Public Health and Wellbeing Act 2008

Instrument of delegation

Interpretation

In this instrument:

Act means the *Public Health and Wellbeing Act 2008*.

duties, functions and powers means the duties of the Chief Health Officer under the provisions of the Act specified in column 1 of the Schedule.

Limitations means the Limitations specified in column 4 of the Schedule.

Officer means the person occupying or acting in the positions in the Department of Health and Human Services that are specified in column 3 of the Schedule.

Schedule means the Schedule attached to this instrument.

Description

The descriptions in column 2 of the attached Schedule are for ease of reference only. They do not affect the interpretation nor limit the powers contained in each of the provisions identified in column 1 of the Schedule.

Delegation

I, **Brett Sutton**, Chief Health Officer, appointed under Section 20 of the Act and 22 of the Act:

(a) **DELEGATE** my duties and powers to the Officer specified in column 3 of the Schedule, subject to the Limitations specified in column 4 of the Schedule; and

(b) **REVOKE** the previous instrument of delegation made by the Chief Health Officer under the Act dated 19 June 2017.

Commencement

This instrument commences on the date it is signed.

Signed at Melbourne in the State of Victoria

This 8th day of November 2019

Dr Brett Sutton
Chief Health Officer
Department of Health and Human Services

VICTORIA State Government | Health and Human Services

Schedule

COLUMN 1 Provisions	COLUMN 2 Descriptions	COLUMN 3 Delegate	COLUMN 4 Limitations
Section 113(1)	Power to make an examination and testing order	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 113(3)	Power to include specified items in an order or make the order subject to any conditions	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 114(4)	Duty to revoke an examination and testing order	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 117(1)	Power to make a public health order	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 118(3)	Duty to revoke a public health order	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 118(4)	Power to vary a public health order	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 118(5)	Power to extend a public health order	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	

COLUMN 1 Provisions	COLUMN 2 Descriptions	COLUMN 3 Delegate	COLUMN 4 Limitations
Section 118(6)	Power to extend a public health order as many times as considered necessary	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 121(3)	Duty to review a public health order	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 125	Duty to facilitate reasonable request for communication	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 134(1)	Power to make an order for a test if incident has occurred	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 134(3)	Power to make an application to a Magistrates' Court for an order	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 134(5)	Power to make an order for a person who is dead	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 134(8)	Power to include any conditions on an order	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	

COLUMN 1 Provisions	COLUMN 2 Descriptions	COLUMN 3 Delegate	COLUMN 4 Limitations
Section 134(9)	Power to vary or revoke an order	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 135(2)	Power to authorise the testing of a sample of blood or urine	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 136(1)	Power to examine or require the provision of health information	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 136(4)	Power to disclose health information	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 139(1)	Power to receive test results conducted under an order or authorisation	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 139(2)	Duty to give notice of test results	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 139(4)	Duty of to give notice of positive test results	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	

COLUMN 1 Provisions	COLUMN 2 Descriptions	COLUMN 3 Delegate	COLUMN 4 Limitations
Section 141(1)	Power to give directions	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 156(1)	Power to require a registered medical practitioner to carry out an autopsy on a body	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 156(2)	Duty to comply with section 157 in relation to an autopsy	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 156(3)	Power to order that possession of a body be given to a registered medical practitioner	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 157(1)	Duty to give a notice of decision to perform an autopsy to next of kin	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 188(1)	Power to direct a person to provide information in relation to a direction to provide information	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 188(4)(a)	Duty to warn a person	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	

COLUMN 1 Provisions	COLUMN 2 Descriptions	COLUMN 3 Delegate	COLUMN 4 Limitations
Section 188(4)(b)	Duty to inform a person in relation to a direction to provide information	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 189	Power to authorise authorised officers to exercise public health risk powers	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 191(4)	Power to extend period of authorisation to exercise public health risk powers	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	
Section 229(2)	Power to authorise a person or Council to take action under public health risk powers	• Deputy Chief Health Officer (Environment) • Deputy Chief Health Officer (Communicable Disease)	Except in relation to emergency powers: • a direction or requirement under section 200; and • an improvement or prohibition notice issued in respect of a contravention to which section 203 applies.

Public Health and Wellbeing Regulations 2019

Instrument of delegation

Interpretation

In this instrument:

Act means the *Public Health and Wellbeing Act 2008*.

