat testing should be undertaken • Management should be as per the relevant category described above
Not tested (declined testing or other reason)	Asymptomatic	• **Subject to the Stay at Home Directions** • Issue End of Detention Notice (standard) • Allow to exit detention	• **Subject to the Stay at Home Directions until they leave Victoria** • Issue End of Detention Notice (standard) • Allow to exit detention
	Symptomatic	• **Subject to the Stay at Home Directions** • Issue End of Detention Notice (respiratory symptoms) • Allow to exit detention • Strongly advise to be tested • Document that they are symptomatic, and that they have been offered and refused testing • If requiring transport, they should go by NEPT and should wear PPE while in transit	• **Subject to the Stay at Home Directions until they leave Victoria** • Issue End of Detention Notice (respiratory symptoms) • Strongly advise to be tested • Document that they are symptomatic, and that they have been offered and refused testing • Each instance must be discussed with the Deputy Public Health Commander for a risk assessment, a further

			Direction and Detention Notice may be considered, in consultation with the Public Health Commander and DHHS Legal • DHHS will accommodate in quarantine hotel until test is agreed and result known, if they have no other appropriate/safe accommodation to isolate in in Victoria • If required, transport by NEPT and wear PPE while in transit
Close contact (not tested)	All close contacts	• **Subject to the Diagnosed Persons and Close Contacts Direction** • Issue End of Detention Notice (standard) • Close contacts of confirmed cases must isolate for 14 days since last contact with the confirmed case during their infectious period • All close contacts of confirmed cases should be encouraged to separate from the confirmed case so that their new quarantine period can commence • Close contacts from Victoria are permitted to isolate at home, if they can do so safely and appropriately • DHHS will accommodate in hotel if they have no other appropriate/safe accommodation to isolate in in Victoria • If required, transport by NEPT and wear PPE while in transit	• **Subject to the Diagnosed Persons and Close Contacts Direction** • Issue End of Detention Notice (standard) • Close contacts of confirmed cases must isolate for 14 days since last contact with the confirmed case during their infectious period • All close contacts of confirmed cases should be encouraged to separate from the confirmed case so that their new quarantine period can commence • **Must not travel interstate** • If there is a concern that they will not follow this advice (i.e. if refusing to isolate in Victoria and planning to travel interstate), a new Direction and Detention Notice should be considered, in consultation with the Public Health Commander and DHHS Legal • DHHS will accommodate in hotel if they have no other appropriate/safe accommodation to isolate in in Victoria • If required, transport by NEPT and wear PPE while in transit

COVID-19 testing

Indications for testing

Symptomatic testing should occur whenever clinically indicated (i.e. if the person is symptomatic).

If a person screens positive for symptoms or a temperature at the airport, the on-call Human Biosecurity Officer (HBO) should be contacted. The HBO should arrange for ambulance transfer to the Royal Melbourne Hospital for clinical assessment and testing. Please see the current *Border Health Measures Protocol* for further information.

Routine testing for COVID-19 is recommended for all individuals in mandatory quarantine on Day 3 and Day 11 of the quarantine period.

General testing process

COVID-19 testing is voluntary. Quarantined individuals cannot be forcibly tested.

Testing should be carried out as early as possible on the day of testing (unless otherwise indicated), to ensure tests are processed and results reported in a timely manner.

Informed consent

- Information on the testing process must be provided to individuals at the beginning of the quarantine period and again before testing is carried out.
- Consideration must be given to persons from non-English speaking backgrounds who may require interpreters to give their consent.
- Informed consent must be sought and documented in the nursing health record; if a test is declined, this should also be documented.
- Refusal of testing by symptomatic persons should be escalated to the appropriate lead and included in the daily report to the Public Health Commander.

Temperature and symptom check

- A temperature and symptom check should be performed and documented each time COVID-19 testing is offered.
- If a temperature or symptoms are present, the person should be treated as a suspected case, and advised to isolate separate from other persons until the test result is known.

Personal protective equipment

Personal protective equipment (PPE) should be used as per current department recommendations (available here: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19).

Diagnostic testing for symptomatic individuals

Individuals who are symptomatic should be tested for COVID-19 as soon as is practicable.

A returned traveller who has signs or symptoms consistent with COVID-19 should be considered a **suspected case**. Suspected cases should be given the option to isolate separate from their travel companions until the test result is known.

Of note, persons may happen to develop symptoms on Day 3 or Day 11. They should still be tested as part of the Day 3 and Day 11 testing process, but it should be clearly marked on the pathology request that they are symptomatic.

Diagnostic testing for symptomatic individuals should be coordinated by the doctors and nurses working in the hotels. In this instance, the requesting medical practitioner should be the doctor looking after that particular hotel on that date. The requesting medical practitioner is responsible for provision of the result to the quarantined individual, in addition to notifying the department if there is a confirmed case.

Routine testing on Day 3 and Day 11

The purpose of Day 3 testing is to detect cases of COVID-19 early in the quarantine period, so that appropriate isolation arrangements can be made both for the case and their close contacts, but also to reduce the possibility of an extended quarantine (and possibly detention) period.

The purpose of Day 11 testing is to detect cases of COVID-19 before they are due to exit mandatory quarantine, so that appropriate isolation arrangements can be put in place, and to reduce the risk of transmission in the community.

Tailored information on the Day 3 and Day 11 testing process must be provided to individuals at the beginning of the quarantine period and again before testing is carried out. Consent should be sought and documented as per the above procedure.

Day 3 and Day 11 testing will **NOT** be requested of the following groups:

- persons who are confirmed cases of COVID-19 (unless specifically indicated (e.g. if there is a specific clinical or public health indication, as determined by the treating medical practitioner and the department's CCOM)).
- persons who already have a COVID-19 test result pending.
- approved transit passengers who are generally in transit for less than 72 hours.

It should be noted that close contacts of confirmed cases who are residing at the COVID-19 designated hotel **should** be offered Day 3 and Day 11 testing, as per standard practice.

Where it is identified in advance that individuals are observing Ramadan and are unable to have a swab taken on the morning of Day 11, the test may be conducted on the evening of Day 10.

Confirmed cases should not be tested again unless specifically indicated (e.g. if there is a specific clinical or public health indication, as determined by the treating medical practitioner and the department).

Provision of results

Results should be provided by the medical practitioner who requested the test (currently Dr Garrow of Medi7 or a delegate general practitioner from Medi7).

Results of routine COVID-19 tests should be provided to individuals as soon as is practicable, with priority given to the communication of positive results before negative results, and Day 11 results before Day 3 results.

For positive results:

- Notification to be made personally via phone to explain the results.
- Interpreters to be used as required.
- Consultation to be documented in the medical record.
- On site nurses should be notified when guests have been informed of their positive results to facilitate timely relocation arrangement, where required.
- Positive cases should be notified of their result before they are contacted by the Case and Contact team.

All results:

Nurses on site at each hotel are responsible for delivering written test results to all guests.

- Nurses receive printed copies of results (positive and negative) from VIDRL by VCS.
- On-site nurses deliver printed copy of results to each individual in their hotel room along with either:
  - 'Information for people with positive results from routine testing' letter
  - 'Information for people with negative results from routine testing' letter
- Translation and interpreters to be used as required.

Notifications to DHHS

Notification of confirmed cases to the department must be carried out by the nominated medical practitioner described above, in addition to the testing laboratory.

Repeat swabbing

Repeat testing should not be carried out for confirmed cases, unless recommended by the department or required for a specific purpose (e.g. to return to work in high risk settings, to enable visitor access to hospital, etc).

Clearance testing is not currently required for release from isolation, nor for release from mandatory quarantine.

Case and contact management

Confirmed cases

Nurses should temperature check and review symptoms of confirmed cases daily. This should be documented in the nursing record, along with the date of the acute illness onset.

Diagnosed in mandatory quarantine

Confirmed case management is provided by a Case and Contact Officer (CCO) from the department.

Positive cases (regardless of symptom status) should be transferred to the COVID-19 hotel for the remainder of the mandatory quarantine period.

Isolation periods will be determined as follows:

- If a person is currently asymptomatic and has no history of symptoms in the last 14 days, then the test date will be taken as a proxy for a symptom onset date (Day 0) and they will be required to isolate for 10 days from this date.
- If a person is symptomatic, their isolation period will be determined as per the department's release from isolation criteria.

When the 14-day mandatory quarantine period is complete:

- Individuals from Victoria who are still infectious (who have not yet met the department's criteria for release from isolation of a confirmed case) may return home to complete their isolation, if they can do so safely and appropriately at home.
- Individuals from interstate, and Victorians who cannot safely isolate at home, may continue to isolate at the COVID-19 hotel until they meet the department's criteria for release from isolation of a confirmed case.

Positive cases requiring transport should be transported by Non-Emergency Patient Transport (NEPT) and should wear PPE whilst in transit.

Entering mandatory quarantine

Confirmed cases (currently infectious or recovered) entering mandatory quarantine should be accommodated in the COVID-19 hotel.

The required isolation period will be determined by the Case and Contact team on a case-by-case basis.

COVID-19 hotel

If a confirmed cases is due to exit mandatory quarantine within 24 hours to isolate at home in Victoria, the need for transfer to the COVID-19 hotel can be assessed on a case by case basis (taking into account the duration of time the person will need to say at the COVID-19 hotel, and the risks associated with transfer between sites).

If a confirmed case (and potentially their family members or close contacts) are being transferred to the COVID-19 hotel, these transfers should take place during the day where possible.

Close contacts

Close contact management is provided by a Case and Contact Officer (CCO) from the department.

Close contacts of confirmed cases (whether symptomatic or asymptomatic):

- Must isolate for 14 days since last contact with the confirmed case.
- Should be encouraged to separate from the confirmed case so that their new quarantine period can commence.

Close contacts from Victoria who have completed the mandatory quarantine period but not the close contact quarantine period will be permitted to isolate at home (if safe and appropriate isolation arrangements can be made), otherwise they will be accommodated by DHHS in appropriate accommodation.

Isolation and exit arrangements

Isolation arrangements

Persons sharing a room must be informed that this may have implications for the amount of time they are required to quarantine (although not their mandatory detention period) should one of them become a confirmed case.

Where one person in a room becomes symptomatic or a confirmed case, the persons in the room should be advised to isolate in separate rooms.

Release from isolation

Symptomatic cases

Confirmed cases of COVID-19 will be considered for release from isolation and early release from mandatory quarantine, once they meet **ALL** the department's criteria for release from isolation of a confirmed case:

- 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

Clearance testing is not required for release from isolation, either in the home or in mandatory quarantine.

Asymptomatic cases

Asymptomatic cases of COVID-19 will be considered for release from isolation and early release from mandatory quarantine once they have been asymptomatic for 10 days since the test result.

Process for release from isolation

As per the DHHS guidelines for health services and general practitioners (see https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19), the department will determine when a confirmed case no longer requires to be isolated in mandatory quarantine, hospital or in their own home.

- Every confirmed case that is diagnosed in Victoria is notified to the department and assigned a case and contact officer (CCO), regardless of whether they are diagnosed in detention or outside of detention. Every confirmed case receives daily contact from the case and contact team.
- The CCO will advise when it is appropriate for consideration for release from isolation, and will issue a clearance certificate (via email) to COVIDquarantine@dhhs.vic.gov.au for the case when they meet the criteria for release from isolation.

Exit arrangements

Appropriate transport, accommodation and isolation/quarantine arrangements should be planned and in place for close contacts, confirmed and suspected cases about to exit mandatory quarantine. These arrangements should be in keeping with DHHS policy as per Table 2 above.

Any deviations from the agreed policy must be escalated to and approved by the Compliance and Enforcement Lead, and the Deputy Public Health Commander for Physical Distancing.

Transport arrangements

All quarantined individuals requiring transport during the mandatory quarantine period should wear PPE whilst in transit. Non-emergency transfers of individuals where relevant (e.g. to the COVID-19 hotel) should be by Non-Emergency Patient Transport (NEPT). In the case of an emergency, transfer should be by emergency ambulance by calling 000.

Annex 3 – COVID–19 Operational guidelines for mandatory quarantine

Annex approver: DHHS Commander COVID-19 Accommodation

Last version date: v2.0 1 June 2020

Purpose

The purpose of this Annex is to provide operational guidance in order to manage each stage of the mandatory quarantine process. This Annex outlines the activities required to provide safe, efficient and effective hotel operations for the management of passengers arriving at Victorian ports who are subject to mandatory quarantine within Victoria.

Permission to access this document or any links contained, can be requested by emailing DHHSOpSoteriaEOC@dhhs.vic.gov.au.

Scope

This document addresses the public health operational requirements for managing mandatory quarantine.

Audience

This document is intended for use by DHHS staff, other agencies, health care workers and other people involved in the care of individuals in mandatory quarantine (detention).

Standard Operating Procedures (SOPs) have been developed for all cells of operation and outline the roles and responsibilities of staff in transitioning new arriving passengers through the **Ports of Entry (in draft),** **Mandatory Quarantine Hotels** and the **Emergency Operations Centre.**

1. Emergency Operations Centre (EOC)

The Operation Soteria Emergency Operations Centre is located in Fitzroy. The EOC is organised around an AIIMS structure with four leadership roles (Commander, and three Deputy Commanders) and three core functional sections, Operations, Planning and Logistics. The Standard Operating Procedures for the EOC are currently under development.

2. Ports of Entry (airports and maritime).

Priorities for DHHS operation staff include:

- Supporting the health and wellbeing of incoming passengers, DHHS staff, and staff from other agencies contracted for airport and maritime operations.
- Liaison with ports command (including both airport and maritime) and staff from all agencies to ensure the safe and appropriate movement of arriving passengers, deemed by compliance for transfer to the mandatory quarantine hotels, or for those passengers requiring immediate health and wellbeing attention to appropriate hospitals care. This includes transport and accommodation needs.
- Providing situational awareness and intelligence to inform transport providers, hotel operations and State – level emergency management of the current number and requirements for newly arriving passengers and/or crew as required.
- Provide a point of reference to all site and virtual staff to resolve issues for resolution, including logistics, compliance and escalation to command.
- Ensure appropriate records management processes adhered to.

- Conduct operational priorities in a manner that align to Standard 1: *Rights of people in mandatory quarantine* as outlined in Annex 2 of this document.
- Provision of welcome pack to all arriving passengers, assess. liaise and coordinate the immediate needs of arriving passengers and provide advice as required. EOC command will be provided intelligence on the high-risk immediate needs of arriving passengers.

2.1 Airport screening and assessment of immediate health and wellbeing risk factors

In accordance with Annex 2, Standard 2; *Screening and follow up of health and welfare risk factors* DHHS nurses and Department of Agriculture, Water and the Environment (DAWE) biosecurity officers will screen all passengers arriving from overseas for symptoms of COVID-19. This symptom check includes questions about cough, sore throat, breathing difficulties, headaches and other symptoms of unwellness (as per the health screening protocol for Melbourne airport). Nurses will perform a temperature check on each passenger. If a person screens positive on the symptom check, or on the temperature check (temperature >37.8 ˚C), the Human Biosecurity Officer (HBO) will be contacted by the DAWE biosecurity officer to arrange for testing as outlined in Section 2.3 of this document.

2.2 Airport arrival and hotel documentation

Guests receive information when they arrive at the airport. They are required to complete a Welfare questionnaire and a food safety questionnaire to provide at arrival at the hotel.

Upon arrival at the hotel, and throughout their stay, guests will also receive various factsheets and newsletters to provide information that supports them during their stay. All current information being provided to guests is available at current information for hotel guests.

Annex 1 *COVID-19 Compliance Policy and procedures – Detention authorisation* outlines the responsibilities of Authorised Officers at ports of arrival and hotels.

2.3 Management of an unwell person (Suspected or positive COVID-19)

2.3.1 Airports

The lead for this situation is the HBO on behalf of the Deputy Chief Health Officer (Communicable Diseases). Any passengers who screen positive on the airport health check will trigger the DAWE biosecurity officer to contact the HBO on-call for the department via 1300 651 160. After discussion with the HBO, if it is determined that the person meets the criteria for a suspected case of COVID-19, the following actions should be taken.

The HBO should organise an ambulance transfer to the appropriate health service Royal Melbourne Hospital (or Royal Children's Hospital) for testing and assessment.

The DHHS authorised officer (AO) at the airport should:

- Issue the person their detention notice.
- Log the person as requiring mandatory quarantine at a specified hotel.
- Provide an information sheet to travel with the person to provide to the hospital advising that the person is being detained in mandatory quarantine. This includes the phone number for the hospital to call when the person is ready for discharge so that transport can be organised by the hotel team leader (patient transfer/ambulance/maxi taxi etc.) to return the person to the hotel.

Provide a permission to enable the person to be transported to the hospital and, following medical release, be transported back to the hotel.

- Follow-up with the hospital to update on the person's situation.

The person must remain at the hospital until the result of their COVID-19 test is known if they are showing symptoms of COVID-19.

After the test result is known, if they are well enough to be discharged from the hospital, transfer (by patient transfer/ambulance/maxi taxi etc.) can be organised to bring the person to the assigned hotel.

- If the person has a positive test result (i.e. they are a confirmed case), they should be transported to the COVID-19 hotel.
- If the person has a negative test result, they can be situated in a general part of the hotel.
- The AO must ensure the room number is included on the detention notice.

If the person is unwell and requires admission to hospital, the Compliance / AO Lead should be informed and the EOC.

2.3.2 Seaports

All international vessels and goods become subject to biosecurity control on entering Australian territorial seas. Vessels subject to biosecurity control must only enter Australia at ports that have been determined as first points of entry under *The Biosecurity Act 2015 (C'th),* unless permission has been granted to enter a non-first point of entry.

All aircraft and maritime vessels are required to obtain permission (pratique) before docking or landing at Victorian ports and complete a pre-arrival-report (PAR). The PAR for maritime vessels is submitted through the Maritime Arrivals Reporting System and is sent through 12-96 hours in advance of arrival. This information goes to the Maritime National Coordination Centre (MNCC).

If conditions change after the issue of a PAR, the operator of the vessel must notify the port or the MNCC as it may change whether pratique is automatically granted or if the vessel needs to obtain negative pratique from a Biosecurity Officer (BO).

All travellers arriving at seaports who are subject to mandatory quarantine will undergo health screening on arrival at the port of entry (NOTE: individual arrangements may be put in place at seaports depending on the circumstances).

2.3.2.1 Advanced notification of an unwell crew member on a maritime vessel

If there has been advanced notice of a passenger or crew member with COVID-19 symptoms

If a passenger or crew member meets the current criteria for COVID-19 testing in Victoria (https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19), the passenger or crew member will be required to be tested. The BO (or the MPL on behalf of the BO) notifies the HBO and the HBO will either:

- Arrange for testing to be done by the vessel's doctor or a DHHS contracted nurse at the port; OR
- Where testing cannot be done by the vessel's doctor or DHHS contracted nurse, the HBO will arrange ambulance transfer to hospital for testing.

If an onshore healthcare worker is required to board the vessel e.g. to conduct testing, they will not board a vessel at anchorage, it must be berthed.

No one will be allowed on or off the vessel until the results are known except at the discretion of the BO or HBO.

If all testing for COVID-19 is negative, and there are no concerns about other Listed Human Diseases, the HBO will contact the BO and grant pratique.

If any test for COVID-19 is positive, the HBO in conjunction with the DPHC: Physical Distancing will determine appropriate management of cases, and handover to the Case and Contact Management Team (DHHS) for ongoing public health management.

Classification of contacts with confirmed cases of COVID-19 will be made on a case-by-case basis via a risk assessment coordinated by the DPHC: Physical Distancing, with appropriate management of contacts and other people on the vessel depending on the outcome of the assessment.

If the crew member needs non-urgent medical attention and the Biosecurity Officer deems the complaint is not related to one of the Listed Human Diseases (i.e. they do not need to activate the HBO), they may allow the crew member to disembark the vessel to seek medical attention without HBO approval.

2.3.2.2 No previous notification of an unwell crew member on a maritime vessel

If the BO is alerted to an **unwell crew member** (and there has been no previous notification), they will meet and board the vessel to administer a TIC.

- If a person is identified as positive on the TIC form, the BO will contact the HBO, who will undertake further assessment as detailed above

Additional information is outlined in *Border Health Measures at Victorian International Ports (Air and Sea)* (currently in draft and is awaiting approval).

2.4 Refusal of testing

2.4.1 At the airport

If a person refuses to be transported from the airport to hospital for COVID-19 testing, and they are only mildly symptomatic (as per assessment made by the DHHS nurse and the HBO):

- They should be transported to the hotel
- They should be treated as a suspected case of COVID-19 and offered testing again at the hotel
- If they refuse testing at the hotel they should be treated as if they are COVID-19 – they must be situated at the COVID-19 hotel
- They should be encouraged to comply with testing, but they cannot be forcibly tested.

2.4.2 At the hospital

If a person refuses testing for COVID-19 at a hospital and they are well enough to return to the hotel:

- Every effort should be made to encourage them to get tested before leaving hospital to allow for the most appropriate quarantine location at the COVID-19 hotel, they cannot be forcibly tested.
- If they continue to refuse testing, they should be transported back to the hotel and treated as if they are COVID-19 positive - they must be situated the COVID-19 hotel.

If a person refuses testing and treatment at a hospital and is too unwell to be released from hospital, a Human Biosecurity Control Order (HBCO) may need to be considered.

2.5 Management of an unwell person (not COVID-19) related

Incoming passengers may present to the ports of entry with non-COVID-19 related health or wellbeing concerns. These passengers must be reviewed by the nursing staff and assessment and management facilitated through the most appropriate hospital as per the hospital transfer plan.

3. Quarantine and isolation arrangements

3.1 Accommodation options to promote effective quarantine

There are a number of accommodation options for people – such a couple or family – to promote effective quarantine. Request for accommodation preference is requested at the airport by DHHS contracted staff to allow rooms to be allocated on arrival to the hotel. If a person at this time is known to be positive for COVID –19 the companions should be advised of the risk of the options of staying together.

In instances where two or more well people (who are not suspected or confirmed cases of COVID-19) wish to share a room in advance of check-in at the hotel, this should be facilitated. However, they should be informed that sharing a room may have implications for the amount of time they are required to quarantine (although not their mandatory detention period) should their roommate become a confirmed case.

When a person within a party or group is identified as positive for COVID-19 in the hotel, the Doctor is responsible for the notification to the person and the Departments Case and Contact Management team. The case and contact management team will contact the positive person and do a review to identify close contacts, including other family members or friends who have been cohabiting. They will provide advice to the close contact regarding their need to commence a further 14 days of quarantine from the date of last contact with the infectious person (explained further below), including recommendation of the option to separate people – if they consent – at various points in the quarantine journey.

Option 1 – Parties stay together

A couple or family stay together and share a suite or room. If a person becomes positive, an extension of quarantine will be required on a tailored basis for the other persons.

Option 2 – Parties separate from arrival at the hotel

A couple or family are separated from the outset. If a person becomes positive, the other parties do not need to recommence 14 days of quarantine.

Option 3 – Parties are separated once one person becomes positive

A couple or family separate into different rooms (with no contact thereafter) after a person becomes positive for COVID-19.

The non-infected persons then start a new 14-day quarantine period, which is served at home once they complete the mandatory 14-day period in the hotel.

Option 4 – Parties stay together after one person becomes positive

The parties stay together. At the end of the 14-day period, they both leave to home isolation, and the non-infected persons commence a further 14-day quarantine period, as long as they separate in the house to which they go.

It should be noted that returning passengers who reside in states other than Victoria may be unable to travel home to their home state if they become positive or a close contact of an infected individual.

3.2 Communication of these options to people in mandatory quarantine

The DHHS Team Leader will coordinate the movement of guest and their companions to the COVID –19 hotel and the Authorised Officer will manage the change in detention notice. Once movements have occurred the EOC and Public Health will be notified of the locations of affected people.

4. Mandatory Quarantine Hotels

4.1 Team Leaders

Team Leaders are employed by DHHS to provide a safe environment for people who are required to enter a period of compulsory quarantine at a hotel after returning from overseas. They are also responsible for managing all aspects of the passengers stay in accordance with all extant policies and procedures. The Team Leaders' Pack has been developed to provide a summary of all policy and procedures and contains hyperlinks to source documents. The Team Leaders' Pack is a live document and all updates are communicated from the EOC to Team Leaders in daily briefs.

4.2 On arrival

Upon arrival at the quarantine hotels, passengers receive information packs. Current information provided to passengers can be accessed via Current information for hotel guests. Passengers will also receive additional Newsletters. to provide information that supports them during their stay.

The process for passengers arriving at hotels and the documentation they are required to provide is detailed in the Team Leaders' Pack.

4.3 COVID-19 positive hotels

Any person who is confirmed as having COVID-19 as a result of a positive test, should be relocated to the COVID-19 hotel. Appropriate signage, PPE and other consumables should be available at the entrance to this hotel. Further information regarding procedures for managing accommodation for COVID-19 positive guests and their close contacts can be found in Positive Hotels Guidance (draft awaiting approval).

5. Confirmed cases entering detention

5.1 Current infectious cases

In the situation that an arriving passenger is a current infectious case of COVID-19:

- They will still be handed the detention notice and placed in mandatory quarantine.
- They will be given a single-use face mask to wear and will be kept separated from the other passengers where possible.
- At the hotel, they will be asked to provide confirmation of their diagnosis.
- If there is any doubt surrounding the certainty of the diagnosis of COVID-19, they will be offered additional testing.

5.2 Recovered cases

In the situation where an individual self-reports they were a confirmed case of COVID-19 and have recovered from the infection:

- They will still be handed the detention notice and placed in mandatory quarantine.
- The onus is on the individual to provide the evidence that they had a confirmed case of COVID-19 and the required amount of time has passed such that they are no longer considered infectious.
- The department will decide on a case-by-case basis whether evidence from other sources (from testing done overseas) can be considered sufficient proof to inform clinical and public health decision-making.
- If they meet the criteria for release from isolation (see below) and the testing and medical reports provided are considered sufficient by the department; they may be considered for release from detention.

- They will still be handed the detention notice until this can be verified, and the request has been approved.

Note – there are no automatic exemptions for persons who are recovered cases. These requests need to be assessed on a case-by-case situation.

6. Provision of health and welfare services

As per Annex 2, Standard 3 *Provision of health and welfare services*, Operation Soteria has a flexible on-site system for the provision of health and welfare services that can accommodate urgent, non-urgent, complex, planned chronic care and preventive health needs The excerpts below outline these practical procedures.

6.1 Clinical assessment and testing for COVID-19

The objective of this testing program is to identify potential cases of COVID-19 amongst returned travellers who have a higher likelihood of being positive than the Australian population. The SOP for COVID-19 testing containing information on required schedules, PPE, and procedures is found in **Enhanced Testing Programme for COVID-19 In Mandatory Quarantine**.

6.1.1 Indications for testing

If a quarantined individual has any signs or symptoms consistent with COVID-19 infection at any time during the mandatory quarantine period, they must be offered testing that day (or the following morning if overnight).

Indications for testing include:

Signs of symptoms of COVID-19 (e.g. fever, chills, cough, shortness of breath, sore throat, fatigue, runny nose, anosmia).

- A nurse or doctor recommends testing.

The person had a positive test result overseas and the overseas laboratory result does not meet the required reporting standards in Victoria.

- It is requested by Public Health (DHHS) as part of a specific testing initiative.

Nurses and doctors working across the hotels must familiarise themselves with the clinical presentation of COVID-19 and should be familiar with the department's guidance which is available in Health services and general practice - coronavirus disease (COVID-19).

It should be noted that a lower clinical threshold for COVID-19 testing should apply in mandatory quarantine due to the high-risk nature of the setting and the population.

6.1.2 Timing of testing

Individuals in mandatory quarantine should be tested for COVID-19 at the following times:

- If they screen positive on the health screen (temperature and symptom check) at the airport.
- If they report symptoms during a nurse check or welfare check or at any other time during quarantine.
- On day 3 and/or day of 11 of the mandatory quarantine period, regardless of symptoms, persons in quarantine will be offered a voluntary testing.

When testing is indicated, it should be performed that day so that results are returned as soon as possible (which will inform quarantine arrangements). If symptoms occur over night, the testing should occur no later than the following morning.

Failure to offer COVID-19 testing to an individual in mandatory quarantine who is symptomatic should be considered a risk which needs to be reported to the EOC and investigated accordingly.

6.1.3 Refusal of testing

If a quarantined individual has signs or symptoms consistent with COVID-19 (i.e. testing is indicated) is offered testing, but refuses to be tested, this should be documented in detail in the nursing record. The importance of testing should be explained to the person. Any refusal of testing by symptomatic persons should be escalated to the team leader and command at EOC and should be included in the daily report to the Public Health Commander.

6.1.4 Communication of results

It is the responsibility of the medical practitioner who ordered the test to follow-up the result of the test and ensure arrangements are in place to advise the patient of the result, whether negative or positive. If they are not able to do so, they must handover this task to the next doctor on-call, inform the nurse, and record this in the medical record. If the result is positive, the requesting medical practitioner must notify the department on REDACTED

6.2 Case management

6.2.1 Management of suspected cases

The following actions should be taken once a quarantined individual is a suspected case:

- Suspected cases should be isolated in a separate room away from other quarantined individuals if feasible.
- If this is not possible and they are sharing a room with another person or persons, they should be given a single use face mask and advised to physically distance themselves (> 1.5m) from other persons in the room, practise hand hygiene and cough and sneeze etiquette, open a window(if possible), and clean/sanitise surfaces and common areas.
- If they have been isolated in a separate room, when the result of the test is known they can either return to their original room, sharing with other quarantined individuals (if negative), or relocated to the COVID-19 hotel (if positive).

6.2.2 Management of confirmed cases

The following actions should be taken once a quarantined individual is a confirmed case:

They should be accommodated / cohorted at the COVID 19 hotel

- The medical practitioner who requests the COVID-19 test is responsible for notifying the department of a positive result and notifying the patient (or handing this over to the doctor on call)
- A case and contact officer (CCO) from the department will then contact the case and perform a case interview
- The case's roommates will be listed as close contacts and will also be contacted and monitored by the department. They will be given the opportunity to isolate in separate rooms for the remainder of their time at the hotel. They will be required to quarantine 14 days post the last contact with the positive roommate.
- The CCO will have daily contact with the case until they are ready to be released from isolation (and therefore detention)
- Appropriate PPE (droplet and contact precautions) should be worn by all persons having contact with the confirmed case.

Further guidance relating to passengers who receive a confirmed diagnosis of COVID-19 during the 14-day detention period can be found here.

6.2.2.1 Quarantined individual becomes a confirmed case

If a hotel detainee becomes a confirmed case, they are followed up by the New Cases team.

An interview is conducted to identify possible acquisition and close contacts. The difference between the 14-day mandatory hotel quarantine period and the isolation requirements during their infectious period are explicitly explained. The case will have been told this information on arrival and relocated to the COVID-19 hotel.

The EOC is informed via email of the confirmed case. If it is identified that people wish to separate, an additional room is requested in the email.

A confirmed case is contacted daily by the Existing Cases team for a risk assessment of symptoms

Nurses should review confirmed cases daily for symptoms and take their temperature. This should be recorded in the nursing record, and may be used to inform clinical decision-making regarding release from isolation.

If a confirmed case meets the release from isolation criteria within the 14-day mandatory quarantine period, the PH Ops emails COVID quarantine and the EOC and provides a standardised letter informing the case they have met their release from isolation criteria

The case is informed of the release process, and to expect contact by the Hotel Team Leader

If a confirmed case meets the release from isolation criteria after the 14-day mandatory quarantine period is completed and is not a Victorian resident or is a Victorian resident and cannot return to an appropriate location, PH Ops emails the EOC and requests extended accommodation to be arranged. The outcome must be provided back to PH Ops

If a confirmed case meets the release from isolation criteria after the 14-day mandatory quarantine period is completed and is a Victorian resident that can continue to quarantine within their home, the PH Ops emails the EOC to request arrangement of transport. The outcome must be provided back to PH Ops.

6.2.2.2 Quarantined individual becomes a close contact

Close contacts are followed up by the New Close Contact team:

The difference between 14-day mandatory hotel quarantine period and the 14-day quarantine period from last contact with a confirmed case is explicitly explained. If currently sharing a room, they are advised that their quarantine period will be extended and are advised to separate

If they wish to separate, the PH Ops emails EOC and request an additional room be organised for the close contact at the COVID-19 hotel

A close contact is contacted daily by the Existing Contacts team to assess if they have developed symptoms and assess if they are still sharing a room. If still sharing, the Existing Contacts team again recommend separating and explicitly explain that their 14-day quarantine period will be extended. If it is identified that people wish to separate, the PH Ops will email the EOC and request an additional room be organised

If a close contact develops symptoms and requires testing, the Existing Contacts team emails the EOC to arrange testing

If a close contact (Victorian resident) has completed their 14-day mandatory quarantine period but is still within their 14-day quarantine period, the PH Ops emails EOC to request transport be arranged for them to return home for the remainder of their quarantine period. The outcome must be provided back to PH Ops

If a close contact (non-Victorian resident or Victorian resident that cannot return to an appropriate location) has completed their 14-day mandatory quarantine period but is still within their 14-day quarantine period, the PH Ops emails EOC and requests extended accommodation to be arranged. The **outcome must be provided back to PH Ops**

If an interstate resident wishes to return to their home state for the remainder of their quarantine period, this may be considered on a case by case basis

Appropriate hygiene precautions must be taken if travelling by air (i.e. face masks) and people must return straight home. The home jurisdiction must be informed so they can be followed up as close contacts by their home jurisdiction.

The *Operation Soteria Clinical Governance Framework* is currently in draft and awaiting approval from *SaferCare Victoria.*

7. Transport of COVID-19 positive,close contact and other guests

A SOP has been developed to provide guidance on transporting confirmed COVID-19 cases and their close contacts in a way that minimises the risk of further spread of the disease. This document can be found in Transport Guideline, COVID-19 Cases and Close Contacts. It also sets out transport arrangements for presenting to hospital for medical care, and transport arrangements at the end of quarantine. This guide applies to hospitals, health services, mandatory quarantine sites, transport providers, and others needing to coordinate the movement of individuals.

For all medical emergencies call Ambulance Victoria '000'. If 000 is called, the reference number is to be recorded in the Incident Report.