Chief Health Officer means the person appointed in accordance with section 20 of the Act.

duties, functions and powers means the duties, functions and powers of the Chief Health Officer under the provisions of the Regulations specified in column 1 of the Schedule.

Officers means the person(s) occupying or acting in the positions in the Department of Health and Human Services that are specified in column 3 of the Schedule.

Regulations means the Public Health and Wellbeing Regulations 2019.

Schedule means the Schedule attached to this instrument.

Description

The descriptions in column 2 of the attached Schedule are for ease of reference only. They do not affect the interpretation nor limit the powers contained in each of the provisions identified in column 1 of the Schedule.

Delegation

I, **Brett Sutton**, Chief Health Officer, acting under section 22 of the Act, **DELEGATE** my duties, functions and powers to the Officers specified in column 3 of the Schedule.

Commencement

This instrument commences on the date it is signed.

Signed at Melbourne in the State of Victoria

This 11th day of December 2019

Dr Brett Sutton
Chief Health Officer
Department of Health and Human Services

VICTORIA State Government | Health and Human Services

Schedule

COLUMN 1 Provisions	COLUMN 2 Descriptions	COLUMN 3 Description
Reg 19	Power to issue disease vector control notice	• Deputy Chief Health Officer (Communicable Disease) • Deputy Chief Health Officer (Environment)
Reg 111(2)	Power to direct the person in charge of a primary school or children's services centre to exclude an at-risk child	• Deputy Chief Health Officer (Communicable Disease) • Deputy Chief Health Officer (Environment)
Reg 111(4)	Power to direct that, for a child to whom the direction applies, attendance can be resumed	• Deputy Chief Health Officer (Communicable Disease) • Deputy Chief Health Officer (Environment)
Column 4 of item 5 of the Table in Schedule 7 of the Regulations	Power to clear a child who has come into contact with a member of their family or household infected with diphtheria to return to primary school, an education and care service premises or children's services centre	• Deputy Chief Health Officer (Communicable Disease) • Deputy Chief Health Officer (Environment)
Column 4 of item 15 of the Table in Schedule 7 of the Regulations	Power to determine whether a child who has come into contact with a person infected with influenza or an influenza like illness needs to be excluded	• Deputy Chief Health Officer (Communicable Disease) • Deputy Chief Health Officer (Environment)
Column 3 of item 16 of the Table in Schedule 7 of the Regulations	Power to approve the return to primary school, an education and care service premises or children's services centre of a child infected with leprosy	• Deputy Chief Health Officer (Communicable Disease) • Deputy Chief Health Officer (Environment)
Column 4 of item 26 of the Table in Schedule 7 of the Regulations	Power to determine whether a child who has come into contact with a person infected with Severe Acute Respiratory Syndrome (SARS) needs to be excluded	• Deputy Chief Health Officer (Communicable Disease) • Deputy Chief Health Officer (Environment)
Column 3 of item 27 of the Table in Schedule 7 of the Regulations	Power to require the exclusion of a child infected with Shiga toxin or verotoxin producing *Escherichia coli* (STEC or VTEC) and to specify the exclusion period	• Deputy Chief Health Officer (Communicable Disease) • Deputy Chief Health Officer (Environment)
Column 3 of item 30 of the Table in Schedule 7 of the Regulations	Power to approve the return to primary school, an education and care service premises or children's services centre of a child infected with typhoid fever (including paratyphoid fever)	• Deputy Chief Health Officer (Communicable Disease) • Deputy Chief Health Officer (Environment)

COLUMN 1 Provisions	COLUMN 2 Descriptions	COLUMN 3 Description
Column 4 of item 30 of the Table in Schedule 7 of the Regulations	Power to determine whether a child who has come into contact with a person infected with typhoid fever (including paratyphoid fever) needs to be excluded	• Deputy Chief Health Officer (Communicable Disease) • Deputy Chief Health Officer (Environment)