For all non-emergency patient transport (NEPT).

The Ambulance Emergency Operations Centre (AEOC) will coordinate all non-urgent transfers, including St John Ambulance. This service is available seven days a week. As much as possible, these arrangements should be utilised between 08:00 am and 4:00 pm.

Complete the Operation Soteria Patient Transport Request Form

Contact the AEOC on 1300 851 121 between 8:00 am – 8:00 pm.

Commercial taxis

Bookings can be made through 13cabs (03) 9277 3877. Wheelchair accessible commercial passenger vehicles (WAVs) may be used to transport COVI-19 positive passengers where non-emergency patient transport services are not available.

Refer to the current 'Guidelines for health services and general practitioners' (see https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19).

8. Welfare Check Team and Complex Assessment and Response Team

8.1 Welfare Check team

The Welfare Check Team is located offsite from the hotel and their primary role is to conduct two phone surveys with guests on day 3 and 9 of their hotel quarantine period.

On day 3 the Welfare Check Team will undertake a comprehensive health, wellbeing and safety assessment. This will including verifying health information provided by guests upon hotel arrival to ensure essential information about medications, allergies or health issues have been identified and are being managed appropriately.

The team will seek to understand if there is anything that makes the guest feel unsafe, such as family violence and drug and alcohol dependencies and refer for escalation of risks as required. Identify what wellbeing strategies they can utilise to help them cope with hotel quarantine such as exercise, keeping in

contact with loved ones etc. In addition, guests will also be asked to think about their exit strategy, in preparation for their exit from hotel quarantine.

On day 9, a shorter assessment is undertaken with guests to identify whether their needs are being met and to capture any feedback about their experience.

8.2 Complex Assessment and Response Team

Complex Assessment and Response Team is located offsite from the hotel and take referrals from all services supporting the hotel detention including nurses, the hotel team leader, the Welfare Check Team, DJPR and AOs. CART are responsible for undertaking assessments where an individual and/or family is identified as having complex needs and requires support. CART can develop safety plans and risk management plans, which are informed by specialist, and work with professionals to ensure these plans are implemented at the hotel. In addition, they can assist an individual and/or family with an application for financial hardship assistance relating to accommodation stays. Please refer to the Returned Traveller Hardship Policy for further information.

For more information on the specific roles and responsibilities of each team, please refer to Welfare Cell at a glance.

9. Exercise area implementation plan

Quarantined guests will be provided with access to fresh air in line with the endorsed Exercise and Fresh Air Implementation Plan. Team leaders are to ensure that PPE is available, and procedures are followed in accordance with the PPE guidelines pertaining to healthcare workers and hotel security and AOs.

10. Food ordering information

Operation Soteria will endeavour to ensure all passengers dietary requirements will be met. Specific guidance concerning processes for people with food allergies or dietary requirement, including information on reimbursements of meal from external suppliers, is found here.

Passengers that don't have dietary requirements are able to order from any food delivery platform however it will be at their own expense.

Further details on ordering food is located in sections three and four of the Food Management Policy.

11. Hotel delivery policy and acceptance

11.1 Care package delivery

Passengers can arrange to have items picked up from your family and friends in Victoria and delivered to the hotel through the Government Support Service. This service is provided at no charge and can be used twice during their 14-day quarantine. If passengers live interstate, they will need to arrange a Melbourne collection point for their care parcel.

11.2 Supermarket Delivery

Supermarket delivery is available to all passengers. As with home delivery perishable and cooked food, alcohol, and cigarettes will be destroyed if delivered in any care parcel. Illicit drugs will be handed to Victorian Police.

Further information on hotel deliveries are located in sections 4.3 of the Food Management Policy.

12. Medication Policy

All medicines and poisons located and utilised in hotels where passengers are undertaking mandatory quarantine, shall be stored in accordance with the Operation Soteria Medicines and Poisons Storage Policy. The doctor / general practitioner on-duty will determine what pharmaceuticals need to be ordered.

Pharmaceuticals can include:

- Prescription and over the counter (OTC) medications
- Cleaning wipes
- Hand sanitiser
- Batteries for medical equipment
- Covers for medical equipment
- Garbage bags

Additional information on ordering pharmaceuticals can be found in the Team Leader Pack.

13. Infection control and hygiene

Information on infection control and use of PPE can be found of the Department of health and Human Services Website via the following links:

Information for healthcare Workers can be found at:

https://www.dhhs.vic.gov.au/coronavirus-covid-19-guide-conventional-use-personal-protective-equipment-ppe

Information for Community Service Providers can be found:

https://www.dhhs.vic.gov.au/ppe-community-service-providers-prevention-covid-19

14. Escalation Process

Wherever possible, the principle of local resolution should be applied. Team Leaders should utilise resources at their disposal (the hotel, Authorised Officer, nurses and other medical staff) to try and resolve issues directly.

If the hotel team is unable to resolve the complaint, escalate to the EOC Operations Lead via email to dhhsopsoteriaEOC@dhhs.vic.gov.au direct the guest to the DHHS complaints process at https://www.dhhs.vic.gov.au/making-complaint. Available on this website is a fact sheet on how to make a complaint (available in easy-English format and multiple other languages), along with the current DHHS Feedback management policy.

Complaints can be registered online (eform), via email or over the phone. The DHHS Feedback team will register the complaint and refer to the appropriate team for resolution.

HR / staff complaints are to be emailed to the EOC via dhhsopsoteriaEOC@dhhs.vic.gov.au and will be managed by the Deputy Commander Hotels.

Further information with regard to the management of major incidents or alleged major incidents is contained within Quarantine incident Reporting (draft, awaiting approval).

15. Interpreter booking process

For all interpreter requirements ‘Language Loop’ is the provider that is used. The contact number for this service is 03 9280 1955 (For calls greater that 90 minutes use 03 9280 1900 to make a booking). The detailed process for interpreter bookings is located in the Team Leader Pack.

16. Other Logistics

16.1 PPE

Hotels are required to hold a minimum supply of PPE to last three business days. All PPE requests are processed by the EOC logistics team using the PPE Request Form. The completed PPE request form with subject line **PPE Order <hotel name>** is sent from the hotel to the EOC via email to**:** dhhsopssteriaeoc@dhhs.vic.gov.au

16.2 Ordering other stores

Hotels have a limited capacity to order stores directly. All other stores requests (medical, stationary etc) are emailed directly to dhhsopssteriaeoc@dhhs.vic.gov.au and processed through the appropriate channels.

Additional information on ordering stores, and minimum requirement of logistical stores to operate. can be found in the Team Leader Pack.

16.3 Clinical waste

The collection of clinical waste and sharps containers is undertaken by external contractors. The complete process can be found in the Team Leader Pack.

17. Departure – release from mandatory detention

17.1. Departure - Criteria for release from detention

Further information with regard to the criteria for release from detention can be found in Annex 1 *Chapter 5.8 Departure - Release from mandatory detention.*

Clearance testing is **not** required for release from isolation, either in the home or in mandatory quarantine.

Prior to release, health checks will, be undertaken by nursing staff on the second last day prior to the 14-day period ending, this is not mandatory.

If people being detained have a temperature or other symptoms of COVID-19 before leaving or at the health check in, this will not affect the completion of their detention. They will not be detained longer than their 14-day detention period. The policy for exiting processes can be found here Exit of accommodation arrangements.

17.2 Process for release from detention of a confirmed case

The department will determine when a confirmed case no longer requires to be isolated in mandatory quarantine, hospital or in their own home.

Every confirmed case that is diagnosed in Victoria is notified to the department and assigned a case and contact officer (CCO), regardless of whether they are diagnosed in detention or outside of detention. Every confirmed case receives daily contact from the case and contact team.

The CCO will advise when it is appropriate for consideration for release from isolation, and will issue a clearance certificate (via email) to COVID.quarantine@dhhs.vic.gov.au for the case when they meet the criteria for release from isolation.

Nurses looking after confirmed cases in detention should temperature check and review symptoms of confirmed cases daily. The date of acute illness onset should be clearly documented in their records.

Everyone is to be offered a voluntary temperature and symptom check by a nurse 24 hours before release.

17.2.1 Release from detention of a confirmed case

Confirmed cases who leave detention but have not yet met the department's criteria for release from isolation are subject to the *End of Detention Notice (confirmed case not cleared infection)*.

They will not be detained longer than the 14-day quarantine period.

They will be released from detention at the agreed time, but will be subject to an *End of Detention Notice (confirmed case not cleared infection)*.

They should be assisted to self-isolate at home or in another suitable premises in Victoria until they meet the required criteria.

A premises is considered suitable if it has a facility/room where the person can be isolated so as not to cause undue a risk for another householder (i.e. not a hostel or dormitory accommodation).

They will be given a single-use face mask to wear when checking-out from the hotel and in transit to their next destination.

They will be provided with a 'confirmed case' information sheet.

Further information with regard to this process can be found in Annex 1 *Chapter 5.8 Departure - Release from mandatory detention.*

Should a guest not have an appropriate location to travel to or is unable to return to their home state alternative directions may be used on a case by case basis as directed by the Compliance team.

17.2.1.1 Non-emergency ambulance transport

When a confirmed case of COVID-19 who is considered still infectious (but is stable) is assessed as appropriate for transition to isolation in their home and is nearing the end of the 14-day quarantine period, Ambulance Victoria (AV) will be requested by the DHHS Team Leader to provide non-emergency patient transport (NEPT) for that person to a destination in Victoria that is the assessed appropriate home isolation location.

If there are multiple persons to be transitioned to home isolation on the same day, subject to compliance-related logistics and any privacy considerations being met, it is permissible for two or more potentially infectious confirmed cases of COVID-19 to be transported together in one NEPT, i.e. to cohort confirmed cases.

17.2.2 Suspected cases

Any suspected case of COVID-19 who is in mandatory quarantine who has reached 14 days from the start of their mandatory quarantine period (midnight) may leave and should be assisted to safely isolate in an appropriate environment until COVID-19 is excluded. Any suspected case of COVID-19 who is in mandatory quarantine who has NOT reached 14 days from the start of their mandatory quarantine period (midnight) needs to remain in mandatory quarantine.

Any suspected case who has reached the end of their 14-days mandatory quarantine will be issued with an *End of Detention Notice (symptoms of respiratory illness)*

Further information with regard to this process can be found in Annex 1 *Chapter 5.8 Departure - Release from mandatory detention.*

17.2.3 Care after release from mandatory quarantine

It is important that when a quarantined person has health concerns that need ongoing medical care, transfer of care to another healthcare practitioner, including appropriate documentation and/or copy of the medical record, is arranged when the person is released from mandatory detention.

17.3 Quarantine domestic travel checklist

The following is a checklist of what is required for a person to travel domestically whilst they should still be in quarantine (i.e. if they have been released from mandatory quarantine (detention)):

- The requirements for onward travel (e.g. funeral, sick relative).
- Reassessment that the person remains well (afebrile, asymptomatic).
- Person has a supply of single use face masks and hand sanitiser.
- The two rows around the person on the flight are kept empty.

17.4 Other measures

To ensure all parties are kept informed of current residents and cases/contacts:

- Accommodation team to provide daily updates of all residents arriving in detention to PH Ops.
- PH Ops to provide daily updates of all cases and contacts currently in detention.

To ensure all returned travellers seeking assistance on the grounds of hardship are able to access support in accordance with the Returned Traveller Hardship Policy.

These processes will be reviewed as operational needs dictate.

DHHS COVID-19 Quarantine – incident reporting

1. Introduction

This document outlines the Department of Health and Human Services (the department) management requirements for major incidents or alleged major incidents that involve or impact significanty upon passengers/detainees during airport reception, hotel quarantine, and other users or staff during provision of accommodation services during the COVID-19 emergency. Examples include injury, death, sustaining/diagnosis of a life threatening or serious illness, and assault/crime.

The primary audience for this document is departmental staff on site and senior officers who are involved in reviewing, endorsing, processing, recording and analysing incident reports after Parts 1–6 of the incident report have been completed at the service delivery level supported by the appropriate Deputy Commander.

This document was last reviewed on 21 April 2020.

2. Reviewing and endorsing incident reports

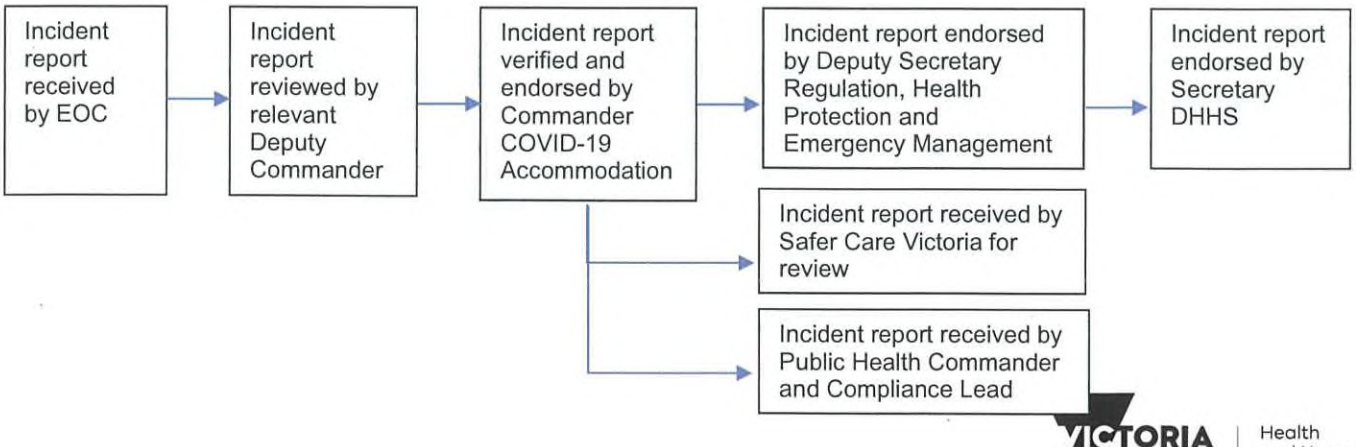
This section outlines the steps required for reviewing and endorsing incident reports, once provided to the DHHS Commander COVID-19 Accommodation via dhhsopsoteriaeoc@dhhs.vic.gov.au following verbal report via phone from the relevant Deputy Commander. Figure 1 below provides an overview of the process.

2.1. Overview

Incident reports (Parts 1–6) are completed by the most senior departmental staff immediately involved in the management of the incident onsite, with support of the relevant Deputy Commander. In the case of any incident, the first priority is making sure passengers/detainees and staff are safe, and in hotels, appropriate care provided (see escalation process for hotel detention). After that, an incident report must be completed and sent to the Commander COVID-19 Accommodation via dhhsopsoteriaeoc@dhhs.vic.gov.au following verbal report via phone. The report includes immediate actions that have been taken and planned follow-up actions.

The specified department officers review the incident report, and complete parts 7-9. The Commander COVID-19 Accommodation is also responsible for sending the report to Safer Care Victoria, the Public Health Commander and the Compliance Lead.

Figure 1: High Level flowchart for reviewing and endorsing an incident report



The incident report form is available from the Operation Soteria Emergency Operations Centre (EOC), dhhsopsoteriaeoc@dhhs.vic.gov.au or relevant Deputy Commander. All reports must be legible and presented in the specified report format.

2.2. Deputy Commander receives an incident report

When an incident report is forwarded to the DHHS EOC, the report is registered in the EOC's electronic file system, TRIM, and allocated a reference number. It is then forwarded to the relevant Deputy Commander as soon as possible (within 1 hour). The staff completing the report will contact the relevant Deputy Commander by mobile to advise of the incident.

2.2.1. Reports about passengers/detainees who are also clients

If a passenger/detainee is a client of other service types, service providers or government departments, information regarding a major incident may be disclosed to other agencies or departments to lessen or prevent a serious or imminent threat to a client's life, health, safety or welfare; and/or with the intent of preventing similar incidents from occurring in the future. The Commander COVID-19 Accommodation is responsible for notifying within the department and/or other organisations where the passenger/detainee is known to be a client, with the lead division will inform any community service organisations involved in providing services if applicable.

2.3. Review of the incident report

The relevant Deputy Commander endorses the incident report by completing Part 6 of the incident report (refer to attachment 1).

They must review the incident report and:

- check that the immediate needs of the passenger/detainee(s) have been addressed
- check that appropriate immediate actions have been taken in response to the incident and that any planned further actions are appropriate
- if a particular requirement has not been undertaken, the reasons why are documented
- ensure that the passenger/detainee and location details have been recorded and are accurate
- ensure all sections of the incident report are completed
- record any additional or required follow-up action (if any).

2.4. Verify and endorse the incident category

The Commander COVID-19 Accommodation verifies and endorses the incident report.

The Commander COVID-19 Accommodation is responsible for escalating an incident report to the Deputy Secretary Regulation, Health Protection and Emergency Management to endorse, and sending the report to the Public Health Commander, the Compliance Lead and Safer Care Victoria via irtreviews@safercare.vic.gov.au for review.

The Deputy Secretary Regulation, Health Protection and Emergency Management is responsible to escalate the incident report to the Secretary Department of Health and Human Services for endorsement.

2.5. File the completed incident report

After Parts 7-9 have been completed and endorsed, the incident report is returned to the Emergency Operations Centre for records management. This constitutes the final completed report.

The final completed report must be placed in a TRIM record must be updated in accordance with the department's record management policy.

Where allegations are made against a staff member, the incident report and any subsequent reports are to be retained in the staff file.

2.6. Incident report records management and privacy

Incident reports (paper versions and related electronic data) must be stored securely and only accessed by staff that have a business purpose for doing so. Paper reports are discouraged, and if required, should be stored in locked filing cabinets. Access to electronic data should be limited to appropriate staff only.

2.7. Local investigation and causal analysis

The Commander COVID-19 Accommodation will ensure that the incident is subject to an appropriate level of local investigation and causal analysis and that, where relevant, an improvement strategy is prepared.

Incident investigations should:

- identify reasons for the incident occurring
- identify opportunities for improvement in management systems or service delivery practice
- make local recommendations and implement improvement strategies in order to prevent or minimise recurrences. These strategies should be actionable and measurable and include an assessment of their effectiveness in delivering improvement
- satisfy mandatory reporting or review requirements (for example, notifying the Coroner or WorkSafe).

3. Privacy

Respecting the privacy of individuals who are involved in or witness to an incident is an important consideration in dealing with incident reports, which often contain personal details and other sensitive information.

Departmental staff must comply with the Department of Health and Human Services privacy policy whenever personal and/or health information about passengers/detainees, staff or others is collected, stored, transmitted, shared, used or disclosed.

The privacy policy is an integrated policy, which supports the sensitive protection and management of personal information and seeks to meet the legislative requirements of the *Privacy and Data Protection Act 2014* and *Health Records Act 2001*. Information relating to privacy is available at intranet.dhhs.vic.gov.au/privacy.

3.1. Sending information by email

For communication within the department, there are risks to privacy in sending information by email. These include misdirection due to errors in typing the address and the ease of copying, forwarding, amending or disclosing emailed information to others. Care should be taken with the list of addressees, and the title of the email should not contain any identifying information.

3.2. Electronic security of passenger/detainee information

In addition to email, passenger/detainee information is stored, accessed and transmitted using a emergency management systems and devices (including computers, laptops, and smartphones). These systems and devices must be as carefully protected as the passenger/detainee information itself.

An 'information security incident' occurs when the security of the information, system or device is compromised. Some examples of these incidents are:

- the details of a passenger is accidentally sent to the wrong email address
- a case worker's smartphone is lost or stolen and there was information about a passenger/detainee stored on it
- a virus infects a computer that stores or accesses passenger/detainee information.

Information security incidents must be reported to the Emergency Operations Centre who, in turn, will report it to the IT Service Centre.

DHHS Quarantine – incident reporting template

Reference number	
Impact (Major only) *e.g. injury, death, sustaining/diagnosing life threatening condition, assault/crime*	Alleged offensive conduct

1. Service provider details

Reporting organisation	DHHS
Address of service delivery	Holiday Inn Airport Hotel
DHHS Service Area *(e.g. Emergency Management)*	Emergency Management0 COVID 19 response
Service type	Support to quarantined detainees

2. Incident dates

Date of incident	19 May 2020
Date accuracy (exact/approximate)	REDACTED Holiday Inn
Time of incident	Approximately 14:00 to 18:00 hrs
Time accuracy (exact/approximate)	At the commencement of nurse's shift- change over
Date incident disclosed	19 May 2020
Time incident disclosed	Approximately 21:00 hrs

3. Incident description

Location of incident	Nurses' room 206

Detailed incident description

At approximately 21:00 hrs, REDACTED approached me for a confidential conversation regarding this alleged incident REDACTED was visibly distressed and started the conversation by saying that RE wanted me to be aware of what happened, and RE wanted this to be addressed anonymously so that RE ability to work for RE agency was not affected by this reporting.

RE advised that at the started of RE shift RE walked into the nurse's room and saw REDACTED REDACTED sitting with RE trouser belt unbuckled and, in a position, where RE appeared to be watching RE phone and what it appeared to be REDACTED advised that RED was not absolutely sure exactly what RED was doing as RE did not explicitly saw that RE was REDACTED

RE advised that RE felt this behaviour or conduct was unprofessional and inappropriate RE advised that RE didn't not know what to do and how to approach this issue however felt that this should not be the type of behaviour that should be occurring in the workplace and in a shared space.

I advised RE that RE did the right thing by reporting the alleged incident and that I will escalated this in a confidential manner within my organisation.

I advised RE that RE should report this to RE agency as they will have to investigate this and take appropriate action. I advised RE that I will be reporting the incident to the department who will contact her agency.

I asked R is how RE was feeling and if RE needed any immediate support. RED advised that RED was okay and felt that RE will be fine. I suggested EAP and assistance from RE employer and gave RE my private mobile number in case RED wanted to chat further. Before RE left the work place at the end of RE shift I spoke to RED again and advised RE of the steps I will be taking in reporting the incident and to ensure RE was okay to drive home safely. I advised RE to call me if RE was still not feeling well.

RE also advised that RE spoke to the mental health nurse REDACTED about the incident and was feeling okay following RE conversation with RED

I called the Team Leader escalation line and reported the incident to REDACTED and completed this report.

4. Individual details – Passenger/detainee 1 [duplicate for each person involved]

Passenger/detainee's full name	N/a
Passenger/detainee incident impact	
Sex	
Indigenous status	
Date of birth	
Passenger/detainee address	
Passenger/detainee unique identifier number *(if applicable)*	
Incident type	
Involvement in the incident (victim, witness, subject of abuse allegation, participant)	
Passenger/detainee's immediate safety needs met (Yes/No)	
Medical attention provided (Yes/No)	
Passenger/detainee debriefing or counselling (Yes/No	
Referral to support services (Yes/No)	
Change passenger/detainee care (support plan) (Yes/No)	
Notified next of kin, guardian or key support person (Yes/No)	

5. Other/s involved in incident [duplicate for each other person involved]

Person's full name	N/a
Date of birth	
Person's job title or relationship to passenger/detainee (carer, paid staff, other)	
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	

6. Service provider response details

Brief summary of incident	At 10:00pm Deputy Commander Hotels, Sandy Austin called REDACT at YNA nursing agency to report the incident. Left a message to call me regarding a staffing issue. The two nurses involved were not scheduled to work until pm the next day. At 8.45am on the 20/5 RED RED returned my call and I explained the incident. I then forwarded the email that came to me.
Reported to police (Yes/No)	No
Name of officer and date reported to police	N/a
Police investigation initiated (Yes/No)	N/a

Staff member stood down/removed (Yes/No)	Yes
Manager's full name	REDACTED
Manager's job title	YNA Nursing Agency
Date incident report reviewed	20/5/2020
Manager telephone number	REDACTED
Manager email	
Immediate actions taken by the organisation in response to the incident	
REDACTED took the call from the REDACTED REDACTED requested an incident report be completed. Sandy Austin contacted YNA Manager. YNA Manager REDACTED said RE will stand down REDACTED until further investigation. RE was to call REDACTED to get her version of events directly RED would also call REDACTED to get a better understanding.	
Deputy Commander full name and signature	Sandy Austin Signature:
Deputy Commander job title	Deputy Commander Hotels (substantive Director, EM, PH and HP, East division)
Date incident report approved	20/5/2020
Comments	I believe the YNA manager has taken this very seriously and will approach this in a professional manner with the parties involved. We will keep in close contact.

7. Incident report authorisation – EOC Command

Delegated authority full name and signature	Pam Williams Signature: Pamela Will
Delegated authority job title	Commander COVID-19 Accommodation
Date incident report approved	20/5/2020
Delegated authority phone number	REDACTED
Delegated authority email address	
Comments Note that this is not a client related incident and therefore might be better handled through another process.	

8. Incident report authorisation – Deputy Secretary

Delegated authority full name and signature	Melissa Skilbeck Signature:
Delegated authority job title	Deputy Secretary, RHPEM
Date incident report endorsed	
Delegated authority phone number	
Delegated authority email address	
Comments (optional)	

9. Incident report authorisation - Secretary

Delegated authority full name	Kym Peake
Delegated authority job title	Secretary
Date incident report endorsed	

DHHS COVID-19 Quarantine – incident reporting

1. Introduction

This document outlines the Department of Health and Human Services (the department) management requirements for major incidents or alleged major incidents that involve or impact significanty upon passengers/detainees during airport reception, hotel quarantine, and other users or staff during provision of accommodation services during the COVID-19 emergency. Examples include injury, death, sustaining/diagnosis of a life threatening or serious illness, and assault/crime.

The primary audience for this document is departmental staff on site and senior officers who are involved in reviewing, endorsing, processing, recording and analysing incident reports after Parts 1–6 of the incident report have been completed at the service delivery level supported by the appropriate Deputy Commander.

This document was last reviewed on 21 April 2020.

2. Reviewing and endorsing incident reports

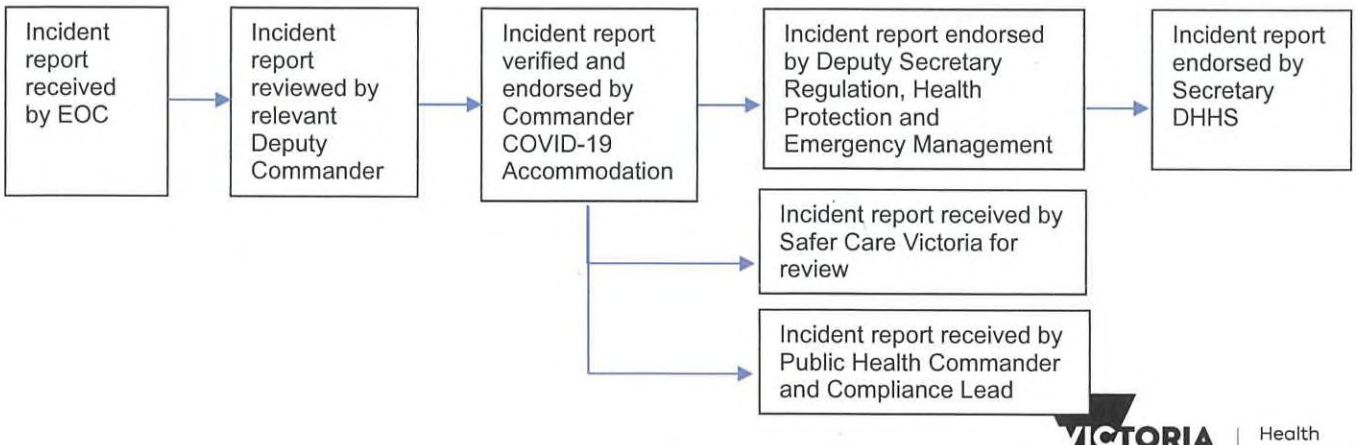
This section outlines the steps required for reviewing and endorsing incident reports, once provided to the DHHS Commander COVID-19 Accommodation via dhhsopsoteriaeoc@dhhs.vic.gov.au following verbal report via phone from the relevant Deputy Commander. Figure 1 below provides an overview of the process.

2.1. Overview

Incident reports (Parts 1–6) are completed by the most senior departmental staff immediately involved in the management of the incident onsite, with support of the relevant Deputy Commander. In the case of any incident, the first priority is making sure passengers/detainees and staff are safe, and in hotels, appropriate care provided (see escalation process for hotel detention). After that, an incident report must be completed and sent to the Commander COVID-19 Accommodation via dhhsopsoteriaeoc@dhhs.vic.gov.au following verbal report via phone. The report includes immediate actions that have been taken and planned follow-up actions.

The specified department officers review the incident report, and complete parts 7-9. The Commander COVID-19 Accommodation is also responsible for sending the report to Safer Care Victoria, the Public Health Commander and the Compliance Lead.

Figure 1: High Level flowchart for reviewing and endorsing an incident report



The incident report form is available from the Operation Soteria Emergency Operations Centre (EOC), dhhsopsoteriaeoc@dhhs.vic.gov.au or relevant Deputy Commander. All reports must be legible and presented in the specified report format.

2.2. Deputy Commander receives an incident report

When an incident report is forwarded to the DHHS EOC, the report is registered in the EOC's electronic file system, TRIM, and allocated a reference number. It is then forwarded to the relevant Deputy Commander as soon as possible (within 1 hour). The staff completing the report will contact the relevant Deputy Commander by mobile to advise of the incident.

2.2.1. Reports about passengers/detainees who are also clients

If a passenger/detainee is a client of other service types, service providers or government departments, information regarding a major incident may be disclosed to other agencies or departments to lessen or prevent a serious or imminent threat to a client's life, health, safety or welfare; and/or with the intent of preventing similar incidents from occurring in the future. The Commander COVID-19 Accommodation is responsible for notifying within the department and/or other organisations where the passenger/detainee is known to be a client, with the lead division will inform any community service organisations involved in providing services if applicable.

2.3. Review of the incident report

The relevant Deputy Commander endorses the incident report by completing Part 6 of the incident report (refer to attachment 1).

They must review the incident report and:

- check that the immediate needs of the passenger/detainee(s) have been addressed
- check that appropriate immediate actions have been taken in response to the incident and that any planned further actions are appropriate
- if a particular requirement has not been undertaken, the reasons why are documented
- ensure that the passenger/detainee and location details have been recorded and are accurate
- ensure all sections of the incident report are completed
- record any additional or required follow-up action (if any).

2.4. Verify and endorse the incident category

The Commander COVID-19 Accommodation verifies and endorses the incident report.

The Commander COVID-19 Accommodation is responsible for escalating an incident report to the Deputy Secretary Regulation, Health Protection and Emergency Management to endorse, and sending the report to the Public Health Commander, the Compliance Lead and Safer Care Victoria via irtreviews@safercare.vic.gov.au for review.

The Deputy Secretary Regulation, Health Protection and Emergency Management is responsible to escalate the incident report to the Secretary Department of Health and Human Services for endorsement.

2.5. File the completed incident report

After Parts 7-9 have been completed and endorsed, the incident report is returned to the Emergency Operations Centre for records management. This constitutes the final completed report.

The final completed report must be placed in a TRIM record must be updated in accordance with the department's record management policy.

Where allegations are made against a staff member, the incident report and any subsequent reports are to be retained in the staff file.

2.6. Incident report records management and privacy

Incident reports (paper versions and related electronic data) must be stored securely and only accessed by staff that have a business purpose for doing so. Paper reports are discouraged, and if required, should be stored in locked filing cabinets. Access to electronic data should be limited to appropriate staff only.

2.7. Local investigation and causal analysis

The Commander COVID-19 Accommodation will ensure that the incident is subject to an appropriate level of local investigation and causal analysis and that, where relevant, an improvement strategy is prepared.

Incident investigations should:

- identify reasons for the incident occurring
- identify opportunities for improvement in management systems or service delivery practice
- make local recommendations and implement improvement strategies in order to prevent or minimise recurrences. These strategies should be actionable and measurable and include an assessment of their effectiveness in delivering improvement
- satisfy mandatory reporting or review requirements (for example, notifying the Coroner or WorkSafe).

3. Privacy

Respecting the privacy of individuals who are involved in or witness to an incident is an important consideration in dealing with incident reports, which often contain personal details and other sensitive information.

Departmental staff must comply with the Department of Health and Human Services privacy policy whenever personal and/or health information about passengers/detainees, staff or others is collected, stored, transmitted, shared, used or disclosed.

The privacy policy is an integrated policy, which supports the sensitive protection and management of personal information and seeks to meet the legislative requirements of the *Privacy and Data Protection Act 2014* and *Health Records Act 2001*. Information relating to privacy is available at intranet.dhhs.vic.gov.au/privacy.

3.1. Sending information by email

For communication within the department, there are risks to privacy in sending information by email. These include misdirection due to errors in typing the address and the ease of copying, forwarding, amending or disclosing emailed information to others. Care should be taken with the list of addressees, and the title of the email should not contain any identifying information.

3.2. Electronic security of passenger/detainee information

In addition to email, passenger/detainee information is stored, accessed and transmitted using a emergency management systems and devices (including computers, laptops, and smartphones). These systems and devices must be as carefully protected as the passenger/detainee information itself.

An 'information security incident' occurs when the security of the information, system or device is compromised. Some examples of these incidents are:

- the details of a passenger is accidentally sent to the wrong email address
- a case worker's smartphone is lost or stolen and there was information about a passenger/detainee stored on it
- a virus infects a computer that stores or accesses passenger/detainee information.

Information security incidents must be reported to the Emergency Operations Centre who, in turn, will report it to the IT Service Centre.

DHHS Quarantine – incident reporting template

Reference number	
Impact (Major only) *e.g. injury, death, sustaining/diagnosing life threatening condition, assault/crime*	Unwelcome sexual advance / sexual assault

1. Service provider details

Reporting organisation	Department of Health and Human Services
Address of service delivery	7 Conventional Centre Place, South Wharf VIC 3006
DHHS Service Area *(e.g. Emergency Management)*	Emergency Management – Novotel Southwharf Hotel
Service type	Quarantine Hotels

2. Incident dates

Date of incident	Wednesday 13 May 2020
Date accuracy (exact/approximate)	Wednesday evening, exact
Time of incident	Evening / PM
Time accuracy (exact/approximate)	Approximate
Date incident disclosed	13 May 2020
Time incident disclosed	Evening / PM

3. Incident description

Location of incident	Novotel Southwharf Hotel – Room REDACTED
Detailed incident description	
The male REDACTED contractor slipped a note under the door of the room with his Snapchat username presumably so that they could follow / interact with him on the Snapchat platform. Guest reports that when RE found the Snapchat username under RE door RE thought it may have been the nurses trying to communicate with RE, so RE messaged the username and the reply was requesting "nudes" from the guest.	