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

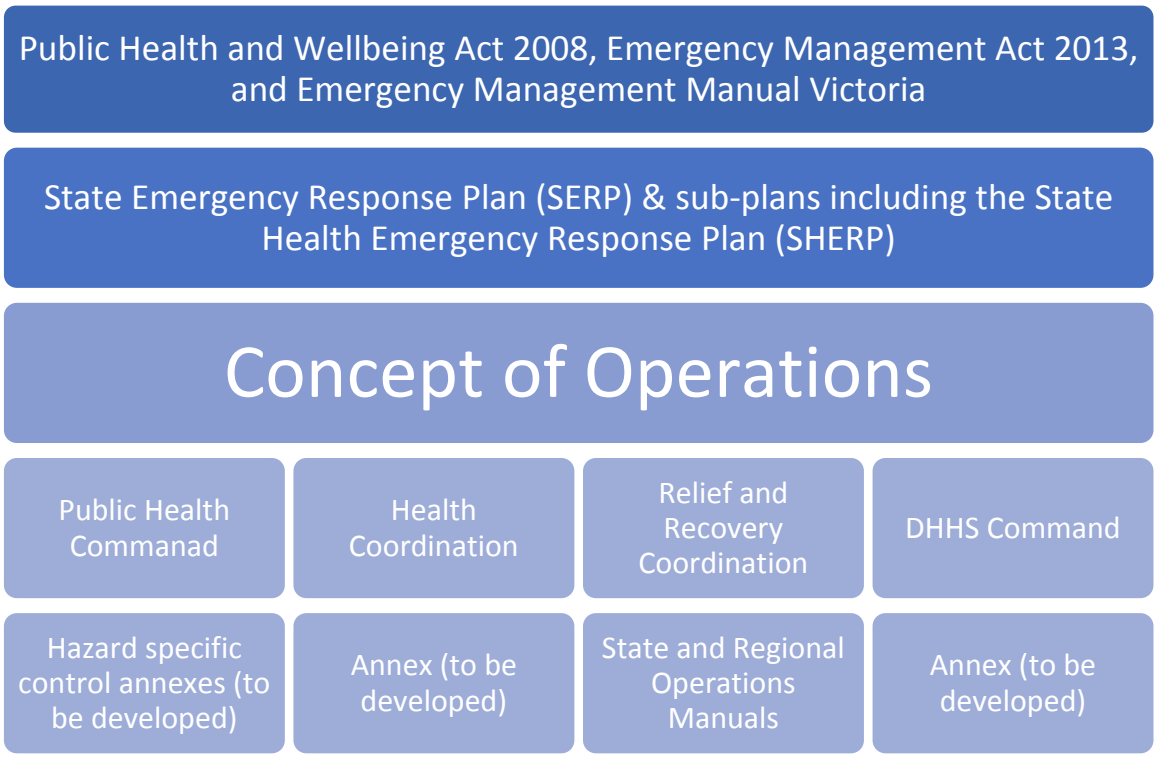
2. Purpose

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.

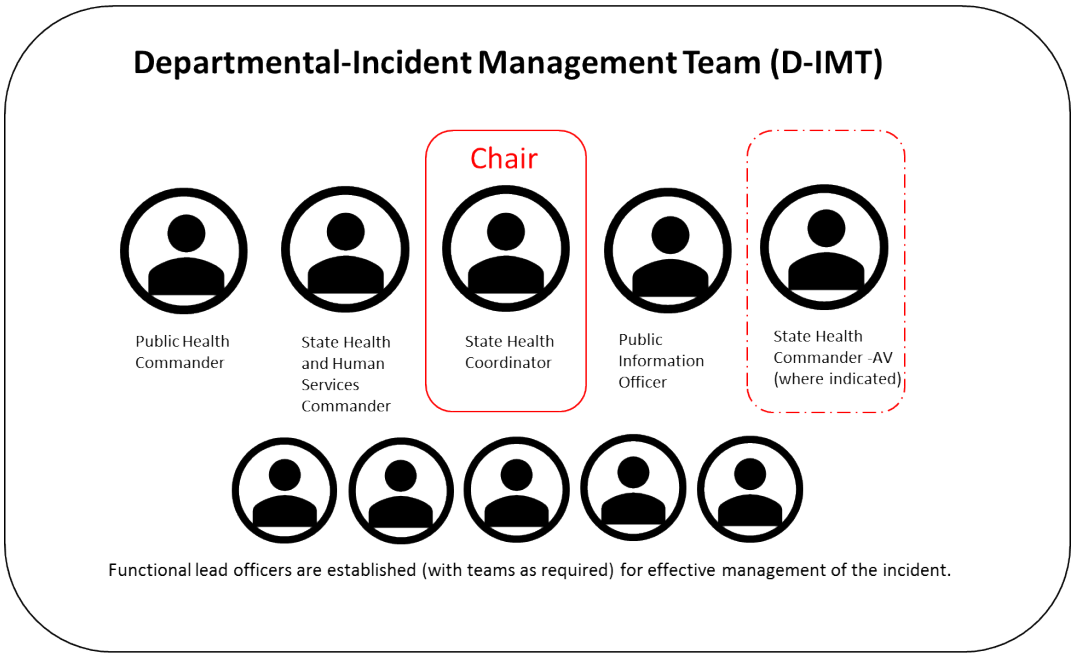
Initial actions for the D-IMT

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

Chief Health Officer

Alert – for immediate attention

Pneumonia cluster in Wuhan, China

Status:	Active
Date issued:	10 January 2020
Issued by:	Dr Brett Sutton, Chief Health Officer
Issued to:	Clinicans and patients

Key messages

- There is a cluster of cases of viral pneumonia in Wuhan, China. The cause is being reported in various media outlets as a novel coronavirus.
- The cluster is centered at the Wuhan South China Seafood City Market (also called the South China Seafood Wholesale Market and the Hua Nan Seafood Market).
- Travelers to Wuhan, China, should avoid living or dead animals, animal markets, and contact with sick people.
- Be alert for patients who have travelled to Wuhan, China, within two weeks of onset of illness and who present with fever and respiratory symptoms. Please place a surgical mask on and isolate these patients as soon as they are identified in a negative pressure room or single room and notify the Department of Health and Human Services on 1300 651 160.

What is the issue?

There is a cluster of cases of viral pneumonia in Wuhan, China. As of January 5, 2020, local, provincial, and national health commissions in China have reported a total of 59 cases with no deaths. The cluster is centered at the Wuhan South China Seafood City (also called the South China Seafood Wholesale Market and the Hua Nan Seafood Market). In addition to seafood, the market sells chickens, bats, marmots, and other wild animals. The market has been closed since January 1, 2020, for cleaning and disinfection.

Health authorities in China are monitoring more than 150 close contacts for illness. To date, there have been no reports of spread from person-to-person or to healthcare workers.

Although the cause of this cluster is unknown, there is concern and reports that the cause is a novel coronavirus. Local authorities have reported negative laboratory results for seasonal influenza, avian influenza, adenovirus, and two specific coronaviruses known to cause respiratory illness (severe acute respiratory syndrome [SARS] and Middle East respiratory syndrome [MERS]).

Who is at risk?

Only people who have travelled to Wuhan, China are considered to be at risk currently. Travelers to other areas of China, or contacts of travelers to Wuhan are not considered to be at risk. This information may change as more becomes known about the characteristics of the virus.

Symptoms and transmission

Reported symptoms include fever, shortness of breath and bilateral lung infiltrates on chest x-ray.

The current definition for a suspected case in Victoria is as follows:

Travel to Wuhan within 14 days of symptom onset AND fever or history of fever AND respiratory symptoms

This case definition information may change as further information emerges.

There have been no reports of spread from person-to-person or to healthcare workers.

Recommendations

Clinicians are asked to be alert for patients of any age presenting with symptoms of pneumonia who meet the suspected case definition above, particularly if they have had contact with the Wuhan South China Seafood City Market. Please ensure that patients presenting with pneumonia to triage are being asked about travel specific to Wuhan, China.

If you have a patient who meets the suspected case definition above:

- Place a surgical mask on the patient;
- Undertake an assessment in a private room with the door closed if negative pressure ventilation is not available;
- Apply airborne, contact and standard precautions - in particular, wear a P2 respirator / N95 respirator during any assessment;
- Notify the Department of Health and Human Services immediately on 1300 651 160, who will assist with conducting a public health risk assessment and short epidemiological questionnaire for suspected cases;
- Undertake testing in your hospital for alternative causes as soon as possible, in particular for respiratory viruses using multiplex PCR if available;
- After discussion with the Department, you may be advised to take;
  - upper respiratory samples (combined nose and throat swabs, or nasopharyngeal swabs)
  - lower respiratory samples lower respiratory tract sample if the lower tract is involved (bronchoalveolar lavage, tracheal aspirate, pleural fluid, sputum)
  - whole blood
- These samples are to be forward for coronavirus testing at the Victorian Infectious Diseases Reference Laboratory.