4. Individual details – Passenger/detainee 1 [duplicate for each person involved]

Passenger/detainee's full name	Ms REDACTED Ms REDACTED
Passenger/detainee incident impact	Concern for safety / security Fear Discomfort

Sex	Females
Indigenous status	Unknown
Date of birth	REDACTED REDACTED
Passenger/detainee address	
Passenger/detainee unique identifier number *(if applicable)*	Unknown
Incident type	Sexual harassment
Involvement in the incident (victim, witness, subject of abuse allegation, participant)	Victim
Passenger/detainee's immediate safety needs met (Yes/No)	Yes
Medical attention provided (Yes/No)	Nursing staff spoke with REDACTE
Passenger/detainee debriefing or counselling (Yes/No	No
Referral to support services (Yes/No)	No
Change passenger/detainee care (support plan) (Yes/No)	Yes
Notified next of kin, guardian or key support person (Yes/No)	No

5. Other/s involved in incident [duplicate for each other person involved]

Person's full name	DJPR to provide
Date of birth	
Person's job title or relationship to passenger/detainee (carer, paid staff, other)	
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	

6. Service provider response details

Brief summary of incident	As above
Reported to police (Yes/No)	No
Name of officer and date reported to police	No
Police investigation initiated (Yes/No)	No
Staff member stood down/removed (Yes/No)	Yes
Manager's full name	REDACTED
Manager's job title	General Manager
Date incident report reviewed	
Manager telephone number	REDACTED
Manager email	REDACTED
Immediate actions taken by the organisation in response to the incident	

• Guests relocated to another room on another floor, now in room REDACTED • Female security guards now appointed to floor 16 for each shift • Female hotel staff only to call guests • Female nursing staff only to call guest (notes in medical progress notes) • DHHS Team Leader also asked that a female AO and Team Leader contact the guest • Novotel Southwharf General Manager liaised with housekeeping contractor to stand down the offending contractor (as observed on the CCTV footage) • Nursing staff also called the guest (Cesarian) to debrief	
Deputy Commander full name and signature	Sandy Austin Signature: Sandy Austin
Deputy Commander job title	Deputy Commander Hotels Director EM, Population Health, and Health Protection, East division
Date incident report approved	20/5/2020
Comments	Incident was managed well, client safety paramount. I informed the DJPR Covid Accom-Lead, Rachaele May at 2.49pm on 15 May 2020. Rachaele replied by 3.23pm that day, agreed it is unacceptable behaviour. We discussed via telephone and subsequently I have replied to her email, confirming that it was a housekeeping contractor. DJPR will be taking the lead on the investigation.

7. Incident report authorisation – EOC Command

Delegated authority full name and signature	Pam Williams Signature: Pamela Williams
Delegated authority job title	Commander COVID-19 Accommodation
Date incident report approved	Wednesday 13 May 2020
Delegated authority phone number	REDACTED
Delegated authority email address	REDACTED
Comments The incident has been well handled with client safety ensured. DJPR to work with contractors to ensure no repeat of behaviour.	

8. Incident report authorisation – Deputy Secretary

Delegated authority full name and signature	
Delegated authority job title	
Date incident report endorsed	
Delegated authority phone number	
Delegated authority email address	
Comments (optional)	

9. Incident report authorisation - Secretary

Delegated authority full name	
Delegated authority job title	
Date incident report endorsed	

DHHS COVID-19 Quarantine – incident reporting

1. Introduction

This document outlines the Department of Health and Human Services (the department) management requirements for major incidents or alleged major incidents that involve or impact significanty upon passengers/detainees during airport reception, hotel quarantine, and other users or staff during provision of accommodation services during the COVID-19 emergency. Examples include injury, death, sustaining/diagnosis of a life threatening or serious illness, and assault/crime.

The primary audience for this document is departmental staff on site and senior officers who are involved in reviewing, endorsing, processing, recording and analysing incident reports after Parts 1–6 of the incident report have been completed at the service delivery level supported by the appropriate Deputy Commander.

This document was last reviewed on 21 April 2020.

2. Reviewing and endorsing incident reports

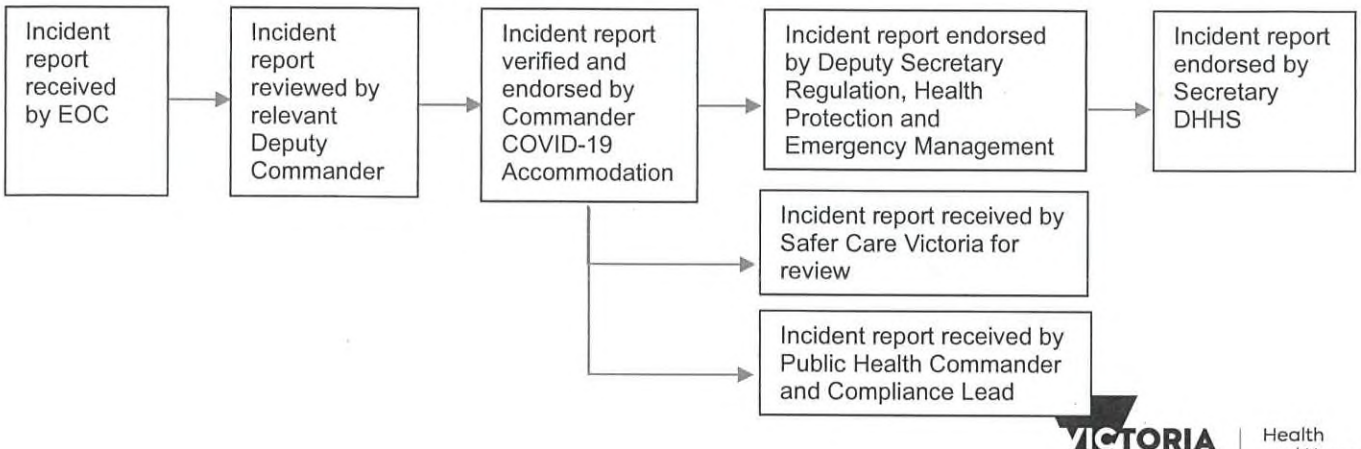
This section outlines the steps required for reviewing and endorsing incident reports, once provided to the DHHS Commander COVID-19 Accommodation via dhhsopsoteriaeoc@dhhs.vic.gov.au following verbal report via phone from the relevant Deputy Commander. Figure 1 below provides an overview of the process.

2.1. Overview

Incident reports (Parts 1–6) are completed by the most senior departmental staff immediately involved in the management of the incident onsite, with support of the relevant Deputy Commander. In the case of any incident, the first priority is making sure passengers/detainees and staff are safe, and in hotels, appropriate care provided (see escalation process for hotel detention). After that, an incident report must be completed and sent to the Commander COVID-19 Accommodation via dhhsopsoteriaeoc@dhhs.vic.gov.au following verbal report via phone. The report includes immediate actions that have been taken and planned follow-up actions.

The specified department officers review the incident report, and complete parts 7-9. The Commander COVID-19 Accommodation is also responsible for sending the report to Safer Care Victoria, the Public Health Commander and the Compliance Lead.

Figure 1: High Level flowchart for reviewing and endorsing an incident report



The incident report form is available from the Operation Soteria Emergency Operations Centre (EOC), dhhsopsoteriaeoc@dhhs.vic.gov.au or relevant Deputy Commander. All reports must be legible and presented in the specified report format.

2.2. Deputy Commander receives an incident report

When an incident report is forwarded to the DHHS EOC, the report is registered in the EOC's electronic file system, TRIM, and allocated a reference number. It is then forwarded to the relevant Deputy Commander as soon as possible (within 1 hour). The staff completing the report will contact the relevant Deputy Commander by mobile to advise of the incident.

2.2.1. Reports about passengers/detainees who are also clients

If a passenger/detainee is a client of other service types, service providers or government departments, information regarding a major incident may be disclosed to other agencies or departments to lessen or prevent a serious or imminent threat to a client's life, health, safety or welfare; and/or with the intent of preventing similar incidents from occurring in the future. The Commander COVID-19 Accommodation is responsible for notifying within the department and/or other organisations where the passenger/detainee is known to be a client, with the lead division will inform any community service organisations involved in providing services if applicable.

2.3. Review of the incident report

The relevant Deputy Commander endorses the incident report by completing Part 6 of the incident report (refer to attachment 1).

They must review the incident report and:

- check that the immediate needs of the passenger/detainee(s) have been addressed
- check that appropriate immediate actions have been taken in response to the incident and that any planned further actions are appropriate
- if a particular requirement has not been undertaken, the reasons why are documented
- ensure that the passenger/detainee and location details have been recorded and are accurate
- ensure all sections of the incident report are completed
- record any additional or required follow-up action (if any).

2.4. Verify and endorse the incident category

The Commander COVID-19 Accommodation verifies and endorses the incident report.

The Commander COVID-19 Accommodation is responsible for escalating an incident report to the Deputy Secretary Regulation, Health Protection and Emergency Management to endorse, and sending the report to the Public Health Commander, the Compliance Lead and Safer Care Victoria via irtreviews@safercare.vic.gov.au for review.

The Deputy Secretary Regulation, Health Protection and Emergency Management is responsible to escalate the incident report to the Secretary Department of Health and Human Services for endorsement.

2.5. File the completed incident report

After Parts 7-9 have been completed and endorsed, the incident report is returned to the Emergency Operations Centre for records management. This constitutes the final completed report.

The final completed report must be placed in a TRIM record must be updated in accordance with the department's record management policy.

Where allegations are made against a staff member, the incident report and any subsequent reports are to be retained in the staff file.

2.6. Incident report records management and privacy

Incident reports (paper versions and related electronic data) must be stored securely and only accessed by staff that have a business purpose for doing so. Paper reports are discouraged, and if required, should be stored in locked filing cabinets. Access to electronic data should be limited to appropriate staff only.

2.7. Local investigation and causal analysis

The Commander COVID-19 Accommodation will ensure that the incident is subject to an appropriate level of local investigation and causal analysis and that, where relevant, an improvement strategy is prepared.

Incident investigations should:

- identify reasons for the incident occurring
- identify opportunities for improvement in management systems or service delivery practice
- make local recommendations and implement improvement strategies in order to prevent or minimise recurrences. These strategies should be actionable and measurable and include an assessment of their effectiveness in delivering improvement
- satisfy mandatory reporting or review requirements (for example, notifying the Coroner or WorkSafe).

3. Privacy

Respecting the privacy of individuals who are involved in or witness to an incident is an important consideration in dealing with incident reports, which often contain personal details and other sensitive information.

Departmental staff must comply with the Department of Health and Human Services privacy policy whenever personal and/or health information about passengers/detainees, staff or others is collected, stored, transmitted, shared, used or disclosed.

The privacy policy is an integrated policy, which supports the sensitive protection and management of personal information and seeks to meet the legislative requirements of the *Privacy and Data Protection Act 2014* and *Health Records Act 2001*. Information relating to privacy is available at intranet.dhhs.vic.gov.au/privacy.

3.1. Sending information by email

For communication within the department, there are risks to privacy in sending information by email. These include misdirection due to errors in typing the address and the ease of copying, forwarding, amending or disclosing emailed information to others. Care should be taken with the list of addressees, and the title of the email should not contain any identifying information.

3.2. Electronic security of passenger/detainee information

In addition to email, passenger/detainee information is stored, accessed and transmitted using a emergency management systems and devices (including computers, laptops, and smartphones). These systems and devices must be as carefully protected as the passenger/detainee information itself.

An 'information security incident' occurs when the security of the information, system or device is compromised. Some examples of these incidents are:

- the details of a passenger is accidentally sent to the wrong email address
- a case worker's smartphone is lost or stolen and there was information about a passenger/detainee stored on it
- a virus infects a computer that stores or accesses passenger/detainee information.

Information security incidents must be reported to the Emergency Operations Centre who, in turn, will report it to the IT Service Centre.

DHHS Quarantine – incident reporting template

Reference number	TBC
Impact (Major only) *e.g. injury, death, sustaining/diagnosing life threatening condition, assault/crime*	Welfare Concerns

1. Service provider details

Reporting organisation	Department of Health and Human Services
Address of service delivery	Novotel on Collins, 270 Collins Street Melbourne 3000
DHHS Service Area *(e.g. Emergency Management)*	Emergency Management (Covid-19 quarantine Hotel)
Service type	Quarantine Hotel

2. Incident dates

Date of incident	16 May 2020
Date accuracy (exact/approximate)	Exact
Time of incident	8.30pm and 9.50pm
Time accuracy (exact/approximate)	Approximately
Date incident disclosed	16 May 2020
Time incident disclosed	Approximately 10.10pm

3. Incident description

Location of incident	Novotel on Collins, 270 Collins Street Melbourne 3000 (Room RED
Detailed incident description	

Approximately 8.30pm, the Mental Health Nurse advised team leader that detainee REDACTED (REDACTE) was not answering RE telephone and a Welfare Check was required (if RE wasn't answering RE phone).

The Team Leader queried the need and the Mental Health nurse advised it had been a regular occurrence for REDACTED as RE wasn't answering RE welfare checks via phone calls. REDA was apparently displaying some behaviour issues and it was confirmed by the mental Health nurse the behaviour wasn't diagnosed as a Mental Health issue.

The Mental health nurse expressed concern for REDACTED's health and wellbeing. The team Leader offered to attend to support the mental Health nurse and RED accepted. Personal Protective Equipment was prepared and security were requested to provide an escort and if needed access to the room (The security guard also knew REDACTED form other welfare checks and said an access card had been required as RE doesn't answer the door).

REDACTED didn't answe RE door and security attempted several times to open the door. The original swipe card didn't open the door and security advised he was concerned the door may be barricaded or the lock tampered with. A hotel staff member walked by and offered his card. Eventually a master key was required and the door was opened by security and the Mental Health nurse. The door was barricaded with an ironing board

and iron and a small coffee table. The Mental health nurse entered and called out to REDACTED eventually answered that RE was asleep and yelled at the Mental Health nurse to get out. The mental Health Nurse did begin to walk out and pointed to the iron and wanted to pick it up. REDACTED then got up and moved quickly toward the door to slam it shut. The Team Leader yelled at the Mental Health nurse to quickly get out of the room and RE did as the door slammed.

The Mental Health nurse expressed concern about REDACTED potentially using the iron cord to inflict self-harm and requested security remove it. Security advised they couldn't enter the room without approval from RE manager.

The team leader queried the level of concern of the Mental Health nurse and the balance of REDACTED's health and safety and that of the Mental Health nurse. The Mental Health nurse advised RE felt REDACTED wouldn't hurt RE however RE was worried RE may hurt REDA with the iron cord.

The Team Leader suggested a short break to let REDACTED settle before a decision is made and the Mental Health nurse, security and Mental health nurse returned to team space on level three.

After short while (approx. 10 minutes) security received clearance to enter the room to remove the iron. The security guard and Mental Health nurse returned to remove the iron. A short time later (minutes) the security guard advised his team on the level reported REDACTE had picked up the iron and threw it out into the corridor.

The Authorised Officer was updated with the situation (REDACTED) with the Security Guard and Mental health nurse present. The AO was concerned about the health and safety of the security guards. The security guard recommended not intervening again to avoid agitating REDACTE RED had apparently said previously to the Mental Health Nurse and Security guard RE was upset and being contacted. It had been explained to REDA REDA that as a result of an earlier disclosure by RE that a welfare check was required and if RE answered RED telephone, then a visit for a welfare check wouldn't be required.

At approximately 9.45pm a room on the same level, RE had opened RE door and was alleged to have stepped into the corridor to film security on RE phone and yell that RE has covid-19 (RE had refused swabbing form the nurses and had no symptoms according to the nurses. RE was due to exit 12pm the following day). At this point, apparently REDACTE opened RE door again and was yelling also.

The AO made the decision that the police were required. RE expressed that RE was concerned REDACTED was demonstrating escalating behaviour and that RE may leave RE room or risk the health and safety of the security guards. The security Guard RED Manager disagreed and recommended leaving the level to settle.

The AO called the police and they arrived approximately 9.50pm and were briefed on the evening. The AO and Mental health nurse, security RED manager and two police went to speak to REDACTE about the detention order and remind RE of the fine if the conditions are breached. REDACTED apparently advised the police RED felt harassed when visited by the Mental Health nurse for a welfare check. The police officer apparently suggested a phone call instead. The security apparently then advised the police that was the first step, however REDACTE wasn't answering RE phone and so the physical visit was to check on RE health and wellbeing. The police then advised the detainee to answer the phone if RE didn't want a physical visit from the mental health nurse.

The AO advised the police had advised REDACTED that RE would be fined if RE left RE room (RE denied leaving RE room). The AO requested the hotel retain security footage from 9pm-10pm in case it was required.

At approximately 10pm, the Team Leader called the after-hours team leader and left a message for then spoke to Melody Bush. The call was intended to request that the Team Leader remain on site after 10p (Schedule finish time) to support the AO and Mental health team as the AO was required with REDACTED and concurrently the nurses had arrived back. The Team Leader remained on the floor until approximately 11pm to ensure the AO had an opportunity to debrief, to ensure adequate supports were in place for the detainee, night Mental health staff and the AO prior to leaving.

The Deputy Commander thanked the Team Leader for being responsible and remaining to support the team, however suggested not to stay longer than required. The Team leader left approximately 11pm. Case notes the

following day indicate the detainee then called police to express concern about the nurses not being real. The escalation to the police appeared to have settled the situation with no reports of any further issues after the police visit that evening. It isn't clear though if any further incidents may have occurred without the intervention. Handover for 17 May 2020 am has some further detail.

Deputy Commander Melody Bush attended the hotel at handover on 17 May 2020. Team Leader provided suggestion for ongoing follow up for all detainee's post exit to follow up the impact of detention for all detainees with existing Mental Health issue or not. To actively follow up in addition to providing links to support services as that places the onus on them to request help and evidence suggests that doesn't always happen and follow up calls may assist to identify any people experiencing ongoing trauma post detention.

4. Individual details – Passenger/detainee 1 [duplicate for each person involved]

Passenger/detainee's full name	REDACTED
Passenger/detainee incident impact	Medium?(distress/behavioural issues)
Sex	REDACTED
Indigenous status	Unknown
Date of birth	REDACTED
Passenger/detainee address	
Passenger/detainee unique identifier number *(if applicable)*	
Incident type	Welfare Concerns
Involvement in the incident (victim, witness, subject of abuse allegation, participant)	Participant
Passenger/detainee's immediate safety needs met (Yes/No)	Yes
Medical attention provided (Yes/No)	Yes
Passenger/detainee debriefing or counselling (Yes/No	(ongoing welfare reduced to one check a day)
Referral to support services (Yes/No)	No
Change passenger/detainee care (support plan) (Yes/No)	Yes, reduced
Notified next of kin, guardian or key support person (Yes/No)	N/A

5. Other/s involved in incident [duplicate for each other person involved]

Person's full name	REDACTED
Date of birth	
Person's job title or relationship to passenger/detainee (carer, paid staff, other)	REDACTED
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	Participant
Person's full name	REDACTED
Date of birth	
Person's job title or relationship to passenger/detainee (carer, paid staff, other)	Mental Health Nurse
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	Participant
Person's full name	
Date of birth	

Person's job title or relationship to passenger/detainee (carer, paid staff, other)	Night Security Manager
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	Participant

6. Service provider response details

Brief summary of incident	A detainee became heighten when staff conducted a welfare check after she barricaded herself in the room with hotel furniture.
Reported to police (Yes/No)	Yes
Name of officer and date reported to police	Required please provide
Police investigation initiated (Yes/No)	No
Staff member stood down/removed (Yes/No)	N/A
Manager's full name	REDACTED
Manager's job title	Operations Manager
Date incident report reviewed	23 May 2020
Manager telephone number	REDACTED
Manager email	
Immediate actions taken by the organisation in response to the incident	
Initial check conducted by nurse and mental health nurse after concerns raised about detainee barricading herself in the room. Access gained via security to ensure safety of individual. Police intervention required to settle the individual and others on the hotel floor. Items removed from room, individual monitored.	
Deputy Commander full name and signature	Melody Bush
Deputy Commander job title	Deputy Commander - Hotels
Date incident report approved	
Comments	

7. Incident report authorisation – EOC Command

Delegated authority full name and signature	Merrin Bomet
Delegated authority job title	Commander COVID-19 Accommodation
Date incident report approved	23/5/2020.
Delegated authority phone number	REDACTED
Delegated authority email address	merrin.bomet + dhhs
Comments ~~N/A~~ NOTE – I am advised that the incident was reported to the Commander, at ~~Report~~ Pam Williams and report provided to myself DZ 23/5/2020	

8. Incident report authorisation – Deputy Secretary

Delegated authority full name and signature	
Delegated authority job title	
Date incident report endorsed	
Delegated authority phone number	
Delegated authority email address	
Comments (optional)	

9. Incident report authorisation - Secretary

Delegated authority full name	
Delegated authority job title	
Date incident report endorsed	

DHHS COVID-19 Quarantine – incident reporting

1. Introduction

This document outlines the Department of Health and Human Services (the department) management requirements for major incidents or alleged major incidents that involve or impact significanty upon passengers/detainees during airport reception, hotel quarantine, and other users or staff during provision of accommodation services during the COVID-19 emergency. Examples include injury, death, sustaining/diagnosis of a life threatening or serious illness, and assault/crime.

The primary audience for this document is departmental staff on site and senior officers who are involved in reviewing, endorsing, processing, recording and analysing incident reports after Parts 1–6 of the incident report have been completed at the service delivery level supported by the appropriate Deputy Commander.

This document was last reviewed on 21 April 2020.

2. Reviewing and endorsing incident reports

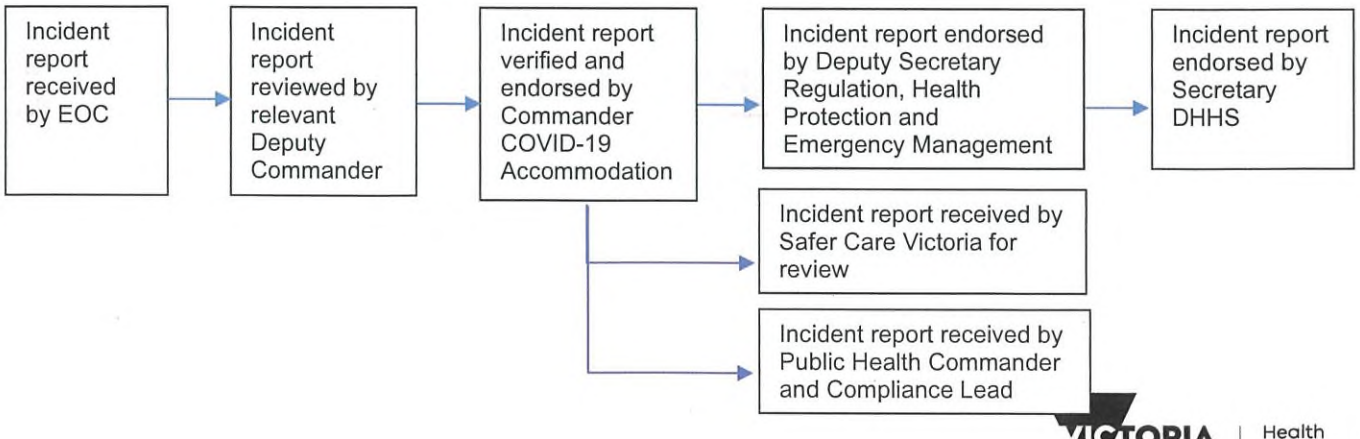
This section outlines the steps required for reviewing and endorsing incident reports, once provided to the DHHS Commander COVID-19 Accommodation via dhhsopsoteriaeoc@dhhs.vic.gov.au following verbal report via phone from the relevant Deputy Commander. Figure 1 below provides an overview of the process.

2.1. Overview

Incident reports (Parts 1–6) are completed by the most senior departmental staff immediately involved in the management of the incident onsite, with support of the relevant Deputy Commander. In the case of any incident, the first priority is making sure passengers/detainees and staff are safe, and in hotels, appropriate care provided (see escalation process for hotel detention). After that, an incident report must be completed and sent to the Commander COVID-19 Accommodation via dhhsopsoteriaeoc@dhhs.vic.gov.au following verbal report via phone. The report includes immediate actions that have been taken and planned follow-up actions.

The specified department officers review the incident report, and complete parts 7-9. The Commander COVID-19 Accommodation is also responsible for sending the report to Safer Care Victoria, the Public Health Commander and the Compliance Lead.

Figure 1: High Level flowchart for reviewing and endorsing an incident report



The incident report form is available from the Operation Soteria Emergency Operations Centre (EOC), dhhsopsoteriaeoc@dhhs.vic.gov.au or relevant Deputy Commander. All reports must be legible and presented in the specified report format.

2.2. Deputy Commander receives an incident report

When an incident report is forwarded to the DHHS EOC, the report is registered in the EOC's electronic file system, TRIM, and allocated a reference number. It is then forwarded to the relevant Deputy Commander as soon as possible (within 1 hour). The staff completing the report will contact the relevant Deputy Commander by mobile to advise of the incident.

2.2.1. Reports about passengers/detainees who are also clients

If a passenger/detainee is a client of other service types, service providers or government departments, information regarding a major incident may be disclosed to other agencies or departments to lessen or prevent a serious or imminent threat to a client's life, health, safety or welfare; and/or with the intent of preventing similar incidents from occurring in the future. The Commander COVID-19 Accommodation is responsible for notifying within the department and/or other organisations where the passenger/detainee is known to be a client, with the lead division will inform any community service organisations involved in providing services if applicable.

2.3. Review of the incident report

The relevant Deputy Commander endorses the incident report by completing Part 6 of the incident report (refer to attachment 1).

They must review the incident report and:

- check that the immediate needs of the passenger/detainee(s) have been addressed
- check that appropriate immediate actions have been taken in response to the incident and that any planned further actions are appropriate
- if a particular requirement has not been undertaken, the reasons why are documented
- ensure that the passenger/detainee and location details have been recorded and are accurate
- ensure all sections of the incident report are completed
- record any additional or required follow-up action (if any).

2.4. Verify and endorse the incident category

The Commander COVID-19 Accommodation verifies and endorses the incident report.

The Commander COVID-19 Accommodation is responsible for escalating an incident report to the Deputy Secretary Regulation, Health Protection and Emergency Management to endorse, and sending the report to the Public Health Commander, the Compliance Lead and Safer Care Victoria via irtreviews@safercare.vic.gov.au for review.

The Deputy Secretary Regulation, Health Protection and Emergency Management is responsible to escalate the incident report to the Secretary Department of Health and Human Services for endorsement.

2.5. File the completed incident report

After Parts 7-9 have been completed and endorsed, the incident report is returned to the Emergency Operations Centre for records management. This constitutes the final completed report.

The final completed report must be placed in a TRIM record must be updated in accordance with the department's record management policy.

Where allegations are made against a staff member, the incident report and any subsequent reports are to be retained in the staff file.

2.6. Incident report records management and privacy

Incident reports (paper versions and related electronic data) must be stored securely and only accessed by staff that have a business purpose for doing so. Paper reports are discouraged, and if required, should be stored in locked filing cabinets. Access to electronic data should be limited to appropriate staff only.

2.7. Local investigation and causal analysis

The Commander COVID-19 Accommodation will ensure that the incident is subject to an appropriate level of local investigation and causal analysis and that, where relevant, an improvement strategy is prepared.

Incident investigations should:

- identify reasons for the incident occurring
- identify opportunities for improvement in management systems or service delivery practice
- make local recommendations and implement improvement strategies in order to prevent or minimise recurrences. These strategies should be actionable and measurable and include an assessment of their effectiveness in delivering improvement
- satisfy mandatory reporting or review requirements (for example, notifying the Coroner or WorkSafe).

3. Privacy

Respecting the privacy of individuals who are involved in or witness to an incident is an important consideration in dealing with incident reports, which often contain personal details and other sensitive information.

Departmental staff must comply with the Department of Health and Human Services privacy policy whenever personal and/or health information about passengers/detainees, staff or others is collected, stored, transmitted, shared, used or disclosed.

The privacy policy is an integrated policy, which supports the sensitive protection and management of personal information and seeks to meet the legislative requirements of the *Privacy and Data Protection Act 2014* and *Health Records Act 2001*. Information relating to privacy is available at intranet.dhhs.vic.gov.au/privacy.

3.1. Sending information by email

For communication within the department, there are risks to privacy in sending information by email. These include misdirection due to errors in typing the address and the ease of copying, forwarding, amending or disclosing emailed information to others. Care should be taken with the list of addressees, and the title of the email should not contain any identifying information.

3.2. Electronic security of passenger/detainee information

In addition to email, passenger/detainee information is stored, accessed and transmitted using a emergency management systems and devices (including computers, laptops, and smartphones). These systems and devices must be as carefully protected as the passenger/detainee information itself.

An 'information security incident' occurs when the security of the information, system or device is compromised. Some examples of these incidents are:

- the details of a passenger is accidentally sent to the wrong email address
- a case worker's smartphone is lost or stolen and there was information about a passenger/detainee stored on it
- a virus infects a computer that stores or accesses passenger/detainee information.

Information security incidents must be reported to the Emergency Operations Centre who, in turn, will report it to the IT Service Centre.

DHHS Quarantine – incident reporting template

Reference number	
Impact (Major only) *e.g. injury, death, sustaining/diagnosing life threatening condition, assault/crime*	

1. Service provider details

Reporting organisation	Department Health and Human Services
Address of service delivery	
DHHS Service Area *(e.g. Emergency Management)*	Emergency Management
Service type	Complex assessment and Response Team (CART)

2. Incident dates

Date of incident	REDACTED
Date accuracy (exact/approximate)	Approximate
Time of incident	Unknown
Time accuracy (exact/approximate)	Approximate
Date incident disclosed	REDACTED
Time incident disclosed	10.22am

3. Incident description

Location of incident	REDACTED - Crown Metropol

Detailed incident description

REDACTED REDAC arrived in Melbourne from RE DA on the REDAC TED 2020, with REDACTED REDACTED is a resident of RE and was granted permission by the Australian government to travel to Australia to enable him to settle REDACTE into an aged care facility. REDACTED presents with advanced Dementia and requires support in all areas of daily living. REDACTED was transferred to The REDA Hospital on RE June 2020.

At 10.22am on the 23 June 2020, REDACTE of the DHHS Welfare Survey Team contacted REDACTE to conduct a Day Three welfare check. REDACTE reported RE was feeling unwell, stating RE had taking too much ADHD medication' (Ritalin). REDACTE attributed this 'error' to not having RE glasses and being unable to read the prescribed amount that should be taken. At 10.35am REDAC referred the matter to RE Team Leader and at 10.45am the Welfare Survey Team Leader REDACTED referred this to RED a Mental Health nurse onsite at the hotel to follow up with the guest. The Welfare Survey Team also referred the case to the Complex Assessment and Response Team (CART).

REDACTED from CART made contact with the Mental Health Nurse and General Nurse at 10.36am requesting information in regard to REDACTE The MH nurse advised that they were unaware of REDACTE nor were they aware of any concern regarding RE medication.

General nurse REDACTED advised that REDACTE requested a new script late afternoon on RE June 2020 for Ritalin reporting that RE mother had thrown RE medication away. This was followed up with the hotel doctor and REDACTE was provided with replacement medication (Ritalin) on the evening of RE June 2020.

REDACTED also advised that REDACTE was contacted on the morning of R June 2020 for a general health check. RE reported that RE was feeling unwell and experiencing diarrhoea. REDAC reports that RE informed REDACTE that this is a possible COVID-19 symptom and that RE should consider a swab. RE reported that REDACTE declined this offer.

The mental health nurse team completed a face to face visit with REDACTE on the afternoon of RE June 2020 and reported to CART staff that RE presented as calm and that they had no concerns about self-harm or risk.

Given the previous behaviour of REDACT and the reported overdose of Ritalin, CART requested that the MH nurse complete a referral to the North West Mental Health Triage team for a full mental health assessment.

At 6.45pm REDACTED from CART spoke to onsite MH nurse who had engaged with REDACTE and reported that RE denied an overdose and denied suicidality, MH nurse reviewed history and determined there was not a history and therefore nil need to refer to North West Mental Health Triage. REDA noted that CART would continue to monitor the situation.

On the afternoon RE June 2020 CART contacted the mental health team regarding the report that REDACTE had taken an overdose of Ritalin. CART was advised of the following:

On RE June 2020 REDACTE was outside of RE room at 10.56pm stating that RE was feeling unwell. REDACTE informed the nurse on duty that RE had taken 3 x 10mg Ritalin tablets and consumed 2 beers. REDACTE was provided with hydrolyte and antacid tablets.

At 11.33pm on R June 2020 REDACTE contacted the MH nurse requesting Xanax. REDACTE stated that RE had taken 3 x 10 mg Ritalin tablets that evening, and approximately 12 x 10mg tablets the day prior which was RE June 2020.

REDAC was notified and assessed REDACTE via phone call. REDACT prescribed 5mg of Diazepam with a recommendation of a further 5mg Diazepam in 2/24 if REDACTE was still feeling anxious.

On R June 2020, the onsite mental health nurse advised CART that REDACTED was scheduled to undertake a GP review. Further to this CART requested a mental health review be undertaken as a priority.

CART contacted REDACTED on RE June 2020 regarding the review that RE had completed with REDACTED advised that REDACTE had reported feeling felt traumatised and stressed about REDACT being transferred to hospital, and that RE subsequently consumed 30 x 10mg Ritalin tablets on the afternoon of RE June 2020.

REDACT advised that REDACT indicated that R developed abdominal cramps, diarrhoea, nausea, and paranoia, all of which had subsided. REDACTE reported to REDACT that RE has a history of addiction to recreational and prescription drugs, particularly Ritalin, with the last episode occurring 13 months ago. REDACTE stated to REDAC that RE does not want to relapse' and was going to attend an online Narcotics Anonymous and Alcoholics Anonymous meeting that afternoon.

REDACT advised that RE had requested REDACTE give all drugs and medication to the Mental Health team for daily administration and that RE will continue to observe REDACTED behaviour.

At 11.00am R June 2020 the Mental Health team completed face to face assessment with REDACTED The Mental Health team confirmed with REDACTE that REDACT had requested R give all drugs and medication to the Mental Health team for daily administration morning.

REDACTE reported that RE is currently 'fine' and that R had 'flushed the remaining Ritalin' stating that RE had 'never taken Ritalin before RE came into quarantine', and that the doctor prescribed it for RE when R was having a hard day with REDACTE

REDACTED reported to the Mental Health team that RE had taken 12-15 x 10mg Ritalin tablets, the afternoon of the R June 2020 because of the stress related to REDACTED

The Mental Health Team reported that REDACTE changed RE story multiple times during the conversation stating that RED currently 'fine and does not require further support'.

Based on both assessments CART requested that a referral be made to North West Area Mental Health.

REDACTED rom NWMH triage team completed an assessment with REDACTED on the RE June 2020 6.30pm, assessing that REDACTED s low risk, with nil suicidal ideation, or plans REDACTED ndicated that REDACTED has strong protective factors including R REDACTED Melbourne.

REDACTED dvised tha REDACTED reported that RE took 85 x 10mg Ritalin tablets the afternoon of the R June 2020 to get 'high' and relieve the stress that RE was experiencing in relation to REDACTED who remained at The RED Hospital under assessment related to REDACTED

REDACTED contacted poisons line who recommended vitals, bloods, and GP review. REDACTED also advised that no more prescriptions be provided to REDACTED and that the hotel GP will consult with REDACTED should REDACTED request or require medication for the duration of the quarantine period.

CART confirmed the following plan in conjunction with REDACTED

- REDACTED ordered for REDACTED to have vitals, blood test and GP review on the RE and RE June 2020
- Commencing the RE June 2020 GP to monitor every alternate day
- MHN to complete a phone check in and a face to face check in each day
- CART to contact REDACTED to discuss psychosocial support and encourage REDACTED to continue to engage with RED NA sponsor and attend daily online meetings.
- CART to develop management/support plan
- NWMH to continue to support REDACTED as required for the duration of the quarantine period
- MH Team to contact NWMH triage team should REDACTED presentation change or decline

CART SUPPORT PLAN

CART is continuing to provide support to REDACTED with the following supports currently in place

- Hotel GP to provide monitoring and contact every alternate day
- MHN to complete a phone check in and a face to face check in each day
- CART to make contact every alternate day to encourage REDACTED identified self-care activities
- NWMH to continue to provide consult and support in relation to REDACTED as required for the duration of the quarantine period
- CART to support Exit planning, with REDACTED scheduled to exit on the July 2020

4. Individual details – Passenger/detainee 1 [duplicate for each person involved]

Passenger/detainee's full name	REDACTED
Passenger/detainee incident impact	
Sex	REDACTED
Indigenous status	N/A
Date of birth	REDACTED
Passenger/detainee address	Unknown- REDACTED
Passenger/detainee unique identifier number *(if applicable)*	
Incident type	Suspected misuse of medication
Involvement in the incident (victim, witness, subject of abuse allegation, participant)	Detainee

Passenger/detainee's immediate safety needs met (Yes/No)	Yes
Medical attention provided (Yes/No)	Yes
Passenger/detainee debriefing or counselling (Yes/No	Yes
Referral to support services (Yes/No)	Yes
Change passenger/detainee care (support plan) (Yes/No)	Yes
Notified next of kin, guardian or key support person (Yes/No)	No

5. Other/s involved in incident [duplicate for each other person involved]

Person's full name	REDACTED
Date of birth	
Person's job title or relationship to passenger/detainee (carer, paid staff, other)	Welfare Survey Team Caller
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	Witness (by phone)
Person's full name	REDACTED
Date of birth	
Person's job title or relationship to passenger/detainee (carer, paid staff, other)	Team Leader, Welfare Survey Team
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	Secondary Witness
Person's full name	REDACTED
Date of birth	
Person's job title or relationship to passenger/detainee (carer, paid staff, other)	General Nurse
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	Witness
Person's full name	REDACTED
Date of birth	
Person's job title or relationship to passenger/detainee (carer, paid staff, other)	Hotel Doctor
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	Witness (by phone)
Person's full name	REDACTED
Date of birth	
Person's job title or relationship to passenger/detainee (carer, paid staff, other)	Hotel Doctor
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	Witness (by phone – not confirmed)

Person's full name	REDACTED
Date of birth	
Person's job title or relationship to passenger/detainee (carer, paid staff, other)	Doctor from North West Mental Health Triage Team
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	Witness (by phone – not confirmed)

6. Service provider response details

Brief summary of incident	Suspected misuse of medication
Reported to police (Yes/No)	No
Name of officer and date reported to police	N/A
Police investigation initiated (Yes/No)	N/A
Staff member stood down/removed (Yes/No)	No
Manager's full name	REDACTED
Manager's job title	
Date incident report reviewed	28/6/2020
Manager telephone number	REDACTED
Manager email	
Immediate actions taken by the organisation in response to the incident	
Reported to Mental Health Nursing and General Nursing onsite at hotel for mental health / health assessment of RE REDACTE D Referral to Complex Assessment and Response Team (CART) for psychosocial assessment and support to REDACTE Escalation to Deputy Commander Welfare and escalation to Commander Emergency Accommodation Request for assessment by North West Mental Health Triage	
Deputy Commander full name and signature	Anita Morris
Deputy Commander job title	Deputy Commander Welfare
Date incident report approved	28/6/2020
Comments	REDACTE D continues to be supported via mental health team and CART. REDACTED mains in hospital at The Alfred, however RE has found this to be a positive experience as RE REDAC is well supported. REDACTE has remained well managed and supported in the hotel since R NWAMH assessment on RE June 2020. No further concerns or escalations reported.

7. Incident report authorisation – EOC Command

Delegated authority full name and signature	Pam Williams Pamela Williams
Delegated authority job title	Commander COVID-19 Accommodation
Date incident report approved	28/6/20
Delegated authority phone number	REDACTED
Delegated authority email address	[redacted] .vic.gov.au
Comments	Appropriate actions undertaken to reduce risk.

8. Incident report authorisation – Deputy Secretary

Delegated authority full name and signature	
Delegated authority job title	
Date incident report endorsed	
Delegated authority phone number	
Delegated authority email address	
Comments (optional)	

9. Incident report authorisation - Secretary

Delegated authority full name	
Delegated authority job title	
Date incident report endorsed	

VICTORIA State Government | Health and Human Services

HHSD/20/64297

Secretary: Instrument of Appointment for Class 2 Controller for health emergencies

Action required by: 7 February 2020 due to current emergency management needs

Recommendation/s

1. **Sign** the attached Instrument of Appointment to appoint additional departmental officers as Class 2 Controllers for health emergencies under the *Emergency Management Act 2013*.

☑ Signed /
☐ Not signed

Comments

KPeake

Kym Peake
Secretary
Date: 7 / 2 /2020

Key issues

1. The Department of Health and Human Services is the control agency for health (Class 2) emergencies. As a control agency, the department is responsible for leading all agencies across the emergency management sector responding to the emergency.
2. On 20 November 2019 you signed an Instrument of Appointment for Class 2 Controllers of health emergencies, appointing the Chief Health Officer and Director Emergency Management branch (ref HHSF/19/87338).
3. The Victorian Bushfires 2019-2020 and current novel coronavirus events have required an increased and sustained need for a departmental emergency management response, including activation of Class 2 Controller arrangements for the novel coronavirus outbreak.
4. To manage current and ongoing demand, the appointment of two additional officers able to perform the duty of Class 2 Controller is now being sought (**Attachment 1**). The Instrument of Appointment has been revised to include:
   - Dr Angela Bone (Deputy Chief Health Officer, Environment); and
   - Mr Jason Helps (Deputy Director, Emergency Operations and Capability, Emergency Management branch).
5. A further proposed change to the existing instrument is the inclusion of the names of the officers for the purpose of the instrument. This denotes that officers are appointed as Class 2 Controller because of their skills, experience and/or training, rather than because of their substantive position.
6. Once signed, this revised Instrument of Appointment will be effective for one (1) year and supersede the instrument previously signed on 20 November 2019.

Additional information

7. The Instrument of Appointment for Class 2 Controllers (**Attachment 1**) was drafted with the assistance of the department's Legal Services branch.
8. The instrument will be reviewed and updated should any of the officers listed in the instrument vacate their substantive role.

Prepared by: REDACTED Senior Project Officer, Emergency Management Branch

Endorsed by: Andrea Spiteri, Director Emergency Management Branch, REDACTE..../..../2020

Approved by: Melissa Skilbeck, Deputy Secretary, Regulation, Health Protection and Emergency Management, REDACT..../..../2020

EMERGENCY MANAGEMENT ACT 2013

INSTRUMENT OF APPOINTMENT

1 Background

A. Section 39(1) of the Act provides that the officer in charge of an agency having overall control of response activities in relation to a Class 2 emergency may, with the consent of the officer in charge of another agency and in accordance with the State Emergency Response Plan, transfer control of any response activity in relation to that emergency to any officer of that other agency.

B. Section 39(2)(a) of the Act provides that acting in accordance with the State Emergency Response Plan, the officer in charge of an agency having overall control of response activities in relation to a Class 2 emergency or an officer in charge of another agency to which control of any response activity is transferred under subsection (1) may—

(a) appoint one or more controllers in relation to—

(i) planning for each anticipated Class 2 emergency in any area of the State; and

(ii) each Class 2 emergency in any area of the State that is occurring or has occurred.

C. Under the State Emergency Response Plan, the Department is a nominated control agency for response to Class 2 emergencies in Victoria and also carries out response activites through the State Health Emergency Response Plan.

D. The Secretary is the officer in charge of the agency for the purpose of section 39(2)(a) of the Act.

E. This instrument sets out the appointment of controllers by the Secretary under section 39(2)(a) of the Act.

2. Interpretation

Act means the ***Emergency Management Act 2013*** **(Vic)**.

Class 2 emergency has the meaning given to that term under the Act.

Department means the Department of Health and Human Services in the State of Victoria.

Secretary means the Secretary to the Department.

State means the state of Victoria.

State Emergency Response Plan has the meaning given to that term under the Act.

State Health Emergency Response Plan is a subplan of the State Emergency Response Plan and describes the arrangements for the management of health emergencies in Victoria.

3. Appointment

I, **Kym Peake**, Secretary to the Department of Health and Human Services as the officer in charge of the agency in accordance with section 39(2)(a) of the Act:

(a) **APPOINT** the officers of the Department named in column 1 of the attached schedule to hold the corresponding position specified in column 2 of the attached schedule; and

(b) **REVOKE** the previous instrument of appointment under the Act dated 20 November 2019

4 Commencement

This instrument commences on the date it is signed.

5. Period of Appointment

The officers in column 1 of the Schedule are appointed for a period of one (1) year from the commencement date of this instrument.

Signed at **Melbourne** in the **State of Victoria**

The 7th day of February 2020

K Peake

Kym Peake
Secretary
Department of Health and Human Services

SCHEDULE

SOURCE OF AUTHORITY / POWER:	**EMERGENCY MANAGEMENT ACT 2013 (VIC)**
HOLDER OF POWER / FUNCTION:	**SECRETARY**
AUTHORITY TYPE	**APPOINTMENT**

COLUMN 1	**COLUMN 2**
APPOINTED OFFICERS	**POSITION**
1. Dr Brett Sutton, Chief Health Officer 1. Dr Angela Bone, Deputy Chief Health Officer (Environment) 2. Andrea Spiteri, Director, Emergency Management Branch 3. Jason Helps, Deputy Director, Emergency Operations and Capability, Emergency Management Branch	Controller in relation to— (i) planning for each anticipated Class 2 emergency in any area of the State; and (ii) each Class 2 emergency in any area of the State that is occurring or has occurred.

REDACTED family

From: Pam Williams (DHHS) <REDACTED
To: Melissa Skilbeck (DHHS) <REDACTED>
Cc: Merrin Bamert (DHHS) <REDACTED
Date: Mon, 22 Jun 2020 12:00:50 +1000

Note that this family is in the REDACTE – not ideal.
We were to have 77 people go into the REDACTE today. We are trying to place them in another hotel.

Pam Williams
COVID19 Accommodation Commander
Department of Health and Human Services
m: REDACTED | e: REDACTED
www.dhhs.vic.gov.au

Soteria (Ancient Greek : Σωτηρία) was the goddess or spirit (daimon) of safety and salvation, deliverance, and preservation from harm.

From: Anita Morris (DHHS) <REDACTED
Sent: Monday, 22 June 2020 11:38 AM
To: Merrin Bamert (DHHS) <REDACTED; DHHSOpSoteriaEOC <DHHSOpSoteriaEOC@dhhs.vic.gov.au>; Stuart Bailey (DHHS) REDACTED
Cc: Pam Williams (DHHS) <REDACTED; Vanessa Brotto (DHHS) REDACTED Melody Bush (DHHS) <REDACTED>
Subject: RE: REDACTED

Thanks Merrin. Stuart, can you confirm based on information provided and we will advise the outcome of testing as soon as results are available?

Happy to discuss.

REDACT

From: Merrin Bamert (DHHS) REDACTED
Sent: Monday, 22 June 2020 11:31 AM
To: Anita Morris (DHHS) REDACTED; DHHSOpSoteriaEOC <DHHSOpSoteriaEOC@dhhs.vic.gov.au>
Cc: Stuart Bailey (DHHS) <REDACTED Pam Williams (DHHS) REDACTED >; Vanessa Brotto (DHHS) <REDACTED; Melody Bush (DHHS) REDACTED
Subject: RE: REDACTED

As agreed, prioritising the swabbing and would be good to support completing detention at an alternate location.

Kind regards

Merrin

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
p REDACTED
e

From: Anita Morris (DHHS) <REDACTED
Sent: Monday, 22 June 2020 11:11 AM
To: Merrin Bamert (DHHS) <REDACTED; DHHSOpSoteriaEOC <DHHSOpSoteriaEOC@dhhs.vic.gov.au>
Cc: Stuart Bailey (DHHS) <REDACTED Pam Williams (DHHS) REDACTED Vanessa Brotto (DHHS) REDACTED>
Subject: REDACTED
Importance: High

Hi Merrin,

As discussed, the REDACTED family are due to exit on Thursday 25 June 2020. Both REDACTED and REDACTED (who is not in hotel quarantine) have been unhappy with the hotel environment for their REDACTED who is understood to have autism. REDACTED has expressed REDACTED concerns to the Ombudsman and the Minister. The department has provided a response to both.

REDACTED are currently at Day REDACTED and I would like Compliance to consider exemption for this family from tomorrow pending the results of REDACTED swabbing REDACTED REDACTED should they REDACTED return negative results REDACTED. If either REDACTED test positive the decision would need to be reserved.

If exemption is approved, I understand that the family would be required to quarantine at their home address until REDACTED would be advised to have supplies ready to enable them to do so.

Please advise if you approve of this request to Compliance. I have briefed Stuart ahead of your approval.

Regards,

REDACTED

Deputy Commander Welfare | COVID19 Emergency Accommodation
Department of Health and Human Services
m REDACTED | e REDACTED
w. www.dhhs.vic.gov.au

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

FW: ADF support

From: Kym Peake (DHHS) <REDACTED
To: Andrea Spiteri (DHHS) <REDACTED, Melissa Skilbeck (DHHS) REDACTED
Date: Wed, 24 Jun 2020 08:41:31 +1000

Andrea – someone will reach out to you.

Kym

From: Kym Peake (DHHS)
Sent: Wednesday, 24 June 2020 7:42 AM
To: REDACTED
Subject: ADF support

REDACTED

The following support from ADF would be hugely appreciated.

Operational coordination and planning support

The State Control Centre and other emergency management arrangements are fully engaged in coordination, operations and logistics, including through whole of government coordination and engagement with other agencies such as the ADF. The mission will involve targeted deployment of DHHS operational capabilities in each region, VicPol capacity (in particular to support enforcement and compliance at hotel quarantine locations and elsewhere) and deployment of ADF personnel and capability in support and logistics roles, and to transport pathology samples interstate for testing if required.
The State Control Centre has remained operational for the duration of the COVID-19 response. Resourcing of the SCC is scalable and will be reviewed by the State Control Team in line with this mission.
EMV have established the combined agency operations group (CAOG). This group combines relevant state agencies and the ADF to provide planning and technical expertise that can assist in a number of areas including planning, logistics and supply chain solutions, and generally assisting at times when normal agency arrangements are becoming overwhelmed. The CAOG forms a part of the overall SCC operating model supporting the State Controller Health.

Staff request: 10-12 planners/logisticians and 4 intelligence officers. This will add to the 9 planners currently operating from the State Control Centre

Contact person: Andrea Spiteri

Medical and co-ordination staff to support drive through testing

In addition to neighbourhood and door to door testing in hotspot suburbs it is essential to maintain a baseline testing level to effectively monitor the spread of the virus across the state.

A baseline target of 10,000 test a day will be set to ensure anyone with mild symptoms can get tested across the state. This is on top of testing of testing associated with any outbreaks, sensitive sights and close contacts of confirmed cases.

Existing retail and drive through sites will be maintained. An additional ten drive through testing sites will be stood up this week. This will include large drive through sites to support the effort, including the showgrounds, race courses and the Melbourne Sports and Aquatic Centre. ADF co-ordination and medical support for these testing sites is requested.

Staff request: 5 planners/logisticians and 200 medical staff

Contact person: REDACTED

Security support services for hotel operations

Similar to support provided in NSW, ADF security support for passengers entering and exiting hotel quarantine is sought.

Personnel request: between 50-100 personnel

Contact person: Melissa Skilbeck (meeting already scheduled with Colonel REDACTED this afternoon)

FW: Finalisation of complaint from REDACTED [SEC=OFFICIAL]

From: Executive Services Directorate (DHHS) REDACTED
To: REDACT (DHHS) REDACTED, Anita Morris (DHHS) REDACTED, Murray Smith (DHHS) REDACTED, Vanessa Brotto (DHHS) REDACTED
Cc: DEPSEC RHPEM (DHHS) REDACTED, Melissa Skilbeck (DHHS) REDACTED, REDACTED REDACTED
Date: Wed, 24 Jun 2020 16:26:00 +1000

Good afternoon all

Please note the below outcome advice provided by the VO for your information.

Thank you in particular to REDACT, Anita Morris, Murray Smith and Vanessa Brotto for facilitating the response to the VO.

This matter is now finalised.

Kind regards,

REDACTE

Prevention, Detection and Complaints
Executive Services | Legal and Executive Services
Department of Health and Human Services | 50 Lonsdale Street, Melbourne VIC 3000
t: REDA | e: REDACTED

From: REDACTED
Sent: Wednesday, 24 June 2020 3:29 PM
To: Executive Services Directorate (DHHS) REDACTED
Subject: Finalisation of complaint from REDACTED [SEC=OFFICIAL]

24 June 2020 File No: REDACT

REDACTED

Dear Mark Grasso

Finalisation of complaint from REDACTED

Thank you for your response of 22 June 2020 in relation to a complaint from REDACT about the Department of Health and Human Services.

I have considered the information provided by the department and REDACT and write to confirm that we will not be taking further action at this stage. I have advised RE of this outcome.

I would like to take this opportunity to thank Murray Smith and Vanessa Brotto for taking the time to speak with me on 19 June 2020, especially in the context of dealing with the current health crisis.

An additional thank you to you, RE, for your assistance and cooperation in relation to this matter. I was particularly appreciative of how efficiently you escalated my request for information given the time sensitivity with this complaint.

If you have any further queries, please contact me via return email.

Yours sincerely

REDACTED

ombudsman VICTORIAN
Level 2, 570 Bourke Street
MELBOURNE VIC 3000

REDACTED | **Regional Callers (excl. mob.):** 1800 806 314

Fax: +61 3 9602 4761 | **DX:** RED Melbourne

https://www.ombudsman.vic.gov.au

FW: Incident report from Stamford Plaza 22 June

From: Pam Williams (DHHS) <REDACTED
To: Melissa Skilbeck (DHHS) <REDACTED
Date: Mon, 29 Jun 2020 13:07:28 +1000
Attachments: RE: Follow up - Stamford Plaza (168.45 kB)

The nurse will not be rescheduled at the hotels

REDACTED
COVID19 Accommodation Commander
Department of Health and Human Services
REDACTED
www.dhhs.vic.gov.au

Soteria (Ancient Greek : Σωτηρία) was the goddess or spirit (daimon) of safety and salvation, deliverance, and preservation from harm.

From: Sandy Austin (DHHS) REDACTED
Sent: Monday, 29 June 2020 1:01 PM
To: REDACTED (DHHS) <REDACTED; Andrea Spiteri (DHHS) REDACTED; Michael Mefflin (DHHS) REDACTED Merrin Bamert (DHHS) REDACTED Melody Bush (DHHS) <REDACTED; Pam Williams (DHHS) <REDACTED
Subject: RE: Incident report from Stamford Plaza 22 June

Pam,
This may be helpful. I had spoken with REDACT and RE had agreed not to roster this MH nurse.

Sandy Austin
Director, Emergency Management and Health Protection, East Division
Department of Health and Human Services
REDACTED e REDACTED
Eastern Metro - Duty Officer 1 300 792 766
Hume - Duty Officer 1 300 164 867
State - Duty Officer 1 300 790 733
East Division relocation notification 1 300 576 518

From: Melissa Skilbeck (DHHS) <REDACTED
Sent: Sunday, 28 June 2020 2:51 PM
To: REDACTED (DHHS) <REDACTED; Andrea Spiteri (DHHS) REDACTED; Michael Mefflin (DHHS) REDACTED; Merrin Bamert (DHHS) REDACTED; Sandy Austin (DHHS) <REDACTED; Melody Bush (DHHS) <REDACTED
Subject: RE: Incident report from Stamford Plaza 22 June

Thank you – report is noted
Pam – can you follow-up as commander on the suggestion that a mental health nurses allowed resident out of room without AO permissioning done – this is unacceptable and if proven, ought to result in that nurse not participating in this program again?

Regards,
Melissa

Melissa Skilbeck
Deputy Secretary | Regulation, Health Protection and Emergency Management
Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
t. (03) REDACT | m: REDACTED | e: REDACTED | w. www.dhhs.vic.gov.au

I am currently on roster due to COVID operations and work from Sundays to Thursdays inclusive.

From: REDACTED
Sent: Saturday, 27 June 2020 3:25 PM
To: Melissa Skilbeck (DHHS) REDACTED; Andrea Spiteri (DHHS) REDACTED >; Michael Mefflin (DHHS) <REDACTED Merrin Bamert (DHHS) REDACTED; Sandy Austin (DHHS) <REDACTED; Melody Bush (DHHS) <REDACTED
Subject: Incident report from Stamford Plaza 22 June

Good afternoon,

Please find attached the above report that has been entered into Trim HHSD/20/291315

Kind regards

REDACTED

Department of Health and Human Services
Emergency Operation Centre – Operation Soteria
Logistics Team
email: REDACTED

VICTORIA State Government | Health and Human Services

Pride Network
Department of Health and Human Services

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

RE: Follow up - Stamford Plaza

From: REDACTED
To: Sandy Austin (DHHS) REDACTED
Cc: REDACTED, Allocations <allocations@swingshift.com.au>
Date: Thu, 25 Jun 2020 19:51:54 +1000

Hi Sandy

We have addressed this issue with the nurse referred to and spoken with RE DA about RE DA actions.

RE DA was accepting of the feedback however we have elected not to return RE DA to any hotel shifts.

I hope you have a good evening.

Kind regards

RE DA
REDACTED
Managing Director

208 Argyle St Fitzroy 3065
P.O. Box 2919 Fitzroy 3065
Ph REDACTED
Fax REDACTED

Australian Nursing Agency Pty Ltd trading as SwingShift Nurses & Australian Nursing Agency

From: Sandy Austin (DHHS) REDACTED
Sent: Thursday, 25 June 2020 7:44 PM
To: REDACTED
Subject: Follow up - Stamford Plaza

Hi RED
I think this is the issue of the MH nurse taking out a guest with no PPE, not telling the security nor the AO. Nurses on duty advised that this was the third shift which the mental health nurse had undertaken at this hotel and that had been previous instances of the mental health nurse not listening and having difficulty sharing information.

Please ensure that REDACTED is reminded to follow the procedures and protocols for all fresh air walks. No guest is to go out without prior AO permission and must be escorted by a security guard.

Regards,

REDACTED
REDACTED
Deputy Commander, Hotels
Operation Soteria

From: REDACTED
Sent: Thursday, 25 June 2020 4:11 PM
To: Sandy Austin (DHHS) REDACTED
Subject: FW: Follow up - Stamford Plaza

Hi Sandy
Am hoping this is my last email to you about this matter – I have just found information in one of the handover notes for the RE/6/2020 that states an IR was submitted to the EOC. See below cut and paste.
The handover notes does not have the PM TL name but according to our working roster the TL should have been REDACTED

Mental health nurse took guest in room REDACTED for unauthorised walk - see summary of incident as emailed to EOC:

Dear REDACTED

As per conversation earlier, please see below details of the incident this evening at the Stamford in relation to an unauthorised walk.

A bit after 7pm the mental health nurse REDACTED took REDACTED (Room RED) for a walk based on concerns about RE mental health.

The Mental Health Nurse did not follow the authorising procedures in place for the walk. Whilst there was good reason for RED to take the guest RE did not seek permission from the AO nor liaise with security. Prior to the walk, RED informed the team leader that RE was taking REDACTED for a walk. The Team Leader understood that REDAC was following the authorising procedures through the AO and in conjunction with security and that REDAC was informing RE of the planned walk as a matter of interest following a discussion with CART around this particularly vulnerable guest.

The AO and Team Leader were alerted to the unauthorised walk when security saw the guest and mental health nurse out the front of the hotel and believed them both to be guests (the mental health nurse was in casual clothes so not immediately identifiable as a nurse).

The ED nurse REDACTED and AO REDAC donned full PPE to go downstairs as it was communicated that a guest was unaccompanied downstairs (this was not the case).

The AO was heading downstairs and met the ED nurse coming up the stairs. The mental health nurse arrived back on the floor via the lift at the same time. The guest had been returned to RE room.

Security and AO initially had a conversation with Mental Health Nurse about the walk being against protocol. Nurse advised that RED had advised Team Leader of the walk and advised RE was not aware of the need to seek authorisation from the AO or involve security. This was true however

Actions:
The lift that the guest travelled in was cleaned – there were no other touch points identified.
The AO, head of security (REDA) and Team Leader spoke with the mental health nurse and advised RE clearly of the authorising procedures in place to allow walks to take place.
The mental health nurse advised that RE now understood the authorising requirements however had previously been unaware and had believed RE discussion with the Team Leader had been sufficient to allow RE to undertake the walk.

Nurses on duty advised that this was the third shift which the mental health nurse had undertaken at this hotel and that had been previous instances of the mental health nurse not listening and having difficulty sharing information. The ED nurse advised they would appreciate not having the mental health nurse on shift again.
The Team Leader observed the mental health nurse to interact warmly with two guests over the phone appeared very focused on the wellbeing of these vulnerable guests.

---

thanks

REDACTED
REDACTED
Department of Health and Human Services | 165-169 Thomas St Dandenong VIC 3175

From: Sandy Austin (DHHS) REDACTED
Sent: Thursday, 25 June 2020 12:50 PM
To REDACTED
Subject: RE: Follow up - Stamford Plaza

Hi REDACTED
Is it possible for the AO that evening to check their records to see if they had approved it? If not, no worries, I will check with Swingshift.

Regards,
Sandy

Sandy Austin
REDACTED
Deputy Commander, Hotels
Operation Soteria

From REDACTED
Sent: Wednesday, 24 June 2020 5:27 PM
To: Sandy Austin (DHHS) REDACTED
Subject: Follow up - Stamford Plaza

Hi Sandy

As discussed today, here are the details of the Mental Health nurse who was on shift at the Stamford Hotel on REDACTEREDACTE

Name: REDACTED

This relates to an alleged incident that occurred on this date (as reported by Security). Security Supervisor (REDACTED advised that on the evening of REDAC 2020, security staff observed a guest walking around the foyar of the hotel unaccompanied. Security staff on shift went downstairs and spoke with the MH nurse who was in a different location. MH nurse advised security that RE needed a swipe card to access the guest lists and to open the guest room. My understanding from security is that the AO had not authorised this walk and security were not informed of the walk occurring.

Unfortunately I don't have any further information and am unable to locate information in the TL handover notes. I am not sure how this guest left RE room in the first instance as we have security on all floors?? I cannot ascertain whether the guest was escorted downstairs by the MH nurse in the first instance or whether other staff on site that evening were notified of the walk prior to this occurring.

Thanks

REDACTED
REDACTED
Department of Health and Human Services | 165-169 Thomas St Dandenong VIC 3175

RE: Heads up: Bed bugs

From: Pam Williams (DHHS) <REDACTED
To: press (DHHS) <press@dhhs.vic.gov.au>, Melissa Skilbeck (DHHS) REDACTED
Cc: Merrin Bamert (DHHS) REDACTED, Melody Bush (DHHS) REDACTED
Date: Sun, 28 Jun 2020 20:29:20 +1000

We are advised that the guest has admitted the bugs probably came from RE luggage and that RED has already asked REDACT to bring two new suitcases into the hotel for RED. Whether RED is prepared to say that to the press is another question. RE wants to move hotels but we are suggesting RE follows normal hotel protocol (change room)

Pam Williams
COVID19 Accommodation Commander
Department of Health and Human Services
REDACTED

Soteria (Ancient Greek : Σωτηρία) was the goddess or spirit (daimon) of safety and salvation, deliverance, and preservation from harm.

From: press (DHHS) <press@dhhs.vic.gov.au>
Sent: Sunday, 28 June 2020 8:01 PM
To: Melissa Skilbeck (DHHS) <REDACTED vic.gov.au>; Pam Williams (DHHS) REDACTED
Cc: Merrin Bamert (DHHS) <REDACTED; Melody Bush (DHHS) REDACTED
Subject: RE: Heads up: Bed bugs

Hi @Pam Williams (DHHS)

Can we confirm that someone has actually looked at the luggage and whether the family has accepted that it's bed begs from luggage?

Will change the way we respond significantly is all- keen to be sure and get to Mins ASAP as deadline almost passed.

Thanks!

REDACTE D

From: Melissa Skilbeck (DHHS) <REDACTED
Sent: Sunday, 28 June 2020 7:24 PM
To: press (DHHS) <press@dhhs.vic.gov.au>; Pam Williams (DHHS) <REDACTED
Cc: Merrin Bamert (DHHS) REDACTED; Melody Bush (DHHS) REDACTED
Subject: RE: Heads up: Bed bugs

Our entomologist is in COVID team – don't know if RED rostered on - so Annaliese may know

Regards,
Melissa

Melissa Skilbeck
Deputy Secretary | Regulation, Health Protection and Emergency Management
Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000

t. (03) REDACTED w. www.dhhs.vic.gov.au
I am currently on roster due to COVID operations and work from Sundays to Thursdays inclusive.

From: press (DHHS) <press@dhhs.vic.gov.au>
Sent: Sunday, 28 June 2020 7:22 PM
To: Pam Williams (DHHS) <REDACTED au>; Melissa Skilbeck (DHHS) REDACTED
Cc: Merrin Bamert (DHHS) <REDACTED >; Melody Bush (DHHS) REDACTED
Subject: RE: Heads up: Bed bugs

Thanks Pam

We are working with MO who have been approached by Herald-Sun. REDACTED is my contact at DJPR who is working through the lines I think.

Thanks

REDACTED

From: Pam Williams (DHHS) REDACTED
Sent: Sunday, 28 June 2020 7:20 PM
To: press (DHHS) <press@dhhs.vic.gov.au>; Melissa Skilbeck (DHHS) <REDACTED
Cc: Merrin Bamert (DHHS) <REDACTED Melody Bush (DHHS) REDACTED
Subject: Heads up: Bed bugs

I am not sure who I go to with this query – a guest has informed us and the Herald Sun that there is a bed bug in their room at Rydges and RE has been bitten.
There is a view that the bug may have come in luggage as it is a well-fed adult while Rydges has had a complete clean and has been empty for several weeks.
We are trying to work out how best to investigate and remove the bedbug. We are nervous to move the person as it may be in RED luggage. RE is travelling with REDACTED who do not appear to have a bite. Is there a bedbug section in Public Health?

Pam Williams
COVID19 Accommodation Commander
Department of Health and Human Services
m: REDACTED
www.dhhs.vic.gov.au

Soteria (Ancient Greek : Σωτηρία) was the goddess or spirit (daimon) of safety and salvation, deliverance, and preservation from harm.

Re: Urgent matter regarding quarantined Muslims

From: REDACTED
To: Merrin Bamert (DHHS) <REDACTED, Melissa Skilbeck (DHHS) REDACTED
Cc: Pam Williams (DHHS) <REDACTED
Date: Fri, 15 May 2020 17:53:20 +1000

Thanks for the update Merrin.

Get Outlook for iOS

From: Merrin Bamert (DHHS) REDACTED
Sent: Friday, May 15, 2020 5:33:40 PM
To: REDACTED; Melissa A Skilbeck (DHHS) REDACTED
Cc: Pam Williams (DHHS) <REDACTED
Subject: RE: Urgent matter regarding quarantined Muslims

Hi RE and Melissa

We spoke to RE this morning and he provided the details of the guest and was happy we called RED

We have tried all day and just now were able to speak with RED. RE is a guest at Crown Metropol. RE is very appreciative of contact. RE was told the Crown Metropol have a policy where they do not begin delivering meals until 6:30pm in the evening. RE is keen that meals are delivered around 5pm. RE is also keen for microwaves to be delivered to rooms so they can heat up breakfast items.

We have committed to confirm the policy with the hotel regarding the timing of meal delivery as this is inconsistent with what DJPR have advised across the hotel network and request they improve the service

We have notified the guest that microwaves are unlikely but we can check with the hotel to confirm that breakfast items supplies are not things that need to be heated.

We will work with the hotel and team leader and will follow up with the guest in the morning.