If you traveled to Wuhan and feel sick, you should:

- Avoid contact with others, except for seeking medical care
- Don’t travel while sick.
- Seek medical care right away. Before you go to a doctor’s office or emergency department, call ahead and tell the doctor about your recent travel and your symptoms.
- Cover your mouth and nose with a tissue or your sleeve (not your hands) when coughing or sneezing.

Travelers to Wuhan, China, should avoid living or dead animals, animal markets and contact with sick people, and should wash hands often with soap and water.

More information

Clinical information

https://www.who.int/china/news/detail/09-01-2020-who-statement-regarding-cluster-of-pneumonia-cases-in-wuhan-china

Consumer information

https://wwwnc.cdc.gov/travel/notices/watch/pneumonia-china

Contacts

For more information please contact the Communicable Disease Prevention and Control section at the Department of Health and Human Services on 1300 651 160 (24 hours).

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Chief Health Officer

Alert – for immediate attention

2019 Novel Coronavirus (2019-nCoV)

Status:	Active
Date issued:	29 January 2020 (Update to 24 January 2020)
Issued by:	Dr Brett Sutton, Chief Health Officer
Issued to:	Clinicans and patients

Key messages

- A novel coronavirus (2019-nCoV) outbreak has been identified, focused on Hubei Province in mainland China. Please see the departmental website for regular updates: https://www.dhhs.vic.gov.au/novelcoronavirus
- The department is now advising all people who have visited Hubei province in mainland China to stay at home and avoid public settings until 14 days after leaving Hubei Province. Anyone who has been in close contact with a confirmed case of 2019-nCoV should also stay at home and avoid public settings until 14 days after their last contact.
- The department was has now confirmed two cases of novel coronavirus in Victoria, including one man in his 50s notified on 25 January and a second case in a man in his 60s confirmed on 28 January.
- The second confirmed case attended a restaurant dinner at the House of Delight restaurant in Glen Waverley between 1730 and 1900 on 26 January 2020. Anyone who was at the restaurant at that time should contact the department on 1300 651 160. There are no other locations of concern.
- The department has updated guidelines to health services and general practitioners, with modifications to the case definition and exclusions recommendations. These are now available at: https://www.dhhs.vic.gov.au/information-health-services-novel-coronavirus
- Be alert for patients who have travelled to Hubei province, mainland China within 14 days of onset of illness and who present with fever and respiratory symptoms.
- Please ensure a surgical mask is placed on the patient as soon as they are identified and place them in a negative pressure room or single room. Notify the Department of Health and Human Services on 1300 651 160.
- Routinely ask a travel history in patients with respiratory symptoms. See below for a detailed case definition to inform testing.
- The Department of Foreign Affairs and Trade have updated a Smartraveller travel advisory for Hubei province to level 4 – ‘do not travel’ and for China overall to level 3 – ‘reconsider your need to travel’.
- A public information hotline is serviced by Nurse-on-Call – 1800 675 398.

What is the issue?

A novel coronavirus (2019-nCoV) outbreak has been identified associated with Wuhan City, Hubei Province, China. As of 29 January 2020, health authorities in China have reported more than 5000 cases and over 100 deaths.

Confirmed cases have been identified in mainland China, as well as Hong Kong, Macau, Taiwan, Thailand, Japan, Malaysia, South Korea, Vietnam, Cambodia, Sri Lanka, Singapore, Nepal, France, USA and Canada.

Most confirmed cases have a history of travel to Hubei province or have links to the province. There is some evidence of human-to-human transmission outside of Wuhan.

The 2019 novel coronavirus (2019-nCoV) identified in this outbreak has not previously been identified in people. Coronaviruses are a large and diverse family of viruses that include viruses that are known to cause illness of variable severity in humans, including the common cold, severe acute respiratory syndrome (SARS-CoV) and Middle East Respiratory Syndrome (MERS-CoV). They are also found in animals such as camels and bats.

Victoria's Department of Health and Human Services confirmed the first Australian case of the 2019 novel coronavirus on 25 January 2020. A second case was confirmed on 28 January 2020.The man, in his 60s, visited Wuhan, China in the days before his illness onset. He has been reviewed in hospital and is isolated at home.

Novel coronavirus 2019 is now a notifiable condition under the Public Health and Wellbeing Regulations 2019 and is required to be notified by medical practitioners and pathology services as soon as practicable

Who is at risk?

The situation is evolving rapidly as we find out more about this new virus.

Anyone who has travelled to Hubei Province, mainland China or is a close or casual contact of a confirmed case of the novel coronavirus (2019-nCoV) is at risk. See below and the website for a full case definition.

Anyone unwell person who presents with a letter, email or other correspondence from a state or territory public health or communicable disease unit informing them they are a contact should be treated as a suspected case.

Anyone who attended the House of Delight restaurant in Glen Waverley between 1730 and 1900 on 26 January 2020 should contact the department on 1300 651 160.

Symptoms and transmission

Reported symptoms include fever and respiratory symptoms such as cough, shortness of breath and breathing difficulties. Sore throat and headache have also been reported. Recent information on the transmission of the virus suggests that cases may be infectious up to 48 hours before the onset of symptoms.

The following case definitions are now in place in Victoria:

Confirmed case

A person tested for 2019-nCoV at the Victorian Infectious Diseases Reference Laboratory and found to have 2019-nCoV infection.

Suspected case

Both clinical **and** epidemiological criteria need to be met for a person to be classified as a suspected case.

Clinical criteria:

Acute respiratory infection (shortness of breath or cough or sore throat) with or without fever

AND

Epidemiological criteria:

A history of being in Hubei province, China, including Wuhan City, in the 14 days prior to symptom onset

OR

Close contact within 14 days of symptom onset with any of the following:

- *a confirmed or suspected case of 2019-nCoV;*
- *a healthcare facility in mainland China, Hong Kong or Macau (where limited hospital-associated infections have been reported).*

Note: a patient with severe acute respiratory infection (SARI) and a history of travel to any part of China in the 14 days prior to symptom onset, after discussion with the department, may be classified as a suspected case and

tested for novel coronavirus. As per the World Health Organization definition SARI is an illness with fever AND cough AND admission to hospital. A casual contact with compatible symptoms, after discussion with the department, may be classified as a suspected case and tested for novel coronavirus.

Recommendations

Advice for clinicians

Clinicians are asked to be alert for patients of any age presenting with respiratory symptoms who meet the suspected case definition above. Please ensure that patients presenting with compatible symptoms, especially pneumonia, are asked about travel specific to Hubei province, China.

If you have a patient who meets the suspected case definition above:

- Place a surgical mask on the patient;
- Undertake an assessment in a private room with the door closed if negative pressure ventilation is not available;
- Apply droplet and contact precautions (single-use face mask, eye protection, gown and gloves). If available, Airborne Precautions can be applied as well by wearing a P2 respirator (N95 mask) instead of a single use face mask during any assessment;
- Notify the Department of Health and Human Services immediately on 1300 651 160, who will assist with conducting a public health risk assessment and short epidemiological questionnaire for suspected cases;
- Undertake testing in your hospital or with your primary pathology service for alternative causes as soon as possible, in particular for respiratory viruses using a multiplex PCR if available;
- After discussion with the Department, you may be advised to take:
  - Respiratory specimens – combined nasopharyngeal and throat swabs in ambulatory patients and sputum (if produced) and/or endotracheal aspirate or bronchoalveolar lavage
  - Blood (serum) - these samples are to be sent for novel coronavirus testing at the Victorian Infectious Diseases Reference Laboratory.

Advice for travellers

The department has updated its recommendations and is now advising all people who have visited Hubei province in China to stay at home and avoid public settings until 14 days after they left Hubei. Likewise, anyone who has been in close contact with a confirmed case of 2019-nCoV should also stay at home and avoid public settings until 14 days after their last contact. In line with this updated advice, students and teachers who have travelled to Hubei Province in China should not attend school or university until 14 days after leaving Hubei.

Students and teachers who have travelled to other parts of China are **not** required to stay away from school or university unless the following applies:

- The person is a confirmed case of novel coronavirus, or
- The person is a close contact with a confirmed case of novel coronavirus in past 14 days.

If you traveled to Hubei province and feel sick, you should:

- Avoid contact with others, except for seeking medical care.
- Don’t travel while sick.
- Seek medical care right away. Before you go to a doctor’s office or emergency department, call ahead and tell the doctor about your recent travel and your symptoms.
- Cover your mouth and nose with a tissue or your sleeve (not your hands) when coughing or sneezing.