Regards

Merrin

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

From: REDACTED
Sent: Friday, 15 May 2020 8:09 AM
To: Melissa Skilbeck (DHHS) <REDACTED
Cc: Merrin Bamert (DHHS) <REDACTED; Pam Williams (DHHS)

REDACTED

Subject: RE: Urgent matter regarding quarantined Muslims

Hi Melissa,

That would be great. RE DA can be reached on REDACTED

Thanks,
REDA

REDACTED

Office of Jenny Mikakos MP
Minister for Health
Minister for Ambulance Services
Level 22, 50 Lonsdale St, Melbourne Vic 3000
REDACTED

From: Melissa Skilbeck (DHHS) <REDACTED>
Sent: Thursday, 14 May 2020 8:43 PM
To: REDACTED
Cc: Merrin C Bamert (DHHS) <REDACTED; Pam Williams (DHHS)
REDACTED
Subject: RE: Urgent matter regarding quarantined Muslims

REDAC
TED
Are you comfortable with Merrin or Pam contacting REDACTE D directly to followup the specific issue?

Regards,
Melissa

Melissa Skilbeck
Deputy Secretary | 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

---

From: Merrin Bamert (DHHS) REDACTED
Sent: Thursday, 14 May 2020 7:20 PM
To: Melissa Skilbeck (DHHS) <REDACTED>; Pam Williams (DHHS)
REDACTED
Cc: REDACTED
Subject: RE: Urgent matter regarding quarantined Muslims

Hi Melissa

We currently have 237 of our Muslim guests observing Ramadan across our 12 hotels.

We have spoken to our DHHS team leaders as well as to our DJPR colleagues today to investigate if any of our guests observing Ramadan have raised this serious issue of a delay in receiving their evening meal and none were aware.

We are however aware that this had been an issue for some guests in the past weeks.

Can I offer to speak to REDACTE D the Senior Advisor tomorrow or directly to the Imam at RE request to investigate which particular hotel this was a concern and when to ensure the issue is investigated and rectified.

As a matter of background as advised DJPR have put the following guidance in place to work with hotels to ensure the any guest observing Ramadan is appropriately supported.

Hotel Guidance:

Advice on the changing times of Sohour and Iftar and a link to one example of the prayer and meal time calendar.

Food Advice to Hotels
To be provided in room – for guests to consume at their pace.
Dates, dried apricots, Flat bread, Salada Biscuits or some other cracker, Feta Cheese, Cream Cheese (Greek style), Honey, Jam, Fruit (apples, bananas, oranges), Juice

For Iftar, the meal to break their fast:
Soup, Salad, A substantial hot meal – rice, protein & vegetables (have asked them to be generous with portion sizes), Dessert (cakes, slices, etc)

For Sohour, the last meal before they start their fast:
Boiled eggs, Toast, Porridge , Olives, Cheese, Vegetables (like sliced tomato, sliced cucumber, julienne carrots)

Evening meals for guests observing Ramadan are prioritised ahead of other guests and ahead of the scheduled time for Sohour and Ifta, in line with the prayer calendar.
Some hotels have been providing breakfast items the night before and are labelling the breakfast (Sohour) pack so that there is no mistaking it for dinner.
Hotels are also conscious of how the fast is broken, the importance of the composition of the entire meal and the need to increase portion size for the main meal, as outlined in the guidance provided above.

Regards

Merrin

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
p REDACTED
e

From: Melissa Skilbeck (DHHS) <REDACTED
Sent: Thursday, 14 May 2020 9:35 AM
To: Merrin Bamert (DHHS) <REDACTED >; Pam Williams (DHHS) REDACTED
Subject: FW: Urgent matter regarding quarantined Muslims

Merrin

Can you please follow-up on the issue below urgently?
Appreciate an update I can forward to RE tonight

Regards,
Melissa

Melissa Skilbeck
Deputy Secretary | Regulation, Health Protection and Emergency Management
Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
t. (03) REDACTED | m: REDACTED | e. REDACTED | w. www.dhhs.vic.gov.au

From: Melissa Skilbeck (DHHS)
Sent: Thursday, 14 May 2020 9:31 AM
To: REDACTED REDACTED REDACTED
Subject: RE: Urgent matter regarding quarantined Muslims

REDACTED

Merrin is on roster for Pam today and I will pass it on to her
We have many more than 20-25 residents observing Ramadan …

Regards,
Melissa

Melissa Skilbeck
Deputy Secretary | Regulation, Health Protection and Emergency Management
Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
REDACTED | w. www.dhhs.vic.gov.au

From: REDACTED
Sent: Thursday, 14 May 2020 8:01 AM
To: Melissa Skilbeck (DHHS) <REDACTED>; Pam Williams (DHHS)
REDACTED
Subject: Fwd: Urgent matter regarding quarantined Muslims

Hello, would you be able to manage this one? Thanks REDACTED
Get Outlook for iOS

From: REDACTED>
Sent: Thursday, May 14, 2020 7:50 am
To: REDACTED
Subject: Fwd: Urgent matter regarding quarantined Muslims

Hi REDACTED

Just wanting to raise the below email in relation to mandatory hotel quarantine. Is this something you can liaise with DJPR on or is it best referred to them directly to deal with?

Thanks
REDACTED

Get Outlook for iOS

From: REDACTED
Sent: Wednesday, May 13, 2020 10:21 pm
To: REDACTED
Subject: FW: Urgent matter regarding quarantined Muslims

Hi RED ACTED

I hope you're well.

The Board of Imams, Victoria's peak religious Islamic body contacted me earlier today to say there are up 25 people who are Muslim in quarantine at the moment and are observing their fast for Ramadan.

They are fasting 12 hour days with no food and water and break there fast at sunset, but apparently they're not getting there meals till about 7PM.

Do you know who's the right person to speak to in relation to the matter?

Thanks
RED ACTED

REDACTED

Minister for Corrections
Minister for Youth Justice
Minister for Victim Support
REDACTED

From: REDACTED
Sent: Wednesday, 13 May 2020 5:18 PM
To: REDACTED
Cc: REDACTED
Subject: Urgent matter regarding quarantined Muslims

Dear REDACTED

Assalamu Alaikom Wr Wb,

I would like to raise an urgent matter that had been brought to my attention today concerning a number of Muslims (20-25) who are subjected to mandatory quarantine in city hotels after arriving from overseas travel. The information I had received from members of the community was that these quarantined individuals are not receiving their Ramadan meals on time, where at times delayed 1-2 hours after the time specified for the breaking of fast (sunset), meaning that after a 12 hour fasting day, the person would have to wait a further hour or two before their meal is provided to them. In addition to this, I was told that the type of food they are being provided is not befitting to a fasting person nor does it comply with the traditional practices of breaking the fast, such as it being complemented with dates, nuts and soup followed by a large fulfilling meal. The Board of Imams Victoria is happy to provide a meals guideline appropriate to Ramadan and any further resources and information relating to this matter should the relevant bodies request it.

For this I kindly ask that you communicate this important message back to the relevant authorities so that they can address this as soon as possible.

Walsalam,

REDACTED
Board of Imams Victoria | General Manager
Address: 945 Sydney Rd Coburg North, VIC 3058 | Mail: PO Box 137 Coburg, VIC 3058
REDACTED W: www.boiv.org.au

RE: Operation Soteria catch-up

From: "Melissa Skilbeck (DHHS)" <"/o=exchangelabs/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=2accaadd5a2c436ba67c029d4458f627-mski1812">

To: "Pam Williams (DHHS)" <REDACTED, "Nick Chiam (DHHS)" REDACTED

Date: Mon, 25 May 2020 22:42:04 +1000

Thanks Pam

I think we will need ADF engagement to a greater scale given the withdrawal of staff from agencies and our own department and the aspirations for student accommodation – that need and timing will be clearer end of this week

Yes – need to talk recruitment – who else should join us?
REDAC – can u coordinate a time?

Regards,
Melissa

Melissa Skilbeck
Deputy Secretary | Regulation, Health Protection and Emergency Management
Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
t. REDACTED | w. www.dhhs.vic.gov.au

From: Pam Williams (DHHS) <REDACTED
Sent: Monday, 25 May 2020 9:10 PM
To: Nick Chiam (DHHS) <REDACTED
Cc: Melissa Skilbeck (DHHS) <REDACTED
Subject: Operation Soteria catch-up

Some feedback for Operation Soteria

- * Met with Emergency Management Commissioner and ADF REDACTED today to talk about Op Soteria progress and also thanks for the ADF contribution. Help was offered beyond the current departure date of 15 June. Our view currently is that we should probably move on to dedicated staff. Interesting to learn of the small input of ADF in Victoria compared to other States where ADF paired with Police in hotel monitoring (similar to our contracted security, in NSW, Qld, WA, NT) and border movement controls (SA, Queensland)
- * Location of EOC: as restrictions are being removed, it is important that we find a new location for the EOC. I understand that there might be some space in the lower levels of 50 Lonsdale Street. I have reached out to REDACTED to discuss.
- * Recruitment of Operational Support. As per the environment scan, I am keen to get an Operational Support Commander into the EOC. The proposed VicPol option is no longer on offer, but I believe at least one of the EOs we interviewed could undertake this role and step in very quickly. REDACTED has also offered a VPS6 with HR expertise who would be very helpful as we try to fill the quickly emerging gaps in our structure. We are not able to give the corporate side enough attention so this is a high priority.
- * Keen to talk EO recruitment when you are available

Pam Williams
COVID19 Accommodation Commander
Department of Health and Human Services
m: REDACTED
www.dhhs.vic.gov.au

Soteria (Ancient Greek : Σωτηρία) was the goddess or spirit (daimon) of safety and salvation, deliverance, and preservation from harm.

Appointment of class 2 controller

From: "Melissa Skilbeck (DHHS)" <"/o=exchangelabs/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=2accaadd5a2c436ba67c029d4458f627-mski1812">

To: "Kym Peake (DHHS)" REDACTED

Date: Sat, 01 Feb 2020 21:57:08 +1100

Kym

I recommend that you - as head of agency under the Emergency Management Act - tonight advise the Emergency Management Commissioner that you have appointed the Director, Emergency Management Branch (state health coordinator) as the class 2 controller for 2019 novel Coronavirus outbreak

Regards
Melissa

Melissa Skilbeck
Deputy Secretary
Regulation, Health Protection and Emergency Management

VICTORIA State Government | Health and Human Services

Secretary: Incident report on the death of REDACTED

Recommendation/s

That you:

1. **Note** the attached incident report relating to the REDACTED REDACTED suicide

❒ Noted /
❒ Please discuss

Comments

Kym Peake
Secretary
Date: / /2020

Key issues

1. REDACTED was issued a detention notice on REDAC 2020 after arriving from REDA where the Department of Health and Human Services (the department) understands REDACTED was detained as part of the Victoria government response to the COVID-19 pandemic and a nationally agreed direction to require mandatory quarantine of any international arrivals after midnight [xx] March 2020. RE was detained to RE hotel room, REDACTED REDACTED. The department understand Mr RED was travelling REDA
2. On REDACTED was found deceased in RE hotel room by a DHHS Authorised Officer (AO), and hotel security. REDACT REDACTED REDACTED. This followed a request for the AO to check REDACTED by the health practitioners on site following RE failure to answer RE phone four times throughout the day for RE daily covid screening check (**attachment 1**).
3. Police were immediately called to the scene and the AO and others on site were interviewed.
4. REDACTED was contacted by XXX [Police??]. Counselling support was arranged for staff on the ground as well as other detainees in surrounding rooms who were aware. The on-site registered nurse contacted the General Practitioner who attended REDACTED (**attachment 2**).
5. In addition to the daily covid screen phone calls by the on-site registered health practitioner (**attachment 3**), the department did a welfare check survey with REDACTED REDACTED (**attachment 4**). The check did not indicate any concerns. The department does not have a record of REDACTE contacting the Department of Jobs Precincts and Regions (DJPR) 1800 helpline nor is there any record of contact by the social welfare line where detainee concerns are escalated. REDACTE does not appear to have contacted the department at any point seeking permission to leave the room or request RED detention be completed elsewhere. There are no records of any concerns for REDACTE health and welfare.

Additional information

6. The department conducts a review of detainees to determine whether they should continue to be detained. It was not in receipt of any information that suggested REDACTE should not continue to be detained each day.
7. The department has a draft protocol for mandatory detention operations which require a daily check and a welfare check. Registered health practioners are available on-site 24 hours a day and a registered mental health nurse is regularly rostered to each hotel site.
8. The site is also attended by an AO 24 hours a day to support emergency permissions for temporary leave from rooms and a team site leader is available from [time?]
9. The department followed up on a query by DJPR that REDACT REDACTED REDACTED REDACTED located in a separate room. The department REDACTED and through discussion, which did not reveal RE REDACTED REDACTED
10. REDACT REDACTED [??] on 12 April 2020.
11. The AO and other connected staff continue to be supported through employee wellbeing services.

Prepared by: Meena Naidu, Director Health and Human Services Regulation and Reform, 9096 5254, 0428 773 520, …./…./2020

Endorsed by: Annaliese van Dieman, Acting Chief Health Officer ……/……/2020

Approved by: Jacinda de Witts, Deputy Secretary, , ……/……/2020

EMV
EMERGENCY
MANAGEMENT
VICTORIA

State Health Emergency Response Plan

Edition 4

This plan has been endorsed by the State Crisis and Resilience Council (SCRC) as a subplan to the State Emergency Response Plan.

Authorised and published by the Victorian Government
Melbourne September 2017

ISBN 978-0-7311-7276-4 (Print)
ISBN 978-0-7311-7277-1 (pdf/online)

This document is also available online at **www.health.vic.gov.au/sherp**

Acknowledgment of Country

Emergency Management Victoria (EMV) acknowledges Aboriginal and Torres Strait Islander people as the Traditional Custodians of the land. EMV also acknowledges and pays respect to the Elders, past and present and is committed to working with Aboriginal and Torres Strait Islander communities to achieve a shared vision of safer and more resilient communities.

Photographs courtesy of:
- Monash Clinical School (cover – middle photo)
- John Gollings (page 12)

Printed by Metro Printing, Airport West on sustainable paper (1707010)

Contents

Figures

Tables

Acronyms

Acronyms used in this plan.

ACRONYM	DESCRIPTION
AV	Ambulance Victoria
CAD	computer aided dispatch
CFA	Country Fire Authority
CHO	Chief Health Officer
DEDJTR	Department of Economic Development, Jobs, Transport and Resources
DELWP	Department of Environment, Land, Water and Planning
DET	Department of Education and Training
DHHS	Department of Health and Human Services
DTF	Department of Treasury and Finance
ED	emergency department
EMC	Emergency Management Commissioner
EM-COP	Emergency Management Common Operating Picture
EMJPIC	Emergency Management Joint Public Information Committee
EMMV	Emergency Management Manual Victoria
EMT	Emergency Management Team
EMV	Emergency Management Victoria
EPA	Environment Protection Authority Victoria
ESTA	Emergency Services Telecommunications Authority
FEMO	Field Emergency Medical Officers
GP	general practitioner
I-HIMT	Incident tier Health Incident Management Team
IMT	Incident Management Team
MOUs	memoranda of understanding
PHCP	Public Health Control Plan
R-HIMT	Regional tier Health Incident Management Team
SAC	State Agency Commander
SCC	State Control Centre
SCM	State Consequence Manager
SCOT	State Coordination Team
SCRC	State Crisis and Resilience Council
SCT	State Control Team
SEMC	Security and Emergency Management Committee of Cabinet
SEMT	State Emergency Management Team
SERP	State Emergency Response Plan
SHEMC	State Health Emergency Management Coordinator
SHERP	State Health Emergency Response Plan
S-HIMT	State tier Health Incident Management Team
SPLO	Senior Police Liaison Officer

1 Introduction

The State Health Emergency Response Plan (SHERP) provides an overview of the arrangements for the management of health emergencies in Victoria. This plan describes the integrated approach and shared responsibility for health emergency management between the Department of Health and Human Services (DHHS), the emergency management sector, the health system and the community.

Every day, the health system manages a large volume and variety of incidents. These incidents do not typically stretch the system's ability to effectively respond.

Health emergency, in the context of this plan, includes an incident or emerging risk to the health of community members, from whatever cause, that requires a **significant and coordinated effort** to ensure the health system can effectively respond and mitigate the adverse health consequences for communities.

Within the *Emergency Management Act 2013,* health emergencies can be classified as Class 2 emergencies. The Emergency Management Manual Victoria (EMMV) Part 7 – Emergency Management Agency Roles designates DHHS as the control agency for the following types of health emergencies:

- biological materials, including leaks and spills
- radioactive materials, including leaks and spills
- retail food contamination
- food / drinking water contamination
- human disease (including mass, rapid onset human disease from any cause).

This plan has been developed by DHHS in conjunction with the Victorian emergency management sector. It is a sub-plan of the State Emergency Response Plan (SERP), published as Part 3 of the EMMV, the principal document guiding the State's emergency management arrangements.

This plan replaces the third edition of the SHERP and the Public Health Control Plan (PHCP) to establish a common operating structure for DHHS, Ambulance Victoria and the broader health system when responding to health emergencies.

1.1 Purpose

The purpose of this plan is to describe the integrated approach and shared responsibility for health emergency management between DHHS, Ambulance Victoria, the emergency management sector, the health system and the community and how these differ to, or elaborate upon, the arrangements in the SERP.

1.2 Objective

The objectives of this plan are to:

- reduce preventable death, illness and disability in all health emergencies and other emergencies with health impacts
- maximise health outcomes by providing treatment in a safe, timely and coordinated manner
- provide timely, tailored and relevant information and warnings to the community
- provide clarity on roles, responsibilities, escalation and communication channels to enable an effective and efficient health emergency response.

1.3 Scope

The scope of this plan includes:

- planning and preparedness for the health response in emergencies, including consequence planning, community preparedness, and capability planning for the health system
- public information and warnings processes, roles and responsibilities
- command, coordination and control arrangements at the state, regional and incident tiers for the health response in emergencies
- control arrangements where DHHS is the control agency, as well as where DHHS is a support agency
- roles and responsibilities across the health system for a health emergency response
- escalation and notification processes for health emergency response.

This plan provides strategic information about the Victorian arrangements for managing health emergencies. Details about the response activities of individual agencies are covered in agency operational response plans.

Relief and recovery activities are outlined in EMMV Part 4 – State Emergency Relief and Recovery Plan.

This plan does not cover activities that DHHS delivers as part of its broader portfolio responsibilities, such as housing and disability service activities.

The State Emergency Management Priorities, available at **www.emv.vic.gov.au**, apply to health emergency responses.

1.4 Authorising environment

The *Emergency Management Act 1986* and the *Emergency Management Act 2013* form the empowering legislation for the management of emergencies in Victoria.

The EMMV contains policy and planning documents for emergency management in Victoria, and provides details about the roles different organisations play in the emergency management arrangements.

The SERP identifies Victoria's organisational arrangements for managing response to emergencies. This plan is a subordinate plan to the SERP and was endorsed by the State Crisis and Resilience Council (SCRC) in July 2017.

In addition to the *Emergency Management Act 2013,* the *Public Health and Wellbeing Act 2008* and related public health legislation and regulations also provide authority for control functions related to the management of public health incidents and emergencies (refer to Appendix B: Victorian public health legislation relating to SHERP).

1.5 Activation of the plan

The arrangements in this plan apply on a continuing basis and do not require activation. Escalation of the arrangements in this plan is outlined in Section 6.3.

1.6 Audience

The audience for this plan comprises all relevant health service providers and agencies, including the Victorian government and agencies within the emergency management sector. This also includes business and community groups with a significant role in the management of emergencies, and other organisations that provide additional capacity during a health emergency response.

Although the wider community is not a primary audience, community members may find the contents of this plan informative.

1.7 Linkages

This plan reflects Victorian legislation, the arrangements in SERP, the strategic direction for emergency management in Victoria and the accepted state practice for managing emergencies. Arrangements in the SERP have not been repeated unless necessary to ensure context and readability.

There are also a number of Commonwealth Government and national plans relevant to health emergency response, such as the Australian Health Management Plan for Pandemic Influenza (refer to Appendix C: National plans relating to SHERP).

Coordination of inter-jurisdictional support, collaboration and Commonwealth resources when the state government requests assistance is governed by the Australian Emergency Management Arrangements (managed by Emergency Management Australia) and the National Health Emergency Response Arrangements (managed by the Commonwealth Department of Health).

This plan may be used as a framework to support national arrangements within Victoria. The Emergency Management Commissioner is responsible for liaising with Emergency Management Australia during an emergency.

1.8 Exercising and evaluation

This plan will be exercised within one year from the date of approval. The exercise will be evaluated and, where improvements to the emergency management arrangements in this plan are required, the plan will be amended and a revised version issued. Exercises will be conducted in accordance with the State Exercising Framework.

In the event of an emergency response utilising arrangements under this plan, the control agency will organise an operational debrief with participating agencies as soon as practicable after cessation of any response activities under this plan. All agencies, including recovery agencies, shall be represented with a view to evaluating the adequacy of the response and to recommend any changes to agency plans and future operational response activities.

1.9 Review

This plan was current at the time of publication and remains in effect until modified, superseded or withdrawn.

DHHS will review and update this plan every three years. More frequent reviews may be undertaken if required, for example following experience utilising or exercising this plan, or following substantial change to relevant legislation or machinery of government arrangements.

2 The health emergency context

2.1 The Victorian health system

The Victorian health system, in the context of this plan, describes the people, agencies and facilities that work together to provide health services to Victorian communities to ensure they are healthy and safe, and that people are able to lead a life they value.

On a daily basis community members interact with the Victorian health system, a dynamic and interdependent network of health services that provides health advice, diagnostic services, clinical and pharmaceutical treatment to maximise health outcomes.

The Victorian health system also includes public health functions and powers available to the Chief Health Officer (CHO) under the *Public Health and Wellbeing Act 2008*. Public health involves preventing the occurrence and spread of disease and illness, and reducing the risk posed by potentially dangerous substances to ensure safe environments across Victoria.

Under this plan, DHHS and Ambulance Victoria work together as the key government agencies that lead a health emergency response. Hospitals, both public and private, also play a critical role in response to health emergencies. Depending on the nature of an emergency, a broader range of health service providers and experts may also be involved to achieve the best possible health outcomes for affected community members. For example, emergencies of longer duration or widely dispersed in nature, may require additional response capacity and capability and this may involve first aid agencies, general practitioners (GPs), community pharmacists, and field emergency medical officers or coordinators.

This plan and relevant operational response plans facilitate a collaborative approach to emergency response that can scale up and down to best meet health needs (refer to Appendix D for a list of relevant operational response plans).

Continuity of health care service provision, particularly to vulnerable community members, during and following an emergency is also a priority for the health system and complements the arrangements in this plan.

This plan further acknowledges that health system support may continue into the relief and initial recovery activities. Refer to the EMMV Part 4 – State Emergency Relief and Recovery Plan for more information.

2.2 Types of health emergencies

This plan applies to all types of health emergency which, due to the scale or extent of health consequences, require a significant and coordinated effort to ensure the health system can effectively respond and mitigate the adverse health consequences for communities.

This includes:

- Public health emergencies (for which DHHS is the control agency), such as:
  - biological and radioactive incidents, such as transport accidents involving biological releases or radioactive substances, loss of control of biological releases or radioactive substances associated with an authorised practice (for example: spillage or unintended dispersion), and dispersion of a biological release or radioactive substance
  - retail food contamination, such as contamination of food during manufacturing, storage or transport
  - water contamination, such as loss of disinfection of a drinking water supply, contamination of a drinking water supply, contamination of food following natural disasters (due to food spoilage), and infectious disease outbreaks arising from food preparation and consumption
  - human disease, such as communicable diseases, gastro and respiratory outbreaks, thunderstorm asthma, and clusters of non-communicable disease.
- Other health emergencies (for which DHHS is a support agency), such as:
  - natural disasters with health impacts, such as bushfires, floods, storms or extreme heat
  - deliberate acts resulting in casualties, such as warlike acts, acts of terrorism, hi-jacks, sieges or riots
  - other mass or complex casualty situations, such as structure fires, drug overdoses or stampedes at mass gatherings or public events, and transport incidents.

2.3 An integrated response to health emergencies

This plan outlines Victoria's integrated health emergency response arrangements. The arrangements in this plan are specific to the State's health system.

The arrangements integrate the three key lines of health system communication with the necessary line of control for effective emergency management. The three key lines of health system communication are:

- health command (predominantly pre-hospital)
- health coordination (hospital and health services)
- public health command.

This ensures that the roles and responsibilities for decision-making and response coordination are clear and well understood by all stakeholders in the event of a health emergency.

This plan also embeds an 'all communities, all emergencies' approach, focusing on:

- clarifying roles and responsibilities for a coordinated and integrated health emergency response, including decision-making, notification and warning, across health and the emergency management sector and service providers
- identifying how health system agencies and providers can work collaboratively to build sector capacity and achieve the best possible outcomes for community members affected by an emergency, while still meeting the needs of other individuals requiring health services
- outlining actions individuals, health sector agencies and service providers, and governments can undertake to strengthen their resilience to health emergencies, in line with the principle of shared responsibility described within the National Strategy for Disaster Resilience, available at **www.ag.gov.au**, as well as the Victorian Community Resilience Framework for Emergency Management, available at **www.emv.vic.gov.au**.

Given the dynamic and interdependent nature of the Victorian health system, it is vital that all relevant health service providers and agencies follow this plan to ensure a coordinated and effective health response to emergencies.

3 Consequences

The direct consequences of health emergencies are human disease, harm and mortality. Health emergencies may also have broader consequences for our social, economic, and natural environments. Beyond health and wellbeing, appropriate consideration of health emergency consequences can minimise broader, ongoing impacts for communities, including social and economic impacts.

Planning for the effective management of consequences of a health emergency should account for the changing profile and expectations of Victorian communities. This includes considering future implications for the health of the population, for example, rising chronic disease and increasing antibiotic resistance.

The consequences of a health emergency vary greatly, depending on the:

- nature of the particular illness or injury
- scale of people affected, or potentially affected
- extent to which the illness or disease can be contained or controlled
- likelihood and extent of disruption to the delivery of government services (such as health services and schools)
- extent to which health consequences are likely to be worsened by disruption to essential services (such as electricity or telecommunications due to extreme heat).

The nature and extent of consequences will inform response, relief and recovery arrangements for a health emergency. Planning for these consequences will ensure that the community receives timely, tailored and relevant information and services before, during and after a health emergency.

DHHS will work with the Emergency Management Commissioner (EMC), Emergency Management Victoria (EMV) and other government agencies, the health system, industry, business and the community to identify and mitigate potential consequences of the emergency.

3.1 Wellbeing

Health emergencies have direct consequences on individuals affected. This may include physical injuries, illness, permanent disability and mortality. However the consequences of a health emergency extend far beyond these initial physical impacts.

Individuals impacted by a health emergency may experience mental health challenges associated with prolonged illness, ongoing or terminal disease, or the trauma of a mass casualty situation. The mental health consequences of an emergency may also extend to the friends, families or carers of impacted individuals, or to bystanders who may have witnessed multiple injuries or fatalities.

3.2 Community connection

Health emergencies have the potential to impact social connections, due to some methods for controlling the spread of disease such as restrictions on movements or public gatherings. Depending on the scale of the incident, individuals, communities or entire regions across the state may experience mental health (and other) challenges associated with a loss of community connectedness or independence. There may also be community concern and associated mental health challenges in circumstances where the nature and extent of illness from exposure to a biological release or radioactive substance is unknown.

Physical and psychosocial impacts of an emergency can also exacerbate social problems in communities, such as drug and alcohol abuse or family violence.

3.3 Liveability

Health emergencies may disrupt accessibility of critical health infrastructure and services. For example, epidemic thunderstorm asthma has the potential to overwhelm the health system and disrupt services to other patients requiring care. The uncontrolled spread of antibiotic-resistant bacteria and pandemics are examples of health emergencies that can significantly disrupt critical health infrastructure and health services. The longer the emergency, the greater the pressure on the health system to respond to and treat both individuals impacted by the emergency, as well as others who also need to access acute, ambulance, primary and other healthcare services.

Health emergencies may have further consequences for the provision of critical health care services as a result of health care workers being unable to attend work due to illness or the risk of infection.

This risk extends to the delivery of other services. Disruptions to critical infrastructure such as public transport services, essential services (such as water, electricity and fuel) transport of food and goods, education and government services are further potential consequences of health emergencies due to individuals being unable to attend work.

Additional consequences of a health emergency for health services may relate to disruption to relevant vaccinations, pharmaceuticals or medical supplies due to unprecedented demand.

3.4 Sustainability and viability

Health emergencies may have economic consequences at the local, regional or state level. A communicable disease outbreak contained to a community or region for example, may disrupt a local vibrant economy due to employers and/or employees being unable to attend work, or community members being unable to leave their homes and purchase local goods and services as they normally would.

A larger scale health emergency, such as a dangerous highly infectious disease like Ebola, may result in further consequences for the Victorian economy. Depending on the timing of the outbreak, for example, it may have a significant impact on major sporting, music or cultural events due to large number of people being unable to attend due to illness or the risk of infection. Events may be cancelled.

Tourism may also be significantly impacted. Individuals may choose not to visit Victoria due to a perceived risk of infection or, in the case of a health emergency resulting from a mass casualty situation, due to a perceived risk of another event being likely.

A major health emergency may also have significant economic consequences for the state associated with disruption to business and services.

Costs associated with the treatment of illness or injury (including any preventative measures which may be taken) may also be significant, depending on the nature and scale of health consequences.


BENDIGO HOSPITAL

4 Community resilience

'Safer and more resilient communities' is the shared vision of Victoria's emergency management sector and underpins the arrangements in this plan. The Community Resilience Framework for Emergency Management also provides the foundation upon which the emergency management sector's strategies, programs and actions can be planned, integrated and implemented in order to build safer and more resilient communities. Building resilient communities is a shared responsibility. In the health emergency context, building resilient communities requires communities, governments, and the health system to work in an integrated way that puts people at the centre of decision making.

4.1 Shared responsibility for action

The National Strategy for Disaster Resilience, developed by the Council of Australian Governments, provides high-level guidance on disaster management.

The strategy recognises that application of a resilience-based approach is not solely the domain of emergency management agencies; rather it is a shared responsibility between individuals, communities, business and governments. Examples within the health emergency context include:

- individuals taking responsibility for their own health and health of those in their care
- local government and communities conducting first aid training and emergency preparedness programs
- the health system, to which the community may turn for support or advice, preparing for increased or diverse service demand during health events and emergencies
- business and industry, including critical infrastructure providers, engaging in business continuity planning that links with community and emergency management arrangements to ensure they are able to provide services during or soon after an emergency.

- government agencies through:
  - creating partnerships with health service providers to build capability and capacity
  - undertaking monitoring and surveillance of infectious diseases and other notifiable conditions
  - providing timely, tailored and relevant information to the community to allow people to make informed decisions about their health and safety
  - providing education including recommended actions to prepare for or mitigate health impacts of emergencies
  - supporting individuals and communities to prepare for, respond to and recover from health emergencies.

4.1.1 Individual preparedness

Individual community members can prepare for a health emergency by undertaking some or all of the following actions:

- follow any public health directions when ill or there is an increase in illness in the community, such as social distancing and avoiding mass gatherings, immunisation, hand hygiene, cough etiquette
- put together an emergency kit (which includes a first aid kit)
- ensure medication supplies for all family members are kept up to date
- register themselves and their family for a My Health Record (visit: **myhealthrecord.gov.au**)
- learn first aid
- join a volunteer first aid organisation.

4.1.2 Planning for vulnerable people in emergencies

Planning for emergencies should consider the needs of vulnerable people to improve the safety and resilience of vulnerable people and their ability to respond safely to emergencies. Vulnerable people, for the purposes of this plan, refers to those who, due to physical or cognitive impairment, are unable to understand emergency warnings and directions, or are unable to respond in an emergency situation. Vulnerable persons who cannot identify personal or community support networks to help them in an emergency may be included on the Vulnerable Persons Register (search for the Vulnerable people in emergencies policy: **www.dhhs.vic.gov.au**).

4.2 Public information and warnings

Access to timely, tailored and relevant information about an emergency assists a community to make informed decisions and to act purposefully. Communities, individuals and households need to take responsibility for their own safety and act on information, advice and other messages provided before, during and after health emergencies.

Consistent with the State Emergency Management Priorities, public information and warnings issued under this plan will be:

- relevant, timely, clear, targeted, credible and consistent
- responsive and empathetic
- accurate and informed by evidence
- tailored to the impacted community
- provided through a range of communication channels
- aligned with the Victorian Warning Protocol available at **www.emv.vic.gov.au/responsibilities/victorias-warning-system/victorian-warning-protocol**.

Communication may include channels such as CHO Alerts, warnings published through Victorian Warnings System, media conferences, information uploaded to the Better Health Channel, radio, social media, and community information hotlines.

4.2.1 Management of public information and warnings

Collaboration, coordination and early notifications between agencies are necessary to ensure communities receive consistent and complementary messaging before, during and after a health emergency.

DHHS, in collaboration with Ambulance Victoria, is responsible for issuing warnings and providing public information during a health emergency. DHHS as the control agency will authorise all public information and warning messages prior to their release to the community, where practicable.

The CHO will approve all public health messaging, CHO alerts and CHO advisories, in line with the *Public Health and Wellbeing Act 2008,* as required.

Ambulance Victoria may disseminate public information and warnings, in collaboration with DHHS, for the purpose of enabling the community to make informed decisions. For example, where there are significant delays for ambulances, that people should make their own way to hospital. The purpose of providing this information is to increase community awareness regarding current demand for ambulance services.

To facilitate the rapid communication of information and warnings, the State Controller may delegate authority to a Deputy Controller or a public information officer to authorise the release of information and warnings to the community.

All warnings issued should adhere to the Victorian Warning Protocol. The warning protocol can be found at: **www.emv.vic.gov.au**.

The DHHS Public Information and Warning Business Rules and Decision-making Guide outlines the roles and responsibilities for issuing public information and warnings for health emergencies. The DHHS public information officer, the State Control Centre warnings officer or the State Warnings and Advice Duty Officer will issue warnings on behalf of DHHS. Public information and warnings will be available on the VicEmergency website and app. Supporting information may be published on the Better Health Channel or the Department of Health website.

Under the SERP, where the timeframe is short and an extreme and imminent threat to life exists, any response agency personnel (such as Victoria Police or Ambulance Victoria) can issue warnings to people likely to be affected, providing they notify the relevant Controller as soon as possible following issue of the warning.

4.2.2 Emergency Management Joint Public Information Committee

The Emergency Management Joint Public Information Committee (EMJPIC) provides strategic guidance for state-level messages across all state government departments and agencies. EMJPIC is responsible for ensuring public information across all state government departments and agencies is consistent, and distributed in a timely and accurate manner to inform and advise community members during a major emergency, as well as ensuring media needs are met.

The State Controller (or delegate) will engage the support of the EMJPIC to ensure that state-level messages from all agencies with a role or responsibility in managing the impact and consequences of health emergencies are prioritised and included in key messages to the public. This may also include the integration of messaging across all emergencies, such as fires and storms. EMMV Part 8 – Appendices and Glossary provides further information on the role of EMJPIC.

5 Capability and capacity

The *Victorian Preparedness Framework 2017* and supporting documents set the foundation for how Victoria prepares for, responds to and recovers from emergency incidents. The framework identifies 21 core capabilities, each considering the crucial elements of people, resources, governance, systems and processes which are needed to manage events, reduce impacts, protect our community and increase resilience.

While many of the 21 core capabilities are required to effectively manage before, during or after a health emergency, there are three capabilities particularly relevant to this plan:

- health emergency response
- health protection
- planning.

The first two capabilities are especially important in the context of the State Emergency Risk Assessment, which identifies pandemic influenza, bushfires and floods as Victoria's highest priority emergency threats. Each of these threats will involve a significant and coordinated health response. Other core capabilities relevant to health emergency response capability will be outlined in the relevant agency operational response plans.

Planning is critical to the effective delivery of this plan. A collaborative approach to understanding, testing and building capability across the entire health system is fundamental to our ability to effectively respond to health emergencies.

5.1 Health emergency response capability

Health emergency response capability within the context of this plan is the collective ability of people, resources, governance arrangements, systems and processes to limit the adverse health consequences of emergencies on individuals and communities. It is based on the collective capability of all involved in undertaking health emergency response activities, including community members, government, agencies and health service providers.

The Victorian Preparedness Framework 2017 describes health emergency response capability as involving "the planning, provisioning, response and coordination of pre-hospital and health emergency care, including triage, treatment and distribution of patients, in a timely and structured manner, using all available resources to maximise positive health outcomes".

All health service providers with a role or responsibility under this plan are required to maintain their capability to fulfil health emergency response activities.

Agencies should also undertake training to maintain capability and capacity to respond under this plan, in addition to maintaining their relevant clinical or other professional skills, competencies and authorities. Arrangements for obtaining additional capabilities and capacity during a health emergency response are outlined in agency operational response plans.

5.2 Health protection capability

The Victorian Preparedness Framework 2017 describes health protection capability as the ability to "promote and protect the public health of Victorians by monitoring notifiable diseases and responding to any disease outbreaks in order to control and minimise the risk of infection. This includes regulating the safety of food, drinking water and human environmental health hazards such as radiation, legionella and pesticides. This includes informing the community and health providers about public health risks and promoting behaviours and strategies to mitigate and avoid risk. It also includes the development of national policies, standards and strategies to promote improvements in public health generally and support the health system to respond to national public health risks".

Critical tasks to support health protection capability development include development and delivery of programs to detect and identify risks, undertaking and delivering specialist clinical epidemiological analysis and investigation, and communicating health risks through public health promotion and prevention campaigns. Refer to Section 4.2 Public Information and Warnings for more information.

Support arrangements, including arrangements for sourcing additional state, national and international resources to respond to emergencies if required, are outlined in the SERP and the National Health Emergency Response Arrangements.

5.3 Health sector emergency planning and preparedness

The Victorian Preparedness Framework 2017 describes planning capability as the ability to "conduct a systematic process engaging the whole community as appropriate in the development of executable strategic, operational or tactical level approaches to meet defined objectives."

All organisations with roles or responsibilities under this plan must ensure they are adequately and appropriately prepared to respond to health emergencies and emergencies with health impacts. This includes assuring that they have effective plans, processes and systems in place to fulfil their roles and responsibilities under this plan. In addition, all organisations with emergency response plans that interface with this plan need to be familiar with these arrangements.

5.3.1 Health service planning

Health service providers use a nationally recognised set of codes (guided by the Australian Standard (AS) 4083-2010 Planning for emergencies – Health care facilities) to plan for response to and recovery from internal and external emergencies (refer to Appendix G: Summary of relevant emergency codes in hospitals and health care facilities). This includes plans for external emergencies, such as mass casualty incidents (Code Brown), infrastructure and other internal emergencies, such as power failure (Code Yellow) and evacuations (Code Orange).

Health service planning needs to include occupational health and safety planning to ensure that, as far as possible, the physical and psychological wellbeing of staff is protected when they are involved in a health emergency response.

Effective health emergency preparedness and response requires consistent, effective and practised integration of health services providers with other members of the emergency management community, as well as across the health system. Coordinated arrangements for an anticipated or actual emergency enable the provision of seamless and integrated services for communities.

It is important that health services providers develop and exercise their plans as part of normal business operations to minimise service interruption and health consequences for communities in the event of an emergency.

Health service providers should ensure that their plans integrate with this plan to facilitate an effective response where escalation of a health emergency response is required.

Code Brown is a nationally recognised code used by health services to plan, prepare, respond and recover from an external emergency. A guidance note for Code Brown planning for health service providers is available at: **www.health.vic.gov.au**.

6 Collaboration

Victorian Government agencies have roles and responsibilities under this plan to work together to ensure the health system can effectively respond to an anticipated or actual health incident and mitigate the adverse health consequences for communities by:

- managing the safe, effective and coordinated health response to Class 2 health emergencies, and
- coordinating the effective health response to other emergencies with health consequences that require a significant and coordinated effort, beyond normal health system operations, for effective response.

6.1 Emergency Management Commissioner role and responsibilities

Under the *Emergency Management Act 2013,* the Emergency Management Commissioner (EMC) has legislated management responsibilities across major emergencies. These include response coordination, ensuring the establishment of effective control arrangements, consequence management and recovery coordination.

6.2 Agency roles and responsibilities for Class 2 health emergencies

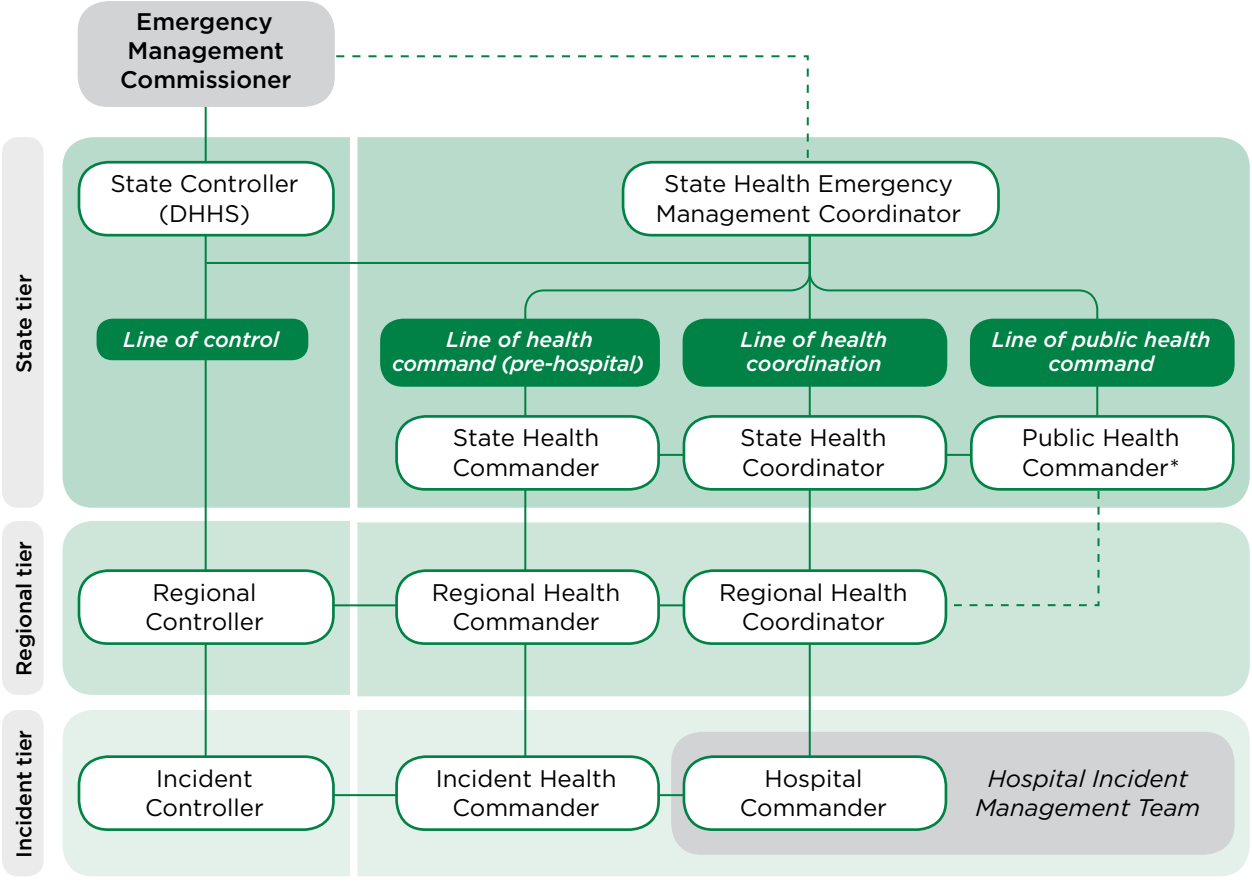
Under the EMMV Part 7 – Emergency Management Agency Roles, DHHS is the nominated control agency for specified health emergencies in Victoria (refer to Section 1).

DHHS is responsible for identifying unfolding or potential health emergencies, and escalating health emergency response arrangements outlined in this plan to ensure the health system can effectively respond and mitigate the adverse consequences for communities (refer to Section 6.3.3).

DHHS may activate the State Emergency Management Centre (located at DHHS) when considered necessary for the effective management of an emergency. To ensure an effective response to adverse health consequences for communities DHHS may also, in consultation with the EMC, request activation of the State Control Centre (SCC) to provide support to the State Controller. The SCC provides a range of services to assist with the coordination and control of emergencies and has well-established protocols for working across all government agencies and for providing information and warnings to the community.

The reporting relationship for Class 2 health emergency response is illustrated at Figure 1.

Figure 1: Reporting relationship for Class 2 health emergencies



* Public Health Commander appointed State Controller for identifiable public health emergencies.

Table 1 outlines the authority and role for key decision-making functions (functional leads) in a health emergency.

Table 1: Key functions in a health emergency (DHHS as both control and support agency)

	AUTHORITY AND ROLE	
FUNCTION	**DHHS AS CONTROL AGENCY**	**DHHS AS SUPPORT AGENCY (DIFFERENCES BY EXCEPTION)**
Emergency Management Commissioner	The Emergency Management Commissioner is accountable for ensuring the response to emergencies in Victoria is systematic and coordinated. This includes ensuring that control arrangements are in place during a Class 2 emergency, responsibility for consequence management for a major emergency, and management of the State Control Centre on behalf of (and in collaboration with) agencies that may use it for emergencies.	
State Controller (DHHS as control) / State Health Incident Management Team Lead (DHHS as support)	As agency lead, the Secretary to DHHS appoints the State Controller (by instrument of appointment) to enable appropriate focus on managing health consequences according to the nature of the emergency: • the Public Health Commander will be appointed State Controller for identified public health emergencies (most likely to occur in circumstances where a public health emergency is anticipated) • all other emergencies, including in the event of a rapid onset health emergency where the causation is unclear, the State Health Coordinator will be appointed as State Controller. The State Controller is responsible for the following initial decisions and actions, in consultation with the appropriate internal and external stakeholders: • verify the relevant response assessment (refer to Section 6.3.3) • determine the strategic objectives for response • determine the incident management model or activate pre-agreed plans for the initial response • establish incident management team(s) (as applicable) • ensure timely and appropriate public information and warnings are provided to the community • notify the EMC, support agencies and relevant health system service providers. The State Controller may appoint a Deputy Controller. The State Controller should delegate their function on the State Health Incident Management Team (that is, Public Health Commander or State Health Coordinator) to a deputy or equivalent.	Where DHHS is the support agency, it is not responsible for the control function. Under these arrangements, the lead of the State Health Incident Management Team where DHHS is a support agency is: • the State Health Coordinator, where coordination of emergency response activities across the health system is required (including hospitals, primary health and other acute services); • the Public Health Commander where the control agency requires public health expertise.

	AUTHORITY AND ROLE	
FUNCTION	**DHHS AS CONTROL AGENCY**	**DHHS AS SUPPORT AGENCY (DIFFERENCES BY EXCEPTION)**
State Health Emergency Management Coordinator (SHEMC)	The SHEMC is an executive-level public administration function performed by DHHS and appointed by the Secretary of the department. The SHEMC is responsible for ensuring that appropriate appointments are made to state tier functions (the State Health Commander, State Health Coordinator and the Public Health Commander), as well as providing executive administrative support to ensure these functions operate effectively. While an instrument of appointment will determine whether the Public Health Commander or State Health Coordinator performs the function of State Controller, the SHEMC may advise the Secretary to DHHS who should fulfil the function of State Controller (with advice from the State Health Incident Management Team) according to the nature of the emergency and response, and consistent with the instrument of appointment.	
Public Health Commander (Public Health Command functional lead)	The Public Health Commander function is performed by the Chief Health Officer (or delegate). The Public Health Commander reports to the State Controller and is responsible for commanding the public health functions of a health emergency response (including investigating, eliminating or reducing a serious risk to public health). Performing the function of Public Health Commander does not alter in any way the management, control and emergency powers of the Chief Health Officer under the *Public Health and Wellbeing Act 2008*. In performing this function, the Public Health Commander will liaise directly with the State Health Commander and State Health Coordinator. For emergencies where the Public Health Commander is not appointed the State Controller, the Chief Health Officer's authority under the *Public Health and Wellbeing Act 2008* remains unaffected, and their decisions on matters of public health should not be overridden by a State Controller.	The Public Health Commander function will be the State tier Health Incident Management Team Lead where the control agency requires public health expertise.

	AUTHORITY AND ROLE	
FUNCTION	**DHHS AS CONTROL AGENCY**	**DHHS AS SUPPORT AGENCY (DIFFERENCES BY EXCEPTION)**
State Health Coordinator (Health Coordination functional lead)	The State Health Coordinator function is performed by a senior DHHS officer appointed by the SHEMC. The State Health Coordinator reports to the State Controller and is responsible for coordinating DHHS' emergency response activities across the health system (including hospitals, primary health and other acute services) at the state tier. In performing this function, the State Health Coordinator liaises directly with the State Health Commander and Public Health Commander.	The State Health Coordinator function will be the State tier Health Incident Management Team Lead for all events where the Public Health Commander is not the Lead.
State Health Commander (Health Command functional lead)	The State Health Commander function is performed by the appointed Ambulance Victoria Emergency Management Director (unless otherwise appointed by the SHEMC). The State Health Commander reports to the State Controller and is responsible for commanding the pre-hospital and field response to an emergency (including ambulance services, first responder assistance, and spontaneous volunteers) at the state tier. In performing this function, the State Health Commander will liaise directly with the State Health Coordinator and Public Health Commander.	

The State tier Health Incident Management Team is responsible for managing the whole of health response to an emergency.

Key support agencies

In addition to DHHS' nominated role as control agency for response to Class 2 health emergencies in Victoria, the department is also responsible for delivering human services and business continuity services during the emergency.

DHHS has further responsibility for leading the coordination of emergency relief and recovery activities at the regional tier. This includes coordination of relief and recovery planning, the provision of personal support (including psychological first aid) at incident sites and across the community, and the provision of interim accommodation following emergencies with major housing impacts.

EMMV Part 7 – Emergency Management Agency Roles lists the key support agencies for Class 2 health emergencies and their responsibilities (refer to Table 2).

Many of these agencies coordinate their response activities across a range of other agencies within their functional sector. The State Controller leads the coordination of these functional sectors through the State Emergency Management Team (SEMT) (refer to Table 4: Functions and membership of key state response teams).

Table 2 identifies the key supporting functions these agencies provide during Class 2 health emergencies. All of these agencies should have internal plans for managing their responsibilities.

This table is not exhaustive and should be read in conjunction with the relevant legislation and the EMMV, noting any government or non-government agency may be requested to assist in a health emergency response (or relief or recovery) if it has the skills, expertise or resources to contribute to the management of the emergency (EMMV Part 7 – Emergency Management Agency Roles).

Table 2: Functions of key support agencies for Class 2 health emergencies

AGENCY	RESPONSIBILITY FOR RESPONSE
Ambulance Victoria	• deploy Health Commanders to relevant tiers to direct the operational health response • respond to requests for pre-hospital emergency care, triage patients, determine treatment priority and provide pre-hospital clinical care • transport and distribute patients to appropriate medical care • provide health support to patients undergoing decontamination • manage additional medical and nursing capacity, such as FEMO and VMAT teams, where required • notify receiving hospitals of patients • support evacuations of vulnerable people • liaise with control agencies to ensure the safety of responders, health care workers, and the public for identified and emergent risks from an incident. This includes activation of personal support arrangements. • liaise with Public Health Commander and Health Coordinator.
DET	• provide emergency notifications and reporting services between schools and emergency services • provide advice and list of suggested resources to non-government schools.
DELWP	• support emergency response for drinking water supply and contamination.
DEDJTR	• Agriculture Victoria provides notifications and coordination with DHHS, regarding agricultural incidents and risks with possible health impacts, for example, food-borne illness outbreaks in primary production systems and zoonotic diseases, including anthrax and vector-borne disease.
EMV	• manage the operation and administration of the State Control Centre • in collaboration with the whole-of-government, lead the coordination of public information and warnings for major emergencies • lead the coordination of consequence management for major emergencies • coordinates relief and recovery activities at the state level.
ESTA	• answer and process Triple Zero (000) emergency calls from the community and dispatch emergency resources • provide early warnings to EMV and agencies of significant incidents, detected through triple zero information channels • maintain support and management of multi-agency operational communication systems.
EPA	• assess the environmental impact of the emergency • advise the emergency services on the properties and environmental impacts of hazardous materials • provide Air Monitoring capability in emergencies to support analyses of community health impacts in accordance with air monitoring protocols • provide environmental public health surveillance, risk assessment and initial response in accordance with environmental public health protocols and MOUs between EPA and DHHS • ensure that appropriate transport and disposal methods are adopted for wastes generated from response activities.
Local Government	• coordinate municipal resources needed by the community and response agencies • facilitate the delivery of warnings to the community and the provision of information to the public and media • support investigations and control of illness outbreaks and other public health incidents.

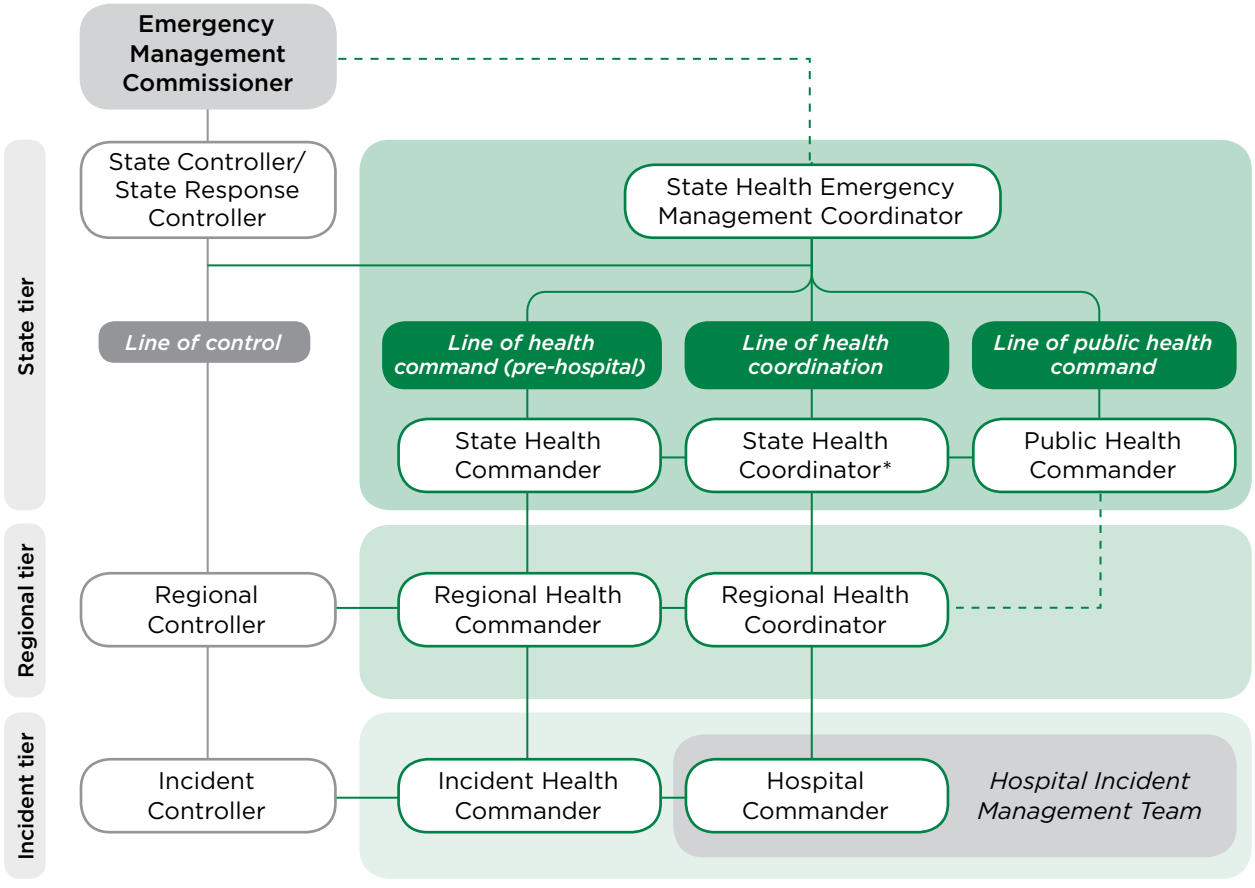
6.2.1 Agency roles and responsibilities for health emergency response (where DHHS is operating as a support agency)

Where monitoring and notifications suggest the health system is, or is likely to, experience an impact over day-to-day operations (e.g. refer to Section 6.3.3: Escalation process), the arrangements outlined in this plan will be escalated as required to ensure the system can effectively respond to and mitigate the adverse health consequences for communities. This includes emergencies other than a Class 2 health emergency.

Where another control agency (such as Victoria Police or a fire service agency) is activated for a major emergency that requires a health response, that control agency directs the emergency response, as depicted at Figure 2.

The Chief Health Officer's authority under the *Public Health and Wellbeing Act 2008* to make decisions on matters of public health and to exercise management, control and emergency powers applies in all health emergency response situations and should be made in consultation with the State Controller.

Figure 2: Reporting relationship for health emergency response (where DHHS is operating as a support agency)



* State Health Coordinator to lead the State Health Incident Management Team for rapid-onset emergency.

6.3 Escalation and notification

The majority of health emergencies are managed by the health system either as business as usual, or using an incident management system as part of normal operations (refer to Section 6.4: Incident management arrangements).

Arrangements will be escalated under this plan when information is received to suggest that an incident is impacting, or likely to impact, the health system's ability to effectively respond to an incident and mitigate the adverse health consequences for communities.

Arrangements may be escalated in anticipation of, or in response to notifications or observations.

6.3.1 Notifications to DHHS

DHHS relies on notifications to inform its situational awareness of the whole of the health system. This is fundamental to determining when arrangements under this plan should be escalated to ensure the health system can effectively respond to an incident and mitigate the adverse consequences for communities.

There are four types of notifications:

- notification of a public health incident, for example notification of a communicable disease outbreak
- notification from Ambulance Victoria of a significant increase or change in the volume and nature of Triple Zero (000) calls or requests to attend
- notification of increased demand on health system, for example Code Brown or Code Yellow activations, information on emergency department presentations provided to DHHS through its real-time monitoring system or information on change in nature or volume of GP presentations
- notification of other situations, for example notification from a Control Agency of a terrorist event with mass casualties.

Notifications are required to include information, to the extent known, on the location, type of incident, hazards, number of cases or patients and the required emergency and/or health services.

This whole-of-system view is an important function for DHHS as part of its system management role in the health system.

Advice, warnings and planning arrangements related to potential threats to public health (such as a new strain of pandemic flu identified overseas) or upcoming events with potential significant health impacts (such as extreme weather days or major public events) are also an important source of information, and needs to be considered in a collaborative manner and

issued in a coordinated manner. This information enables early assessment to determine the appropriate initiation of readiness activities in anticipation of a major emergency or incident with significant health consequences for communities (refer to Section 6.3.3: Escalation process).

6.3.2 Notifications by DHHS to the health system

Appropriate and timely two-way communications between DHHS, hospitals, primary health care providers and the broader health system is integral to an effective health emergency response.

DHHS notifications

Health system practitioners, agencies and hospitals rely on notifications from DHHS to provide situational awareness of the health system. This is fundamental to support planning for mobilisation of resources and the creation of short term capacity (for example, through activating Code Brown) to accommodate additional health system demand and mitigate the adverse health consequences for communities. Health system practitioners, agencies and hospitals should also maintain their own situational awareness and mobile resources as necessary in the absence of notifications from DHHS.

The relevant Commander or Coordinator (or delegate) will issue a 'first wave' alert for any incident that may present a substantial risk to the health and wellbeing of Victorian communities. The alert provides a state-wide communication to the Victorian public and private health sector, including:

- all public health services
- all private hospitals
- other health sector stakeholders, as appropriate, to support the response.

Actions for the health system

All practitioners, agencies and hospitals operating within these arrangements are required to have:

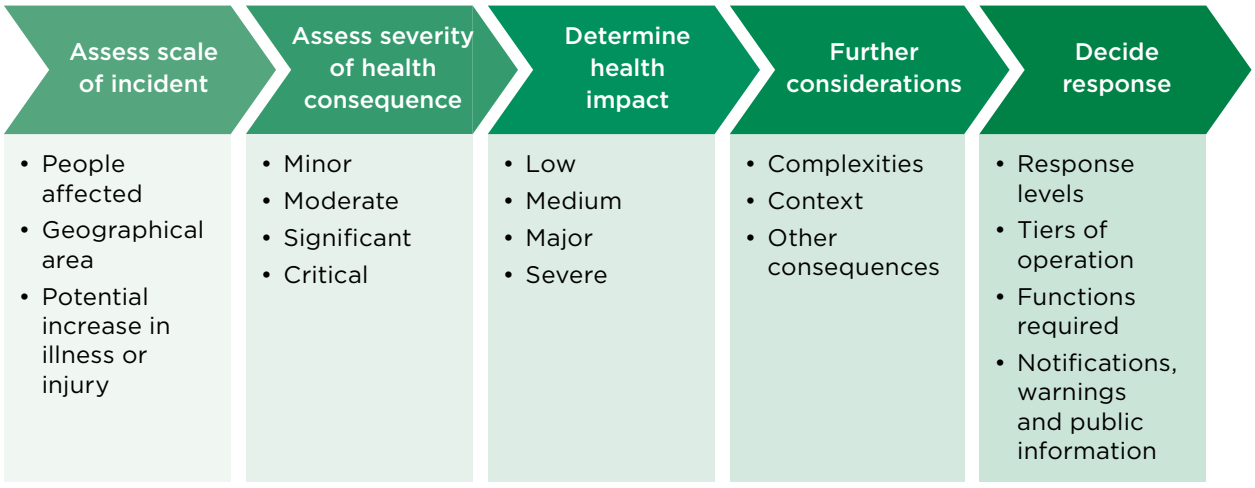
- a single point of contact that is monitored at all times for receiving DHHS notifications
- a plan to escalate their response if and as required.

All health system services that receive a first wave alert need to consider what, if any, impact the incident will have on their operations and respond as required.

6.3.3 Escalation process

Health emergency response is escalated when an incident is assessed as impacting, or likely to impact, the health system's ability to effectively respond to an incident and mitigate the adverse health consequences for communities (refer to Figure 3).

Figure 3: Overview of escalation process



Upon notification of a potential health emergency (either through the notification process or through departmental monitoring activities), the relevant functional lead (or delegate) will undertake an assessment process (see Figure 4) to determine the appropriate level of response.

The aim of the response is to contain or eradicate disease to minimise its impact in the community, or maximise health outcomes for individuals and communities impacted by an emergency.

Responsibilities and incident management structures for health emergency response are outlined in Section 6.4 Incident management arrangements.

The need to escalate or de-escalate should be continually reviewed as the situation changes or new information becomes available.

Figure 4: Escalation process

SCALE

1. Assess the extent to which the incident has impacted, or may impact, the community's health on a small, medium, large or very large scale. Consider:

SCALE	EXAMPLE INDICATORS
Number of people affected	• Volume of Triple Zero calls • Volume of hospital presentations • Number of presentations and volume of calls to GPs, community pharmacies and other health care service providers (such as NURSE-ON-CALL) • Number of notifications of reportable disease or illness
Size of geographical area affected	• Location of Triple Zero calls • Location of increased hospital presentations • Location of notifications of reportable disease or illness • Size of biological or radioactive incidents (actual and predicted) • Extent of food or drinking water contamination
Potential increase in illness or injury (urgency)	• Degree of transmissibility and population vulnerability • Number of individuals potentially impacted and unaccounted for • Likely increase in exposure to threat or hazard • Information from other agencies

CONSEQUENCE

2. Assess the extent (severity), or likely extent, of health consequences for incident for community members using the following scale:

HEALTH CONSEQUENCE	DESCRIPTION
Minor	• Known and treatable illness or injury. Home management likely • No mortality
Moderate	• Illness or injury requires or is likely to require treatment by pre-hospital or primary care services • Minor increase or likely small increase in mortality
Significant	• Illness or injury requires or is likely to require treatment in hospital • Moderate increase or likely moderate increase in mortality
Critical	• Illness or injury requires or is likely to require extended hospital treatment and rehabilitation • Significant increase or likely significant increase in mortality

HEALTH IMPACT

3. Plot the likely scale and consequence of the incident within the following **Response Matrix** to determine the overall community impact:

		HEALTH CONSEQUENCE			
		Minor	**Moderate**	**Significant**	**Critical**
SCALE	**Very large** (All or most of state impacted)	Major	Major	Severe	Severe
	Large (Several communities or regions impacted)	Medium	Major	Major	Severe
	Medium (Community impacted)	Low	Medium	Major	Major
	Small (Individuals impacted)	Low	Low	Medium	Major

IMPACT ON HEALTH SYSTEM	EFFECTIVE RESPONSE TO MAXIMISE HEALTH OUTCOMES FOR COMMUNITIES
Low	• This incident has had, or is likely to have, a low impact on health system operations. • Response can be managed within business as usual arrangements.
Medium	• This incident has had, or is likely to have, a medium impact on health system operations. • Response requires capacity or capability additional to the responding business unit. • This will typically be a non-major emergency.
Major	• This incident has had, or is likely to have, a major impact on health system operations. • Response requires additional capacity or capability across the health system and multiple government departments/agencies. • This may be a major emergency, and may be recognised as a Class 2 health emergency.
Severe	• This incident has had, or is likely to have, a severe impact on health system operations. • The State's capacity or capability to respond has been, or is likely to be, exceeded. Additional capacity or capability is required through multi-jurisdictional and/or international support. • This will be a major emergency and will be recognised as a Class 2 health emergency.

Figure 4: Escalation process (continued)

FURTHER CONSIDERATIONS

4. Do any complexities and consequences of this incident change the assessment? Consider the following and adjust (potentially moving one or more columns to the right) on the response matrix:

CONSIDERATION	EXAMPLE
Complexities	• Concurrent emergencies • Unprecedented response required (no plan exists or plan untested) • Multi-sectoral consequences requiring significant coordination • Multi-jurisdictional or Commonwealth involvement • Specialised technical knowledge and skills required • Security issues • Accessibility difficulties
Context	• Level of community resilience or vulnerability • Need for public information and warnings • Need for communications in relation to the incident • Level of community concern • Level of health system resources required to support response • Level of loss or incapacitation of health structures • Duration of incident

The impact on normal health system operations identified in the response matrix (refer to **Figure 4**) informs a number of decisions by the relevant functional lead (or delegate) to ensure the health system can effectively respond and mitigate the adverse health consequences of an incident. This includes decisions on:

- tiers of operation to be activated (state, regional, incident)
- capacity and capability required of Incident Management Team(s) at relevant tiers (Level 1, 2 or 3, detailed at Table 3)
- functions that need to be established or scaled (up or down)
- notifications, warnings and public information to be issued
- readiness activities in anticipation of a health emergency.

6.3.4 Response levels

There are three levels of health emergency response:

Table 3: Incident response level

INCIDENT LEVEL	DESCRIPTION	KEY CONSIDERATIONS
Level 1	Level 1 incidents are characterised by being able to be resolved through the use of local or initial response resources only. They are typically small and simple incidents, with low overall community impact. Level 1 incidents will have a low-to-medium impact on normal health system operations. Examples of Level 1 incidents include: routine food recalls; a localised outbreak of infectious disease; localised severe weather events with a limited number of associated health complaints.	The response to Level 1 incidents should consider: • Establishment of a Hospital Incident Management Team or an Incident-tier Health Incident Management Team
Level 2	Level 2 incidents may be more complex either in size, resources or risk. They are typically larger in area and more complex than Level 1 incidents, and involve multiple agencies and resources, require public information and medium to major community overall health impact is possible. Level 2 incidents will have a medium-to-high impact on normal health system operations. Examples of Level 2 incidents include: moderate level outbreak of infectious disease; water supply contamination in a small rural town; significant number of injuries/illness at a mass gathering or public event.	The response to Level 2 incidents should consider: • The need for more complex management of emergency response in size, resources or risk • The need for deployment of additional resources/subject matter experts to perform dedicated functions due to the levels of complexity • Establishment of a Health Incident Management Team at the appropriate tier/s
Level 3	Level 3 incidents are characterised by high degrees of complexity requiring substantial response management. Complexities of Level 3 incidents might include size, resources, duration, risks and/or difficulty to control. Level 3 incidents may also have high community and media interest and/or require longer-term response operations. They may have major to severe overall community health impact. Level 3 incidents will have a high-to-very high impact on normal health system operations. Examples of Level 3 incidents include: major disease outbreak or pandemic; actual or suspected terrorist attack with mass casualties; significant chemical, biological radiation incidents creating significant risk to communities and involving multiagency response.	The response to Level 3 incidents should consider: • The need for more complex management of emergency response in size, resources, communications or risk • The need to coordinate concurrent response and relief and recovery arrangements • The need for deployment of additional resources/subject matter experts to perform the full range of dedicated functions due to the levels of complexity • Establishment of a State Health Incident Management Team and multiple agencies involved • Activation of the State Control Centre where necessary • Develop an action plan outlining objectives, strategies and resource allocations

6.3.5 Stand down

Stand down is the return to business-as-usual operations when deployment of resources and personnel is no longer required. For Class 2 health emergencies, the relevant incident controller is responsible for notifying the health system to stand down operations. Agencies involved in a response may consider undertaking one or more stand down activities. These activities may include but are not limited to:

- notifying relevant public health services, private hospitals, the primary health sector and other health sector stakeholders of incident site stand down
- hot debrief of all participants to learn from the emergency management experience
- peer support advice and information for personnel involved in a response, such as access to employee assistance programs.

For any major emergencies, a review of this plan and supporting plans and standard operating procedures will be required (refer to Section 1.9).

6.3.6 Transition to relief and recovery

Emergency response coordinators are responsible for advising all agencies involved in the health emergency of the termination of the emergency response.

Once the emergency response activities have concluded and where relief and recovery activities need to continue, the arrangements for managing the emergency will transition from the arrangements under this plan to the arrangements for managing recovery as outlined in the EMMV Part 4 – State Emergency Relief and Recovery Plan.

6.4 Incident management arrangements

The SERP outlines the arrangements for the management of all emergencies in Victoria. The SERP uses a three-tiered approach to emergency management, with the key control, command and coordination functions performed at the incident, regional and state tiers of emergency response.

Class 2 health emergencies can have unique characteristics such as:

- geographically dispersed and widespread, with no identifiable ‘incident site’
- largely invisible
- communicable
- unfamiliar or unknown.

In some circumstances it will be appropriate to manage health emergencies at the incident tier (for example, an infectious disease outbreak limited to a single hospital facility).

However the management of public health incidents usually occurs centrally, at the state tier. This means that a Regional and/or Incident Controller may not be required. This does not remove the control agencies' responsibilities at either the incident or regional tiers. Therefore, for Class 2 health emergencies where there is no Regional or Incident Controller appointed, the State Controller is responsible for the incident, regional and/or state tiers. This may require the State Controller to appoint a Deputy Controller specifically focused on consequence management and liaison with incident and/or regional teams (as appropriate).

In the event of a major health emergency (Class 2), for example a complex geographically dispersed pandemic, it is expected that all three tiers will be fully operational in a manner consistent with the SERP.

The management of health emergency response to incidents other than Class 2 health emergencies may also be managed at the state level, with or without the support of regional and/or incident- tier incident management teams.

6.4.1 Health emergency incident management system

Health emergency response uses the operational methodologies and structures consistent with established incident management systems, such as Australasian Inter-Service Incident Management Systems (AIIMS), and their underpinning principles.

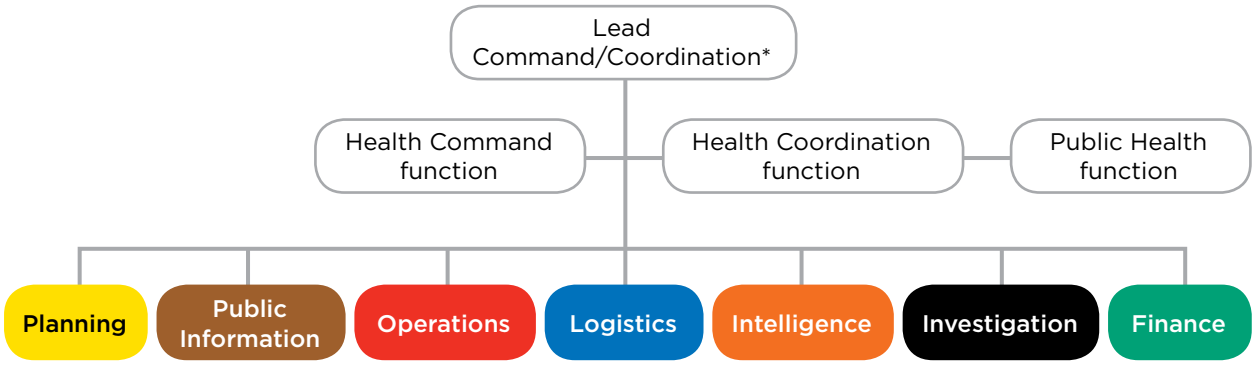
There are seven core functions that can be established within an Incident Management Team to manage an incident. These are: planning, public information, operations, logistics, intelligence, investigation and finance.

Importantly, this system is scalable, and functions can be expanded or reduced depending on the size and complexity of the incident. A Health Incident Management Team may be established at every tier, or one tier only, depending on what is needed to effectively respond to a health incident and mitigate the adverse consequences for individuals or communities. Likewise, a function should only be established where it is necessary and appropriate for the effective management of the incident.

The public information function will usually only be established at the state tier to facilitate consistent, timely and targeted provision of public information. The operations function will typically include a range of activities necessary for the effective response to a health emergency or the health consequences of an emergency. This may include coordination across ambulance, primary health, mental health, health services, aged care and public health. The intelligence function may be activated early to assist with situational awareness of a likely or unfolding incident. Often this information will originate from regional DHHS, Ambulance Victoria or EPA teams, or local health service providers. Investigation and finance functions are more likely to be required for larger or more complex health emergencies.

The response matrix will inform the decision as to which functions will be established and at which tier or tiers and at which locations.

Figure 5: Example health incident management team structure



* At the State tier, the lead is determined by whether DHHS is control or support agency and the nature of incident, as described in Table 1: Key functions in a health emergency. At the regional tier, the Health Coordination function is lead. At the incident tier, the Health Command function is lead.

Health emergency response (where DHHS is operating as a support agency)

The relevant Commander or Coordinator will manage the health response to incidents or emergencies (other than Class 2 health emergencies) with health consequences that go beyond normal health system operations.

On advice from the State Health Commander, State Health Coordinator and the Public Health Commander, the State tier Incident Management Team lead is responsible for activating the State Emergency Management Centre and deploying a State tier Health Incident Management Team (S-HIMT), with functional sections as necessary and appropriate for the effective management of the incident.

6.4.2 State tier governance

The EMC coordinates the state response to major emergencies, including Class 2 health emergencies, through the following five key teams (refer to Table 5).

During or following a large-scale emergency, the Victorian Government's Security and Emergency Management Committee of Cabinet (SEMC) may provide whole of government ministerial oversight.

The State Crisis and Resilience Council (SCRC) provides SEMC with assurance that the broad social, economic, built and natural environmental consequences of the emergency are being addressed at a whole of government level. SCRC also has responsibility for the oversight of the development of a whole of government communications strategy for the approval of SEMC.

Table 4: Functions and membership of key state response teams

TEAM	ROLE/FUNCTION	MEMBERSHIP FOR CLASS 2 HEALTH EMERGENCY
State Coordination Team (SCOT)	• oversees the coordination functions and responsibilities on behalf of the EMC • sets the strategic context of the readiness, response, relief and recovery phases.	EMC and/or Chief Commissioner for Police (CCP) State Controller – Health Emergency Chief Health Officer State Health Coordinator Senior Police Liaison Officer (SPLO) State Relief and Recovery Manager (SRRM) DHHS State Liaison Officer (DHHS SLO) State Consequence Manager (SCM) Others as determined by EMC/CCP
State Control Team (SCT)	• oversees the control functions and responsibilities on behalf of the EMC • implements the strategic context of the readiness, response, and where appropriate relief and recovery phases.	State Controller – Health Emergency EMC Chief Health Officer State Health Commander Chief Officer CFA or State Agency Commander (SAC) Chief Fire Officer DELWP or SAC Chief Officer MFB or SAC Chief Officer Operations SES or SAC SPLO SCM SRRM DHHS SLO Others as determined by EMC/State Controller

TEAM	ROLE/FUNCTION	MEMBERSHIP FOR CLASS 2 HEALTH EMERGENCY
State Emergency Management Team (SEMT)	• oversees the management of strategic risks and consequences of the emergency situation.	EMC CCP State Controller – Health Emergency Chief Health Officer State Health Coordinator State Health Commander SPLO SRRM SACs (CFA, DELWP, MFB, SES, VicPol, AV) Other emergency management functional roles across Government and agencies as appropriate
EMJPIC Executive	• oversees the media and communications functions and responsibilities on behalf of the EMC • sets priorities for EMJPIC in communications and engagement.	EMC Assistant Commissioner VicPol Director Relief and Recovery EMV Executive Director Communications DPC Executive Director Communications and Media DHHS Executive Director Communications VicPol Executive Director Communications DELWP Director Emergency Management Resilience EMV EMJPIC Chair (General Manager Media and Communication, EMV) Executive Director, Strategic Communications DEDJTR Executive Director, Strategic Communication DJR Executive Director, Communications, DET Executive Director, Communications, DTF Others as determined by EMC / EMJPIC Executive
EMJPIC	• coordinates all public emergency messaging • for operational readiness, response and recovery.	General Manager Media and Communication, EMV Executive Director Communications and Media DHHS Communication officers from all agencies and departments

6.4.3 Regional tier governance

The control, command and coordination of a health emergency response will not always be appropriate at the regional tier.

The response to public health incidents for example, will usually be centrally coordinated and led at the State level, but may rely on regional DHHS teams and regional liaison officers from other relevant agencies to distribute information, respond to community concerns and manage consequences.

If a health response at the regional tier is considered necessary and appropriate for the effective management of the incident, the Regional Health Coordinator will form a Regional tier Health Incident Management Team (R-HIMT). This may be on the recommendation of the Regional Health Commander.

6.4.4 Incident tier governance

All major emergencies (Class 1, 2 and 3) may be managed at the incident tier, and the health sector needs to be engaged at that tier to adequately support the health response.

Where health incidents are managed at the incident tier, for example, an incident at a hospital, which is contained to a single facility, it will involve the establishment of a Hospital Incident Management Team (HoIMT).

However as is the case with regional tier governance, control, command and coordination of a health emergency response will not always be appropriate at the incident tier, either because there is no incident 'site' (for example, epidemic thunderstorm asthma) or because the response is most appropriately coordinated centrally (using State tier arrangements).

If a response at the incident tier is considered necessary and appropriate for the effective management of the incident, the Incident Health Commander will form an Incident tier Health Incident Management Team (I-HIMT) with support from Hospital Commanders from affected facilities.

7 Appendices

Appendix A: Glossary

TERM	DEFINITION
Acute care	Victorian acute care includes admitted and non-admitted services such as critical care, surgical services, Hospital in the Home, specialist clinics, trauma and emergency services.
All communities, all emergencies approach	This approach to the planning, response to and recovery from an emergency, is one that is adaptable for a wide range of situations and considers the needs of different community groups.
Business continuity	The uninterrupted availability of all key resources supporting essential business function. Business continuity management provides for the availability of processes and resources in order to ensure the continued achievement of critical services objectives.
Casualty	A person who is sick, injured or killed in an emergency.
Chief Health Officer	The Chief Health Officer appointed under the *Public Health and Wellbeing Act 2008*.
Class 1 emergency	Definition from the *Emergency Management Act 2013:* Class 1 emergency means— (a) a major fire; or (b) any other major emergency for which the Metropolitan Fire and Emergency Services Board, the Country Fire Authority or the Victorian State Emergency Service Authority is the control agency under the state emergency response plan.
Class 2 emergency	Definition from the *Emergency Management Act 2013:* Class 2 emergency means a major emergency which is not— (a) a Class 1 emergency; or (b) a warlike act or act of terrorism, whether directed at Victoria or a part of Victoria or at any other State or Territory of the Commonwealth; or (c) a hi-jack, siege or riot.
Class 3 emergency	Class 3 emergency is not a defined term in the *Emergency Management Act 2013.* For the purpose of this plan, a Class 3 emergency means a warlike act or act of terrorism, whether directed at Victoria or a part of Victoria or at any other State or Territory of the Commonwealth, or a hi-jack, siege or riot.

TERM	DEFINITION
Code Brown	Nationally recognised hospital code for an external emergency.
Command	Directing an agency's people and resources in the performance of its role and tasks. Authority is vertical within the agency.
Control	The overall direction of response activities in an emergency situation. Control acts horizontally across agencies, as it carries the responsibility for tasking other agencies.
Control Agency	An agency nominated through the authority of the EMMV to control response activities for a specific emergency.
Coordinate/ coordination	Bringing together agencies and elements to ensure and effective response to the emergency. It involves the systematic acquisition and application of resources (agencies, personnel and equipment).
EM-COP	The Emergency Management Common Operating Picture (EM-COP) is a web-based platform that enables the emergency management sector to create and publish community notifications and warnings.
Emergency	Definition from the *Emergency Management Act 1986:* 'An emergency due to the actual or imminent occurrence of an event which in any way engagers or threatens to endanger the safety or health of any person in Victoria, or which destroys or damages, or threatens to destroy or damage, any property in Victoria, or endangers or threatens to endanger the environment or an element of the environment in Victoria including, without limiting the generality of the foregoing: (a) an earthquake, flood, wind-storm or other natural event; and (b) a fire; and (c) an explosion; and (d) a road accident or any other accident; and (e) a plague or an epidemic; and (f) a warlike act, whether directed at Victoria or part of Victoria or at any other State or Territory of the Commonwealth; and (g) a hi-jack, siege or riot; and (h) a disruption to an essential service.'
Emergency management	Measures taken in response to particular hazards, incidents or disasters.
Escalation	The act of moving to a higher level of response for appropriate management of the emergency incident. Escalation is based on the risk factors associated with the incident including factors such as size, resources or media interest.
Hazard	A condition or event potentially harmful to the community or environment.
Health Commander	The person responsible for directing the pre-hospital health emergency operations. At each tier the Health Commander will be an appropriate ambulance manager. Otherwise, the appointment is made by the SHEMC.
Health Coordinator	An emergency management role, within the regional and state tiers, responsible for representing and coordinating the activities of DHHS in response to an emergency at that tier.

TERM	DEFINITION
Health emergency	Health emergency in the context of this plan includes an incident or emerging risk to the health of community members, from whatever cause, and requires a significant and coordinated effort to ensure the health system can effectively respond and mitigate the adverse health consequences for communities.
Health response	The significant and coordinated management of pre-hospital and hospital response to a health emergency.
Health service	Relates to public health services, denominational hospitals, metropolitan hospitals and public hospitals, as defined by the *Health Services Act 1988,* with regard to acute and subacute services provided within a hospital or a hospital-equivalent setting.
Health system	For the purposes of this plan, references to the health system include acute, public and primary health service providers.
Incident management system	A flexible, scalable organisational management structure that includes the functions of operations, planning, logistics, administration/finance and public affairs to facilitate efficient management of an incident.
Major emergency	Definition from the *Emergency Management Act 2013:* Major emergency means— (a) a large or complex emergency (however caused) which— i. has the potential to cause or is causing loss of life and extensive damage to property, infrastructure or the environment; or ii. has the potential to have or is having significant adverse consequences for the Victorian community or a part of the Victorian community; or iii. requires the involvement of 2 or more agencies to respond to the emergency; or (b) a Class 1 emergency; or (c) a Class 2 emergency.
Mass casualty situation	An emergency involving such number and severity of casualties for which normal local resources for response may be inadequate.
Operational debrief	A meeting held during or at the end of an operation to assess its conduct or results. Final debriefing needs to be delayed until all information and data are available to inform the operational debrief.
Operational response plan	A plan prepared by an agency/organisation or functional area which describes the operations carried out to support the control agency during health emergency response operations. It is an action plan describing how the agency/organisation or functional area is to be coordinated in order to carry out allocated roles and responsibilities.
Pre-hospital	A functional component of health emergency response, from response at the scene of an incident, to the receiving hospital or other healthcare facility.
Preparedness	The action to minimise loss of life and damage, and the organisation and facilitation of timely, effective rescue, relief and rehabilitation in case of an emergency.
Primary health	The care received at the first point of contact with the healthcare system, for example, when someone sees a physiotherapist because they have a sore back. It is traditionally delivered in community health centres or through private allied health providers.

TERM	DEFINITION
Public health	The organised response by society to protect and promote health of the population as a whole, and to prevent illness, injury and disability.
Public Health Commander	The public health command functional lead performed by the Chief Health Officer (or delegate).
Public health emergency	Public health emergencies (for which DHHS is the control agency) include: • biological and radioactive incidents • retail food contamination • food and water contamination • human disease
Situation report	A brief report that is published and updated periodically during an emergency that outlines the details of the emergency, the health tasks generated, and the responses undertaken as they become known.
Stand down	The return to business-as-usual operations when deployment of resources and personnel is no longer required.
Standard Operating Procedures	The internal response procedures which document operational and administrative procedures to be used.
State Control Centre (SCC)	Victoria's primary control centre for the management of emergencies. The purpose of the SCC is to provide a facility to support the EMC to meet the state control priorities and objectives.
State Emergency Management Centre	Used to coordinate the health and human services response and recovery operations of medium to large-scale emergencies. It is located on Level 1, 50 Lonsdale St, Melbourne.
State Health Emergency Management Coordinator	An executive-level public administration function performed by DHHS and appointed by the Secretary of the Department.
Support agency	An agency that provides essential services, personnel or material to support or assist a control agency or affected persons. Any agency may be requested to assist in any emergency if it has skills, expertise or resources that may contribute to the management of the emergency.
Tiers of operation	There are three tiers of incident control for emergency response in Victoria: incident, regional and state.
Triage	The process by which casualties are sorted, prioritised and distributed, according to their need for first aid, resuscitation, emergency transportation and appropriate care.
Vulnerable person	A vulnerable person under this plan refers to someone living in the community who is: • frail, and/or physically or cognitively impaired; and • unable to comprehend warnings and directions and/or respond in an emergency situation.

Appendix B: Relevant Victorian public health legislation

	ADDITIONAL LEGISLATION RELATED TO THIS PLAN
1	*Ambulance Services Act 1958*
2	*Health Records Act 2001*
3	*Health Services Act 1988*
4	*Local Government Act 1989*
5	*Occupational Health and Safety Act 2004*
6	*Safe Drinking Water Act 2003*
7	*Food Act 1984*
8	*Radiation Act 2005*

Appendix C: National plans relating to SHERP

PLAN	DESCRIPTION
AEMA	The Australian Emergency Management Arrangements, which provide an overview of how Commonwealth, state, territory and local governments collectively approach the management of emergencies, including catastrophic disaster events.
AHMPPI	The Australian Health Management Plan for Pandemic Influenza, a national health plan for responding to an influenza pandemic based on international best practice and evidence. It outlines the measures that the health sector will consider in response to an influenza pandemic. This plan may call on elements of SHERP4 in support.
AUSASSISTPLAN	Outlines the coordination arrangements for the provision of Australian Government assistance, be it financial, technical or physical, to an overseas disaster in countries eligible for official development assistance (ODA) as well as for non ODA countries.
AUSTRAUMAPLAN	Provides an agreed framework and mechanisms for the effective national coordination, response and recovery arrangements for mass casualty incidents of national consequence resulting from trauma. Includes the Severe Burn Injury annex (AUSBURNPLAN).
COMDISPLAN	Coordination arrangements for the provision of Australian Government physical assistance to states and territories in the event of a disaster where the jurisdiction's own resources are exhausted or unavailable.
NatHealth arrangements	The National health emergency response arrangements, which direct how the Australian health sector (incorporating state and territory health authorities and relevant Commonwealth agencies) would work cooperatively and collaboratively to contribute to the response to, and recovery from, emergencies of national consequence.
National arrangements for mass casualty transport	The national arrangements to plan for and coordinate medical transport within Australia in response to a mass casualty event.
NATCATDISPLAN	Describes the national coordination arrangements for supporting states, territories and the Commonwealth governments in responding to and recovering from catastrophic natural disasters in Australia.
National counter terrorism plan	This plan outlines responsibilities, authorities and the mechanisms to prevent (or if they occur, manage) acts of terrorism and their consequences within Australia.
OSMASSCASPLAN	The National response plan for mass casualty incidents involving Australians overseas, which details the primary response arrangements to overseas incidents involving Australian nationals and other approved persons.

Appendix D: List of relevant operational response plans and supporting documents

Status correct at time of publication and subject to change

PLAN	DESCRIPTION	STATUS
Communicable Disease Incident and Emergency Operational Response Plan	Outlines DHHS' arrangements for managing a response to communicable disease incidents and emergencies. This includes the roles and responsibilities of the relevant DHHS branch responsible for initiating and managing the response.	Under development
Food Incident and Emergency Operational Response Plan	Outlines DHHS' arrangements for managing a response to food contamination incidents and emergencies. This includes the roles and responsibilities of the relevant DHHS branch responsible for initiating and managing the response.	Under development
Water Incident and Emergency Operational Response Plan	Outlines DHHS' arrangements for managing a response to drinking water contamination incidents and emergencies. This includes the roles and responsibilities of the relevant DHHS branch responsible for initiating and managing the response.	Under development
CBRNE Incident and Emergency Operational Response Plan	Outlines DHHS' arrangements for managing a response to chemical, biological, radiological, nuclear and explosive incidents and emergencies. This includes the roles and responsibilities of the relevant DHHS branch responsible for initiating and managing the response.	Under development
Epidemic Thunderstorm Asthma Preparedness and Operational Response Plan	Describes the DHHS arrangements for preparing for and managing a response to an Epidemic Thunderstorm Asthma event. This includes arrangements for the forecasting and monitoring of epidemic thunderstorm in preparation for future pollen seasons.	Active (under revision)
Ambulance Victoria Emergency Response Plan	Outlines Ambulance Victoria's arrangements for the management of major incidents across Victoria. It describes key responsibilities and activities of AV including the role of personnel in the pre-hospital line of command, the management of communication and information, and the mobilisation of AV resource capability during a major incident.	Under revision
ESTA Critical Incident Response Plan (CIRP)	Provides a guideline for implementing various strategies that mitigate impacts to service delivery during periods of surge. It describes how ESTA escalates its response and manages critical incidents.	Active
Heat Health Plan for Victoria (2015)	Outlines a coordinated and integrated response to extreme heat in Victoria and sets out the actions and systems in place to support those most at risk during periods of extreme heat.	Active

PLAN	DESCRIPTION	STATUS
State Smoke Framework (2016)	Describes a cross-government approach to smoke events that impact air quality and the health of communities and outlines the strategies and tools for smoke management measures.	Active
Victorian Medical Assistance Team Policy (2015)	Describes the authorising environment, resilience activity, deployment arrangements, response and mobilisation at incident level for VMAT operations. The policy specifies the health services nominated to maintain VMAT capability.	Active
Victorian Medical Assistance Team Protocol (2016)	Describes the selection, training, equipping, deployment and administrative arrangements for VMAT. It lists the various major, metropolitan and regional trauma centres at which VMATs have been established, the composition of each VMAT team, training and exercising requirements, and the process by which VMAT assistance may be activated.	Active
DHHS Public Information and Warnings Business Rules and Decision-making Guide (2017)	Outlines the roles and responsibilities for issuing public information and warnings for health emergencies, to the extent that these differ to the arrangements in the SHERP.	Active
DHHS First Wave Notification	Outlines the consideration for issuing a first wave notification and the process by which one is sent. A first wave notification provides a means of alerting the health sector about incidents (actual or potential) that may result in widespread or catastrophic consequences on the Victorian community or health infrastructure.	Active
Epidemic Thunderstorm Asthma Warnings Protocol	Outlines the procedures for the Chief Health Officer and the Emergency Management Commissioner to approve thunderstorm asthma warnings.	Active (under revision)
Guidelines for multiple burns casualties (2015)	Outlines the response strategies required for an incident resulting in multiple burn casualties in Victoria. In particular, it describes the means by which the State's two burn services will support and respond to an incident involving multiple burn casualties.	Active
Victorian health management plan for pandemic influenza (2014)	Provides a framework for government and the health sector to minimise transmissibility, morbidity and mortality associated with an influenza pandemic, and to manage the impact of a pandemic on the community and the health system.	Active
Mass Casualty and Pre-hospital Operational Response Plan	Provides additional detail for managing a health emergency response involving mass casualties and pre-hospital arrangements. It describes the leadership and management arrangements for a health emergency response within the incident tier of operations.	Under development

PLAN	DESCRIPTION	STATUS
Additional Capability and Capacity Operational Response Plan	Outlines scalable arrangements to mobilise additional capability and capacity across the health sector. This includes arrangements to engage first aid agencies, general practitioners (GPs), community pharmacists, and Field Emergency Medical Officers or coordinators in a health emergency response. The aim of this plan is to improve health sector preparedness for emergencies by increasing system wide capacity and capability enabling greater scalability, availability, and accessibility of required resources in the event of an emergency.	To be developed
Regional Health Emergency Operational Response Plan	Provides additional detail for managing a regional health emergency response. It describes the leadership and management arrangements for a health emergency response within the regional tier of operations.	Under development
SUPPORTING DOCUMENTS		
Public Events and Mass Gatherings Guidelines	Provides information to assist event organisers in their health emergency preparedness activities. Includes a checklist to assist in planning a health emergency response.	Under development
Code Brown Guidelines	Provides information to assist health services prepare Code Brown Plans. The guidelines aims to clarify the purpose of Code Brown plans and highlights some key steps to take before, during and after an external emergency.	Active
Emergency Incident Casualty Data Collection Protocol	Describes the procedures for the provision of emergency incident information between health services and DHHS. The protocol applies to all Victorian public and private health services with an Emergency Department or Urgent Care Centre. Its objective is to collate reliable, accurate, timely and consistent information on presentations to health services resulting from an emergency incident.	Active
Key Function Descriptions	Describes the roles, responsibilities and functions of the State Health Emergency Management Coordinator (SHEMC), Public Health Commander, State Health Coordinator and State Health Commander. It also describes the key attributes, qualification and/or training required to fulfil the role of the SHEMC, Public Health Commander, State Health Coordinator and State Health Commander.	Under revision
Primary Health Networks Guidelines	Provides information to assist primary health networks to prepare for and respond to emergencies.	Under development

Appendix E: Summary of relevant health care facility emergency codes

The following codes are based on *Australian Standard (AS) 4083 – 2010 Planning for emergencies – Health care facilities.*

CODE COLOUR	DESCRIPTOR	DESCRIPTION OF EMERGENCY
Code Red	Fire / smoke	Fire or smoke emergency
Code Blue	Medical emergency	Medical emergency (for example cardiac arrest)
Code Purple	Bomb threat	Bomb threat or suspicious item / mail
Code Yellow	Infrastructure and other internal emergencies	Any internal emergency that affects service delivery, for example: • electricity supply disruption • information technology disruption • structural damage • staffing and overcrowding emergencies • bushfires and cyclones.
Code Black	Personal threat	Person threatening or attempting to harm self or others. Includes Code Black Alpha for infant or child abduction
Code Brown	External emergency	A multi-casualty incident that stretches or overwhelms the available health resources, for example: • aircraft crash • structural collapse • explosion.
Code Orange	Evacuation	Requirement to evacuate patients, staff and visitors to a designated assembly area due to an emergency, for example: • fire • bomb threat • structural damage.

EMV
EMERGENCY
MANAGEMENT
VICTORIA

www.emv.vic.gov.au

VICTORIA
State
Government

DHHS Quarantine – incident reporting template

Reference number	CM11399
Impact (Major only) *e.g. injury, death, sustaining/diagnosing life threatening condition, assault/crime*	Injury

1. Service provider details

Reporting organisation	Department of Health and Human Services
Address of service delivery	Stamford Hotel
DHHS Service Area *(e.g. Emergency Management)*	Emergency Management
Service type	Hotel Quarantine

2. Incident dates

Date of incident	07/05/2020
Date accuracy (exact/approximate)	Exact
Time of incident	12pm
Time accuracy (exact/approximate)	Approx.
Date incident disclosed	07/05/2020
Time incident disclosed	

3. Incident description

Location of incident	REDACTED Stamford Hotel
Detailed incident description (written retrospectively by EOC staff)	

1. On 7 May 2020, at approximately 12noon, whilst being escorted by security on a fresh air/exercise break REDACTED was reported to have been jumping, when RE slipped injured R right foot.

- REDACTED declined immediate medical treatment and returned to her room
- However, at 3:50pm REDACTED required to be transported to St Vincent's hospital via ambulance.
- REDACTED received same day treatment at REDACTE hospital, was discharged later on the same night (7 May 2020), back to the Stamford Plaza Melbourne, to continue RE quarantine.
- REDACTED returned wearing a medical cam boot and was prescribed Ibuprofen for pain by MO onsite
- There is no record of a discharge plan supplied by the hospital or REDACTED
- REDACTED received support from health and welfare staff on site for the remainder of her quarantine.

- Following the incident Ms Erasmus and family where transferred to dual connecting rooms, which gave the family more space and provided Ms Erasmus with access to an accessible shower.

4. Individual details – Passenger/detainee 1 [duplicate for each person involved]

Passenger/detainee's full name	REDACTED
Passenger/detainee incident impact	Major
Sex	Female
Indigenous status	
Date of birth	REDACTED
Passenger/detainee address	REDACTED
Passenger/detainee unique identifier number *(if applicable)*	
Incident type	Injury
Involvement in the incident (victim, witness, subject of abuse allegation, participant)	Victim
Passenger/detainee's immediate safety needs met (Yes/No)	Yes
Medical attention provided (Yes/No)	Initially declined but consented later in day.
Passenger/detainee debriefing or counselling (Yes/No	Offered
Referral to support services (Yes/No)	Yes
Change passenger/detainee care (support plan) (Yes/No)	Transferred to REDA via Ambulance Victoria
Notified next of kin, guardian or key support person (Yes/No)	Yes

5. Other/s involved in incident [duplicate for each other person involved]

Person's full name	REDACTED
Date of birth	
Person's job title or relationship to passenger/detainee (carer, paid staff, other)	MO on duty at Stamford Plaza Hotel
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	Provided medical treatment
Person's full name	
Date of birth	
Person's job title or relationship to passenger/detainee (carer, paid staff, other)	

Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	
Person's full name	
Date of birth	
Person's job title or relationship to passenger/detainee (carer, paid staff, other)	
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	

6. Service provider response details

Brief summary of incident	
Reported to police (Yes/No)	
Name of officer and date reported to police	
Police investigation initiated (Yes/No)	
Staff member stood down/removed (Yes/No)	
Manager's full name	
Manager's job title	
Date incident report reviewed	
Manager telephone number	
Manager email	
Immediate actions taken by the organisation in response to the incident	
Deputy Commander full name and signature	SANDY AUSTIN S. Austin
Deputy Commander job title	D/C HOTELS.
Date incident report approved	27/7/2020.
Comments	information was corroborated following a review of records.

7. Incident report authorisation – EOC Command

Delegated authority full name and signature	
Delegated authority job title	
Date incident report approved	
Delegated authority phone number	
Delegated authority email address	

Comments	

8. Incident report authorisation – Deputy Secretary

Delegated authority full name and signature	
Delegated authority job title	
Date incident report endorsed	
Delegated authority phone number	
Delegated authority email address	
Comments (optional)	

9. Incident report authorisation - Secretary

Delegated authority full name	
Delegated authority job title	
Date incident report endorsed	

Incident and Novotel on Collins

From: "Merrin Bamert (DHHS)" <REDACTED>

To: "Andrea Spiteri (DHHS)" <REDACTED>, "Melissa Skilbeck (DHHS)" REDACTED, "Jason Helps (DHHS)" REDACTED "Anthony J Kolmus (DHHS)" <REDACTED>

Date: Thu, 16 Apr 2020 23:10:00 +1000

Hi all

I was called by RE our DHHS staff team leader at 7pm tonight with 2 escalating guest who were agitated for a cigarette. One of the guest was threatening to self harm if RED did not get a cigarette. RE had been seen by the mental health nurse who was hoping to de-escalate RE with a smile rather than RE overdosing on RE meds.

RED name is REDACTED, RE is travelling alone, REDACTED REDACT RE has a PH of mental health PTSD, depression and anxiety and is on medication.

RE had spoken to the AO and staff and in conversation we agreed that RE contact the hotel duty officer and see if there was a safe place for a cigarette. They could hear smashing objects in the room and RE agreed to calm down if they went for a cigarette.

RE then called again at 8pm to say that when RE finished RE cigarette RE became pale and fainted and slipped through a railing into and fell about 1m onto a concrete floor on RE shoulder and face.

RE called for nurses and and ambulance was called. The guest was awake and assessed and transferred to RMH.

I attended the hotel at about 8.30, RE was very distressed, I have spoken to the nurses and AO and security. All staff have completed contemporaneous notes of the event and RE completed and incident report for the hotel.

I called for EAP support and RED attended and has meet with RE and will cal RE tomorrow.

REDACTED is the AO on for the shift and was also offered EAP however felt RE was ok.

Nursing staff for offered support also.

I will stay with RE till R completes RE notes and drove RE to RE car at 50 Lonsdale.

The police attended tonight at 10.50 to advise that REDA has a broken Jaw and is being admitted to hospital for surgery tomorrow.

I have taken photos of notes and will provide in the morning.

Regards

Merrin

Get Outlook for iOS

DHHS Quarantine – incident reporting template

Reference number	
Impact (Major only) *e.g. injury, death, sustaining/diagnosing life threatening condition, assault/crime*	

1. Service provider details

Reporting organisation	Department of Health and Human Services
Address of service delivery	Grand Chancellor Hotel 131 Lonsdale street, Melbourne
DHHS Service Area *(e.g. Emergency Management)*	Emergency Management
Service type	Hotel Quarantine

2. Incident dates

Date of incident	14June 2020
Date accuracy (exact/approximate)	14 June 2020
Time of incident	4am
Time accuracy (exact/approximate)	
Date incident disclosed	8 June 2020
Time incident disclosed	7am

3. Incident description

Location of incident	Front of hotel
Detailed incident description	

- O/N nurses went out to get coffee at around 4am and were followed back to the hotel by a man that was trying to get into the hotel, stating he wanted a room at the brothel to see those girls. He continually tried to get into the building until he left at approx 6am in a taxi – number – REDA. Police were notified ref REDAC.

At approx 9am – nurses went out for coffee and the man was speaking with the police just down from the hotel. The café the nurses went into advised that they had been hassling them also and the nurses advised that they should contact the police as he had been following the nurses.
Have spoken with security who suggested the nurses go out with the security when they are on their breaks.

4. Individual details – Passenger/detainee 1 [duplicate for each person involved]

Passenger/detainee's full name	
Passenger/detainee incident impact	
Sex	
Indigenous status	
Date of birth	
Passenger/detainee address	
Passenger/detainee unique identifier number *(if applicable)*	
Incident type	
Involvement in the incident (victim, witness, subject of abuse allegation, participant)	
Passenger/detainee's immediate safety needs met (Yes/No)	
Medical attention provided (Yes/No)	
Passenger/detainee debriefing or counselling (Yes/No	
Referral to support services (Yes/No)	
Change passenger/detainee care (support plan) (Yes/No)	
Notified next of kin, guardian or key support person (Yes/No)	

5. Other/s involved in incident [duplicate for each other person involved]

Person's full name	
Date of birth	
Person's job title or relationship to passenger/detainee (carer, paid staff, other)	
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	
Person's full name	
Date of birth	
Person's job title or relationship to passenger/detainee (carer, paid staff, other)	
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	
Person's full name	
Date of birth	
Person's job title or relationship to passenger/detainee	

(carer, paid staff, other)	
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	

6. Service provider response details

Brief summary of incident	Members of the public entered the quarantine hotel
Reported to police (Yes/No)	Yes
Name of officer and date reported to police	
Police investigation initiated (Yes/No)	
Staff member stood down/removed (Yes/No)	Security have stood staff down
Manager's full name	
Manager's job title	
Date incident report reviewed	
Manager telephone number	
Manager email	
Immediate actions taken by the organisation in response to the incident	
Deputy Commander full name and signature	
Deputy Commander job title	
Date incident report approved	
Comments	

7. Incident report authorisation – EOC Command

Delegated authority full name and signature	
Delegated authority job title	
Date incident report approved	
Delegated authority phone number	
Delegated authority email address	
Comments	

8. Incident report authorisation – Deputy Secretary

Delegated authority full name and signature	
Delegated authority job title	

Date incident report endorsed	
Delegated authority phone number	
Delegated authority email address	
Comments (optional)	

9. Incident report authorisation - Secretary

Delegated authority full name	
Delegated authority job title	
Date incident report endorsed	

DHHS Quarantine – incident reporting template

Reference number	
Impact (Major only) *e.g. injury, death, sustaining/diagnosing life threatening condition, assault/crime*	Suicide attempt

1. Service provider details

Reporting organisation	Department of Health and Human Services
Address of service delivery	REDACTED
DHHS Service Area *(e.g. Emergency Management)*	Emergency Management
Service type	Hotel Quarantine

2. Incident dates

Date of incident	REDACTED
Date accuracy (exact/approximate)	REDACTED
Time of incident	REDACTED
Time accuracy (exact/approximate)	exact
Date incident disclosed	REDACTED
Time incident disclosed	REDACT

3. Incident description

Location of incident	8 Whiteman Street, Melbourne REDACTED
Detailed incident description	
REDACTED	REDACTED

Client spoke with the mental health nurse at approximately 8pm and was distressed and upset and sited previous mental health issues REDACTED. The client most significant issue was not being able to go for a walk whenever RE wanted to. The DHHS Team Leader spoke with the client to try and find a way to meet RE needs. DHHS Team Leader following the call with the client at approximately 8.30pm indicated he had concerns for the client welfare.

The Mental Health Nurse was in the process of requesting the client's previous medical records when the nursing staff received a call form the guest stating REDACTED

20:45 – client called ambulance and onsite nurses stating REDACTED

20:50-55 – Onsite nursing team attended room

21:04 – Security provided room specific entry care and nurses entered room

21:07 REDACTED

21:10 – REDACTED

21:23 – DHHS Team Leader spoke with nursing staff to check on status of ambulance.

21:30 – DHHS Team Leader called 000 to check on the status of the ambulance. AV advised that it was not being treated as an emergency. DHHS Team Leader said it was an emergency and asked for an ambulance to attend immediately.

21:43 – Paramedics arrived. Over 40-minute response time.

22:04 – Ambulance transported patient to the Royal Melbourne Hospital

4. Individual details – Passenger/detainee 1 [duplicate for each person involved]

Passenger/detainee's full name	REDACTED
Passenger/detainee incident impact	
Sex	REDAC TED
REDACTED	REDACTE
Date of birth	REDACTED
Passenger/detainee address	REDACTED
Passenger/detainee unique identifier number *(if applicable)*	
Incident type	REDACTED
Involvement in the incident (victim, witness, subject of abuse allegation, participant)	REDACT
Passenger/detainee's immediate safety needs met (Yes/No)	Yes
Medical attention provided (Yes/No)	Yes
Passenger/detainee debriefing or counselling (Yes/No	Yes
Referral to support services (Yes/No)	Yes
Change passenger/detainee care (support plan) (Yes/No)	Yes
Notified next of kin, guardian or key support person (Yes/No)	Yes

5. Other/s involved in incident [duplicate for each other person involved]

Person's full name	
Date of birth	
Person's job title or relationship to passenger/detainee (carer, paid staff, other)	
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	
Person's full name	
Date of birth	
Person's job title or relationship to passenger/detainee (carer, paid staff, other)	
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	
Person's full name	
Date of birth	
Person's job title or relationship to passenger/detainee	

(carer, paid staff, other)	
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	

6. Service provider response details

Brief summary of incident	REDACTED
Reported to police (Yes/No)	No
Name of officer and date reported to police	
Police investigation initiated (Yes/No)	
Staff member stood down/removed (Yes/No)	
Manager's full name	
Manager's job title	
Date incident report reviewed	
Manager telephone number	
Manager email	
Immediate actions taken by the organisation in response to the incident	
Deputy Commander full name and signature	
Deputy Commander job title	
Date incident report approved	
Comments	

7. Incident report authorisation – EOC Command

Delegated authority full name and signature	
Delegated authority job title	
Date incident report approved	
Delegated authority phone number	
Delegated authority email address	
Comments	

8. Incident report authorisation – Deputy Secretary

Delegated authority full name and signature	

Delegated authority job title	
Date incident report endorsed	
Delegated authority phone number	
Delegated authority email address	
Comments (optional)	

9. Incident report authorisation - Secretary

Delegated authority full name	
Delegated authority job title	
Date incident report endorsed	

RE: Stamford Plaza concerns - as discussed

From: Personal Information (DJPR)" Personal Information@global.vic.gov.au>
To: DHHSOpSoteriaEOC <dhhsopsoteriaeoc@dhhs.vic.gov.au>
Cc: Personal Information (DEDJTR)" Personal Information@global.vic.gov.au>, Personal Information Personal Information@jarrahis.com.au>, jventra <jventra@bigpond.com>, trevor.richardson58@gmail.com
Date: Sun, 14 Jun 2020 15:29:02 +1000

Hi Jason,
Thank you for the chat earlier and raised the below mentioned issues.
I would have appreciate if the team leader would have reported to me and it would have been resolved straight away.
Anyway I can assure you that I am going to have a talk with the security who was in charge this morning and insure the social distancing and rules of gathering is followed during the briefing.
I will also arranging with the security and nurses so that all the security members are trained how to use the PPE.

In regards to the hairdresser we do have a procedure that is been followed however any suggestion is welcome to insure better safety'

We are still waiting for the log book and procedure guideline to be implemented /Team leader aware.

Kind regards,
Personal Informat

From: DHHSOpSoteriaEOC <DHHSOpSoteriaEOC@dhhs.vic.gov.au>
Sent: Sunday, 14 June 2020 2:12 PM
To: Personal Information (DJPR) Personal Information@global.vic.gov.au>
Cc: DHHSOpSoteriaEOC <DHHSOpSoteriaEOC@dhhs.vic.gov.au>
Subject: Stamford Plaza concerns - as discussed
Hi Personal Inform

As discussed please see the issues raised with us regarding the Stamford Plaza Hotel. As discussed there are multiple issues here that we need to address as soon as possible. I understand from our discussion that the security company engaged at the Stanford is NSS. We have significant concerns about the response provided by Security when approached by our Team Leader this morning, and about the ongoing issues regarding the correct use of PPE. I have attached for your reference, as discussed, the documentation relating to correct usage of PPE however note the additional efforts that our team have been attempting to implement in the hotel to address this issue.

Can you please consider the below and respond to me as soon as you can with proposals to address the issues raised.

Regards

Jason

Jason Dodson
Manager, Emergency Management, Eastern Metro Region
Department of Health and Human Services
883 Whitehorse Road, Box Hill
M. 0427 075 562 | e. jason.dodson@dhhs.vic.gov.au

From: StamfordPlaza (DHHS)
Sent: Sunday, 14 June 2020 8:24 AM
To: DHHSOpSoteriaEOC <DHHSOpSoteriaEOC@dhhs.vic.gov.au>
Subject: Public Health Concern re Security at Stamford

Good Morning,

Three public health concerns:
1.
I entered the hotel today to find the 70 security for Stamford standing shoulder to shoulder in a room 6x6 metres.
I spoke to the head security Trevor to remind him about social distancing and rules of groups gathering. He advised me his meeting was more important than the rule.
I advised him he can not gather in those numbers and not social distance.
I suggested he break his team meeting into smaller numbers and use a larger area such as downstairs so that security can stand apart from one another.

Nurses have raised concerns that they have tried to address the PPE breaches with security previously and have not succeeded. The security have been observed to wear full PPE to the toilet, gloves in the bathroom, not wash hands after toileting (women and men), wearing gloves all day, touching their clothes, phones, faces etc.
Yesterday I have them the PPE procedure and a video showing them how cross contamination occurs and how easy it happens. I have seen a decrease in glove use however the gathering this morning is a huge concern. Nurses also advised that as the 70 were leaving the hotel they were hugging each other etc.
There are positives from this flight that remain in the hotel (one child tested positive and family of 5 negative) however it is unlikely the child is the only positive guest given he was unlikely to not touch anything on the flight.

2.
On 6 June I raised concerns to EOC about the hairdressers being open and working from the reception area of the Stamford. In summary, clients to the hairdresser enter the hotel reception to enter the hairdressers. They use the lifts and stairs that take them to the floor where DHHS staff, security, nurses, supplies and food is prepared. They use the same space which guests of the hotel use to walk through to go for fresh air walks and smokers walks. They loiter in reception, door to hairdressers is open to reception and guests do not correctly use PPE or take precautions.

3.
There is still no log book at the Stamford for people/staff arriving to the hotel. I am conscious that this has been mandatory procedure for a couple of weeks now.

The AO team Leader is present and agrees that the gathering is a concern.

For your consideration and notice

[redacted]
DHHS Team Leader – Quarantine Hotel

Fwd: OFFICIAL - Sensitive: FW: Attn PIO: hotel food - frog

From: "Merrin Bamert (DHHS)" <REDACTED>
To: "DJPR COVID Accom-Lead (DJPR)" <REDACTED>
Cc: "Pam Williams (DHHS)" <REDACTED>, DHHSOpSoteriaEOC <dhhsopsoteriaeoc@dhhs.vic.gov.au>, "Melody Bush (DHHS)" REDACTED
Date: Mon, 15 Jun 2020 12:40:58 +1000

Hi Rachaele

FYI

We may get comms, suggest engagement with hotel however public health and Melbourne city council will manage the review.

Regards

Merrin

Get Outlook for iOS

From: Melissa Skilbeck (DHHS) REDACTED
Sent: Monday, June 15, 2020 12:15 pm
To: Merrin Bamert (DHHS)
Subject: FW: OFFICIAL - Sensitive: FW: Attn PIO: hotel food - frog

fyi

Regards,
Melissa

Melissa Skilbeck
Deputy Secretary | Regulation, Health Protection and Emergency Management
Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
t. (03) REDACTED | w. www.dhhs.vic.gov.au

OFFICIAL: Sensitive

From: Angie Bone (DHHS) REDACTED
Sent: Monday, 15 June 2020 12:10 PM
To: Melissa Skilbeck (DHHS) <REDACTED>
Subject: FW: OFFICIAL - Sensitive: FW: Attn PIO: hotel food - frog

Just in case you weren't aware and are asked.
Angie

OFFICIAL: Sensitive

From: FSV (DHHS) REDACTED
Sent: Friday, 12 June 2020 8:05 AM
To: Angie Bone (DHHS) <REDACTED>
Cc: REDACTED
RED
Subject: FW: OFFICIAL - Sensitive: FW: Attn PIO: hotel food - frog

Dear Angie,

The food safety unit has been included in the email below regarding alleged foreign matter (green tree frog) in salad served to a detainee at the Pan Pacific Hotel.

As you can see a raft of people are included in the email traffic including OpSoteria.

It appears to have been posted to the social media team so may be picked up in local media etc.

Kind regards,

REDACTED

REDACTED | Food Safety Science Officer
Food Safety Unit | Health Protection Branch
Department of Health and Human Services | 50 Lonsdale Street Melbourne Victoria 3000
p.REDACTED | e.REDACTED
w. www.health.vic.gov.au/foodsafety

OFFICIAL: Sensitive

From: DHHS EmergencyCommunications (DHHS) <em.comms@dhhs.vic.gov.au>
Sent: Thursday, 11 June 2020 7:55 PM
To: DHHSOpSoteriaEOC <DHHSOpSoteriaEOC@dhhs.vic.gov.au>; FSV (DHHS) <foodsafety@dhhs.vic.gov.au>
Cc: REDACTED (DHHS) <REDACTED>; Social Media <socialmedia@dhhs.vic.gov.au>; DHHS EmergencyCommunications (DHHS) <em.comms@dhhs.vic.gov.au>
Subject: RE: OFFICIAL - Sensitive: FW: Attn PIO: hotel food - frog

Hi REDACTED

Thanks for the speedy reply and great to know this is already underway.

Regards

REDACTED

CURRENTLY SECONDED TO THE DHHS COVID-19 EMERGENCY MANAGEMENT COMMUNICATIONS TEAM
E REDACTED

T REDACTED
E

OFFICIAL: Sensitive

From: DHHSOpSoteriaEOC REDACTED
Sent: Thursday, 11 June 2020 7:30 PM
To: DHHS EmergencyCommunications (DHHS) <em.comms@dhhs.vic.gov.au>; FSV (DHHS) <foodsafety@dhhs.vic.gov.au>
Cc: REDACTED <socialmedia@dhhs.vic.gov.au>
Subject: RE: OFFICIAL - Sensitive: FW: Attn PIO: hotel food - frog

Hi,

Thanks for this.

This was referred West Division Health Protection yesterday. West Division will refer the matter to the City of Melbourne, Food Safety Unit. We will seek an update on the status of the investigation.

We will ask the hotel to contact the guest to check in and advise them the matter is being investigated.

Regards
REDA

OFFICIAL: Sensitive

From: DHHS EmergencyCommunications (DHHS) <em.comms@dhhs.vic.gov.au>
Sent: Thursday, 11 June 2020 7:10 PM
To: DHHSOpSoteriaEOC <DHHSOpSoteriaEOC@dhhs.vic.gov.au>; FSV (DHHS) <foodsafety@dhhs.vic.gov.au>
Cc: DHHS EmergencyCommunications (DHHS) <em.comms@dhhs.vic.gov.au>; REDACTED (DHHS) <REDACTED
Subject: OFFICIAL - Sensitive: FW: Attn PIO: hotel food - frog

Hi Operation Soteria and Food Safety teams

Please see below an image that has been posted online regarding hotel food.

Can you please raise with the hotel urgently and advise the social media team on how you'd like them to respond?

Regards

REDACTED

CURRENTLY SECONDED TO THE DHHS COVID-19 EMERGENCY MANAGEMENT COMMUNICATIONS TEAM
E REDACTED

T REDACTED
E

OFFICIAL: Sensitive

From: REDACTED (DHHS) <REDACTED
Sent: Thursday, 11 June 2020 6:59 PM
To: DHHS EmergencyCommunications (DHHS) <em.comms@dhhs.vic.gov.au>
Cc: Social Media <socialmedia@dhhs.vic.gov.au>; REDACTED (DHHS) <REDACTED
Subject: Attn PIO: hotel food - frog

Hi - this is disturbing.
Needs to be followed up ASAP with the hotel before something happens.
Cheers,
REDACTE
D

REDACTED

REDACTED

35m • Tag

REDACTED

Communications and Media
Department of Health and Human Services | 50 Lonsdale Street, Melbourne VIC 3000

My rest days are Friday and Saturday. Please contact REDACTED on Friday, and REDACTED on Saturday.
Need social media help out of hours?
1. If you can, Log the job through the online publishing request form (JMS)
2. Email digitalmedia@dhhs.vic.gov.au with the job reference number and details or brief
3. Contact the on-call digital officer via REDACTED and they will get in contact with us

DHHS Quarantine – incident reporting template

Reference number	
Impact (Major only) *e.g. injury, death, sustaining/diagnosing life threatening condition, assault/crime*	Unknown

1. Service provider details

Reporting organisation	Novotel on Collins
Address of service delivery	270 Collins St, Melbourne
DHHS Service Area *(e.g. Emergency Management)*	OpSoteria
Service type	Quarantine Hotel

2. Incident dates

Date of incident	5th June 2020
Date accuracy (exact/approximate)	Exact
Time of incident	12.15pm
Time accuracy (exact/approximate)	approximate
Date incident disclosed	5th June 2020
Time incident disclosed	12.30pm

3. Incident description

Location of incident	Royal Melbourne Hospital, short stay emergency department
Detailed incident description	

Notes from AM Team Leader – REDACTED
RE had been transferred to RMH for likely admission to psych ward due to psychosis on 3/6/2020. R has a past psych history.

10am team meeting: Remains in RMH. R is due to exit hotel on Sunday. Discussed making a plan of removing any remaining belongings on Sunday if R has not returned;

1. RE (psych bed access co-ordinator for RMH) rang **approx 11.30am** advising that RE will be admitted to RED medical ward as psych ward is not set up for quarantine guests. Highly unlikely R will return to hotel before R hotel exit date.
2. Advised that RE has had a Covid swab done whilst at RE and this result was negative. Is to be swabbed again today/tomorrow. Asked for DHHS TL to be notified of result when known.
3. RE contacted AO on AO phone directly today saying R was coming back – this info fed back to RED. AO aware that RE is not returning.
4. Will need Nurse to enter room to pack up RE belongings, security to bring down
5. Need to arrange where these belongings go – stored here, taken to RE, next of kin????

NOTE: Times are approx
12.30pm: REDACTED rang back to advise that RE has absconded from RED. VicPol have been notified and I was

told apprehension order had been completed.

- Advised team and security that he had absconded and possible that RE will head back to hotel

12.40pm: Call received from ED dept at RMH – letting us know that R had absconded, VicPol notified and provided with description. Confirmed that the next of kin we had on record is REDACT. Also confirmed that MH person at RED was contacting the REDACTED directly to let her know.
12.42pm: rang EOC. Phone engaged. Sent Urgent email to provide heads up and advise next steps.
12.45pm: Discussed with security – plan is to chat calmly with guest if RE arrives, call VicPol and wait for them to arrive. Plan B is to escort RE to R room if calm chat downstairs not successful. Safety of everyone is prime concern.
12.50pm: Called RE – asked if they could email description of RE to Novotel Collins. Provided R with DHHS email address for Novotel – this was received at
1.00pm: RN checked REDACTED – advised only incidentals remain in the room (eg: Shampoo, water bottle)
1.15pm: Call received from REDACT in ED Dept at REDACTED checking we were aware of RE absconded. Advised we were. RE was able to confirm the following:

- RE absconded approx 12.15pm
- Does have RE backpack with RE - yes
- RED was Covid swabbed on 3/6/2020 in evening - result was negative – day 10
- RED still in process of writing and submitting Apprehension order

1.25pm: REDACTED rang to confirm knowledge of R absconding and advise process. F no apprehension order, police do not have authority to take RE back to RED.
1.30pm: Advised security that as apprehension order not in play at present, the plan is for RE to be immediately and calmly escorted to RE room if RE arrives.
1.44pm: RN's Received call (through hotel switchboard) from VicPol North Melbourne have received apprehension order and are ready when/if required.
1.46pm: Advised security that there are 2 plans of action that can be implemented if R arrives

- If R arrives, downstairs security will inform security supervisor who will ring VicPol and then contact TL
- If calm and security can chat with RE downstairs until VicPol arrive – plan A.
- Plan B – escort RE calmly to RE room and await VicPol, with security immediately outside RE door.

1.50pm: Rang RE, EOC to advise we have received acknowledgement that apprehension order has been received.
2.40pm: Rang VicPol North Melbourne to provide TL phone number so they can ring us directly if they find R elsewhere

Notes from PM Team Leader – REDACTED

1730: T/L REDACTED phoned RED to see if there was an update on guests location. Put through to Nurse Unit Manager (REDAC who said that the guest had been located in REDA and was being brought back to RE by REDAC Police. No further details provided. T/L phone number provided and asked to be called as further information was available.
1735: Melody Bush from EOC phoned and provided with updated
1745: North West Police Station phoned (spoke to Constable REDACT and provided with update as they had not heard from RMH or Bendigo Police
1842: NUM from RMH (RED called back to say that previous NUM spoken to provided incorrect information and guest was not on their way and they were unsure where guest was. NUM stated that they received a call from REDA Police and team leader advised we call REDA Police
1846: REDAC Police phoned and asked for update on guest whereabouts. Police officer REDACTED stated guest was not currently in custody and had been transferred to REDA Health – advised to call REDA Health
1852: REDA Health phoned and they advised they had no record of guest at hospital
1858: REDA Police phoned again and spoke to Constable RED Team Leader advised Constable RED that guest was not at REDA Health. Constable RED unable to provide further information on guest whereabouts and said they would call back following conversation with Sergeant.
1900: AO REDACTE informed of situation and Melody Bush also called. Melody requested copy of passport to be sent through ASAP. AO unable to locate and was only able to provide passport number (which was incorrect).
1919: Team Leader phoned RED again to determine further details on how NUMs were advised of guest being located. NUM REDAC first spoken to at 1730) said that the guests REDA phoned RED after having cited guest and NUM then phoned REDA Police asking them to collect guest.
1923: Constable REDA phoned back and spoke to AO (REDACTE) to inform that guest had been located at REDAC residential address in REDA and REDA Police and Ambulance were on their way to collect guest and bring RE back to REDAC Health ED.
1926: Melody Bush phoned by Team Leader and provided an update on situation. Informed that all details with names and times of calls will be entered into incident report. Details of events of this shift have been emailed through to both AO and Melody in the interim.
1934: AO REDACTED phoned REDAC Health to inform them that guest is still in Quarantine Detention (Spoke to

REDACTED – NUM).
2000: Team Leader called North Melbourne Police station again (spoke to Constable REDACT and advised that guest is on their way to REDA Health with REDAC Policy
2041: Phone call received from REDA Police to confirm guest has been left at REDA Health following police drop off
2046: AO phoned REDACTED (REDA Health ED NUM) to confirm guest has been admitted to ED. NUM has AO Phone number.

Guest will see out the remainder of quarantine as an inpatient of REDAC Health. An AO will issue a new detention notice on 6/6/20 to the guest at REDAC Health.

4. Individual details – Passenger/detainee 1 [duplicate for each person involved]

Passenger/detainee's full name	REDACTED
Passenger/detainee incident impact	
Sex	REDACTED
Indigenous status	
Date of birth	
Passenger/detainee address	REDACTED
Passenger/detainee unique identifier number *(if applicable)*	
Incident type	Absconded from hospital
Involvement in the incident (victim, witness, subject of abuse allegation, participant)	Participant
Passenger/detainee's immediate safety needs met (Yes/No)	Unclear
Medical attention provided (Yes/No)	No
Passenger/detainee debriefing or counselling (Yes/No	No
Referral to support services (Yes/No)	Yes – REDAC Health and REDAC Police involved
Change passenger/detainee care (support plan) (Yes/No)	Yes – Care being cared for by REDAC Health
Notified next of kin, guardian or key support person (Yes/No)	RED ED dept advised that MH team at RED was contacting REDACTED REDA

5. Other/s involved in incident [duplicate for each other person involved]

Person's full name	
Date of birth	
Person's job title or relationship to passenger/detainee (carer, paid staff, other)	
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	
Person's full name	
Date of birth	

Person's job title or relationship to passenger/detainee (carer, paid staff, other)	
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	
Person's full name	
Date of birth	
Person's job title or relationship to passenger/detainee (carer, paid staff, other)	
Person's involvement in the incident (victim, witness, subject of abuse allegation, participant)	

6. Service provider response details

Brief summary of incident	Please see notes above
Reported to police (Yes/No)	Yes
Name of officer and date reported to police	Please see notes above as multiple police involve
Police investigation initiated (Yes/No)	Yes
Staff member stood down/removed (Yes/No)	
Manager's full name	REDACTED
Manager's job title	DHHS Team Leader – Novotel on Collins
Date incident report reviewed	
Manager telephone number	REDACTED
Manager email	REDACTED
Immediate actions taken by the organisation in response to the incident	
See above; Security and hotel notified AO Team notified and aware EOC notified	
Deputy Commander full name and signature	
Deputy Commander job title	
Date incident report approved	
Comments	

7. Incident report authorisation – EOC Command

Delegated authority full name and signature	
Delegated authority job title	
Date incident report approved	

Delegated authority phone number	
Delegated authority email address	
Comments	

8. Incident report authorisation – Deputy Secretary

Delegated authority full name and signature	
Delegated authority job title	
Date incident report endorsed	
Delegated authority phone number	
Delegated authority email address	
Comments (optional)	

9. Incident report authorisation - Secretary

Delegated authority full name	
Delegated authority job title	
Date incident report endorsed	

Operation Soteria

Op.Soteria-Minutes-2020-04-21-1330hrs

EM-COP Library Filename – { FILENAME * MERGEFORMAT }

Operation Soteria

Meeting Details

Meeting Date	21 April 2020	Start	1400hrs
Teleconference	9037 8885	End	1414hrs
Location	State Control Centre, Bogong Room		
Minutes	SRC Executive Support		

Members	Name	Members	Name
Deputy State Controller – Op Soteria (Chair)	Chris Eagle (CE)	**DOT**	-
EMC	-	**VicPol**	REDACTED
State Controller Health	-	**DPC**	REDACTED REDACTED
DHHS	Pam Williams (PW)	**DHHS Comms**	REDACTED
DHHS (Airport)	-	**AFP**	REDACTED
DJPR	Rachaele May (RM) REDACTED	**Assurance and Learning**	-

Operation Soteria

Op Soteria-Minutes-2020-04-21-1330hrs

Actions from Previous Meetings

No	Meeting Date	Action	Assigned to	Due Date
1.	18/4/2020	Soteria Comms Plan will be circulated once it has been approved.	JH	18/4/2020

Item	Subject
1.	**Situational Awareness** **Deputy State Controller - Health** • Later start today due to the National Coordination Mechanism (NCM) meeting this afternoon.
2.	**Operations** *Key issues, pressure points, dependencies and information sharing* **DHHS** • Focus will be on refining processes and working through strategic planning documents. A catalogue of documents is being collated making sure that the most up to date and right processes are included. The ADF have offered resourcing this area as they have people with expertise in this area. • Other resource requests for the EOC are being worked through and are coming together. **DJPR** • Working with DHHS on the consolidated approach particularly around people exiting with a big day forecast for Saturday. • Hoping to better understand the flights (through the repatriation tracker) that may be coming to be able to better plan for the possibility of extra hotels. **DOT** • - **VicPol** • - **AFP** • ADF to contact PW offline in regards to the late notice for an escort from the airport this morning. **DPC** • -

3.	**Planning** *Forward look at following day/s* *Update from Chris Eagle from the National Coordination Mechanism meeting* • The process for the repatriation flights with prioritisation and coordination of airlines continue but the process changing. (1) Commercial flights continue as per normal schedule (2) Government coordinated commercial flights will now be required to provide a manifest prior to departure so that the NCM can best allocate the destination for the flight based on the time of arrival and numbers of traveller to best suit the availability of capacity in each state. (3) Private charter flights will be asked to submit a manifest prior to approval for flight destination / time, as well passengers will be required to have completed medical screening before being able to travel. • NCM is meeting twice daily to discuss inbound flight scheduling. • NCM has Victoria capacity figures at 3,700. We are currently around this number of people in hotels and will likely remain at this level for the next 5-6 days. • 8 flights scheduled from India of which Victoria may be asked to receive two (CE estimate only). Currently 4 flights are in the repat tracker: ○ 270 pax – Lahore – Saturday ○ 188 pax – Buenos Aires – Sunday ○ 330 pax – Manilla – Sunday ○ 120 pax - Johannesburg - Thursday • Domestic flights are being monitored for those exiting after 14 days. • Nationally statistic show that in the last 3.5 weeks 18,000 Australians have returned, 5,500 of those have arrived in Victoria, with slightly higher number arriving in Sydney. • Australians still to return: ○ 500 – Pacific ○ 2,700 – South East Asia ○ 2,200 Middle East and Africa ○ 450 North America ○ 600 Latin America • Canberra looking to not overload any states and ensuring capacity is monitored.
4.	**Health and Wellbeing (staff and travellers)** • -
5.	**Communication** • -
6.	**Other Business** • -
7.	Next Scheduled Meeting **– 1330hrs, 23 April 2020**

Actions

No	Action	Assigned to	Due Date
1.	CE to circulate repatriation tracker data and the new dashboard data being proposed by the National Coordination Mechanism.	CE	21/4/2020

Coronavirus (COVID-19)

Healthcare worker PPE guidance –
Update 26 March 2020

Information about protecting yourself against coronavirus (COVID-19)

During the coronavirus (COVID-19) pandemic, the Victorian Department of Health and Human Services will regularly update its personal protective equipment (PPE) guidance as new evidence becomes available. This information is also available in the department's *Coronavirus disease 2019 (COVID-19) Guideline for health services and general practitioners*. To find out general information about coronavirus (COVID-19) visit the department's website at www.coronavirus.vic.gov.au

What should you do if you feel unwell?

Only go to work if you are well. Prior to going to work each day, you should consider whether or not you feel unwell and take your own temperature.

If you work in a Victorian public health service you are required to report to your manager if you have the following symptoms prior to starting work or at any time while at work:

- fever; or
- symptoms of acute respiratory infection (for example, shortness of breath, cough, sore throat, nasal congestion).

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

What PPE should be worn in Victorian public health services during routine patient care, during the COVID-19 emergency?

For the purposes of this document, 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.

All healthcare workers 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 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.

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

What PPE is recommended for routine care of a suspected or confirmed coronavirus (COVID-19) case?

Droplet and contact precautions need to be in place while you are caring for a suspected **or** confirmed coronavirus (COVID-19) case, including during initial triaging. This means:

- single-use face mask (surgical mask)
- eye protection (for example, safety glasses/goggles or face shield. Note: 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. If the gown is reusable (non-disposable), take it off and get it reprocessed.

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 coronavirus (COVID-19).

When are airborne and contact precautions required?

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.

Airborne and contact precautions are now recommended in the following circumstances:

- Where you are undertaking an aerosol generating procedure* on a suspected or confirmed case of COVID-19;
- Where you are undertaking an aerosol generating procedure and it is not possible to determine if a patient is a suspected case of COVID-19, for example, where a person is found unconscious and a history cannot be obtained;
- Where you are undertaking an aerosol generating procedure involving a high-risk procedure on a patient (regardless of COVID-19 status) involving:
  - head and neck - including ENT surgery/endoscopy;
  - neurosurgery that involves sinus surgery;
  - ophthalmology;
  - maxillofacial surgery;
  - gastroscopy, or
  - bronchoscopy.

**Examples of AGPs include:*

- *bronchoscopy*
- *tracheal intubation*
- *non-invasive ventilation (for example, BiPAP or CPAP)*
- *high flow nasal oxygen therapy*
- *manual ventilation before intubation*
- *intubation*
- *cardiopulmonary resuscitation*
- *sputum induction*
- *suctioning*
- *nebuliser use (nebulisers should be discouraged and alternative administration devices such as a spacer should be used).*

When should P2 respirators (N95) masks be discarded after use?

P2/N95 masks should be:

- **Discarded** and **replaced** if contaminated with blood or bodily fluids
- **Discarded** following the AGP
- **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 (e.g. between wards, break room, reception area) and are to be removed before proceeding to care for patients that are not isolated for coronavirus (COVID-19).

What physical distancing measures do you need to adhere to?

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.

Using your mobile phone at work

We touch our phones as much as we touch our faces. Your mobile phone 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.

Looking after yourself when wearing PPE

It is important that you look after yourself during this time of increased use of PPE. Ensure that upon removal of PPE you remember to hydrate yourself, practice hand hygiene and avoid touching your face. You should also consider regular application of hand cream and ensure you wear non-latex gloves if you need them.

How should high-risk patients be triaged and managed on arrival to hospital?

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

- presenting with acute respiratory tract infection
- presenting with fever (≥37.5 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.

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. Screening clinics can support the management of high-risk patients if they are in place at the health service. All staff at triage points and screening clinics 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 isolation 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.

Prioritising PPE for health care workers

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

Single-use face masks (surgical masks)

- Prioritise use to frontline staff (ICU, ED, coronavirus (COVID-19) wards, acute respiratory assessment clinics and theatre)
- Surgical mask supplies are to be stored in secure areas or supervised by a staff member and not accessible to patients
- Unless moist or soiled, a surgical mask can be worn for the duration of a clinic shift (3.5 hours) or for 4 hours during a nursing/midwifery/allied health shift.

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)

Where can I find out more information?

For Victorian updates to the current incident, go to: www.coronavirus.vic.gov.au

For national updates: health.gov.au/news/latest-information-about-novel-coronavirus

For international updates: who.int/westernpacific/emergencies/novel-coronavirus

WHO resources who.int/health-topics/coronavirus