More information

Clinical information

https://www.dhhs.vic.gov.au/information-health-services-novel-coronavirus

https://www.who.int/china/news/detail/09-01-2020-who-statement-regarding-cluster-of-pneumonia-cases-in-wuhan-china

Consumer information

https://www.dhhs.vic.gov.au/information-public-novel-coronavirus

https://www.who.int/health-topics/coronavirus

https://www.smartraveller.gov.au/destinations/asia/china

Contacts

For more information please contact the Communicable Disease Prevention and Control section at the Department of Health and Human Services on 1300 651 160 (24 hours).

A public information hotline is serviced by Nurse-on-Call – 1800 675 398.

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Public Health and Wellbeing Act 2008

Instrument of authorisation under section 199

Interpretation

In this instrument:

Act means the *Public Health and Wellbeing Act 2008*.

Authorisation

I, **Adjunct Clinical Professor Brett Sutton**, **Chief Health Officer of Department of Health and Human Services** authorise Dr Annaliese van Diemen, Deputy Chief Health Officer (Communicable Disease), an authorised officer appointed by the Secretary to the Department of Health and Human Services, to exercise any of the public risk powers and emergency powers under the Act.

I believe it is necessary to grant the authorisation to eliminate or reduce a serious risk to public health.

That serious risk to public health exists arises from Novel Coronavirus 2019 (2019-nCov), and exists throughout the State of Victoria.

This authorisation is given under section 199 in Part 10, Division 3 of the Act.

There are no restrictions or limitations of the public health risk powers or emergency powers that may be exercised under the authorisation.

Commencement

This instrument commences on 17 March 2020 and continues in force until 13 April 2020.

Signed at Melbourne in the State of Victoria

This 17th day of March 2020

Time: 9.47 pm

Adjunct Clinical Professor Brett Sutton
Chief Health Officer
Department of Health and Human Services

Request for assistance from Chief Health Officer to Chief Commissioner of Police under s 202 of the *Public Health and Wellbeing Act 2008*

Pursuant to section 202(2) of the Public Health and Wellbeing Act 2008 (Act), I, Brett Sutton, Chief Health Officer, request of the Chief Commissioner of Police that police officers provide assistance to authorised officers exercising a power under section 199 of the Act to enforce compliance with the directions made under section 200 of the Act dated 16 March 2020.

Signed at Melbourne in the State of Victoria
This 16th day of March 2020

Adjunct Clinical Professor Brett Sutton
Chief Health Officer
Department of Health and Human Services

Public Health and Wellbeing Act 2008

Request for assistance from Chief Health Officer to Chief Commissioner of Police

Interpretation:

Act means the *Public Health and Wellbeing Act 2008*.

Chief Health Officer means the person appointed as Chief Health Officer under section 20 of the Act.

emergency powers means the powers set out in section 200 of the Act.

public health risk powers means the powers set out in section 190 of the Act.

serious risk to public health has the meaning set out in section 3 of the Act.

state of emergency means a state of emergency declared under section 198 of the Act.

A state of emergency was declared in Victoria on 16 March 2020.

Pursuant to section 202(2) of the Act, I, **Adjunct Clinical Professor Brett Sutton**, **Chief Health Officer of Department of Health and Human Services,** request of the Chief Commissioner of Police that police officers provide assistance to authorised officers exercising public health risk powers and emergency powers for the purpose of eliminating or reducing the serious risk to public health during the state of emergency, including all reasonable steps to enforce compliance with directions made under section 200 of the Act. This request includes, but is not limited to, any actions that police officers need to take to monitor compliance with the directions, investigate and respond to alleged breaches of the directions and, where it is determined that persons have failed to comply with the directions without lawful excuse, take any necessary enforcement action, by taking steps to compel compliance and or by issuing of fines or charging people for breaching s203 of the Act or any other steps lawfully available to them.

Signed at **Melbourne** in the **State of Victoria**

This 29th day of March 2020

Time: 7pm

Adjunct Clinical Professor Brett Sutton
Chief Health Officer
Department of Health and Human Services

Direction from Chief Health Officer in accordance with emergency powers arising from declared state of emergency

Public Health and Wellbeing Act 2008 (Vic)
Section 200

I, Brett Sutton, Chief Health Officer, consider it reasonably necessary to protect public health to give the following directions pursuant to ss 200(1)(b) and (d) of the *Public Health and Wellbeing Act 2008* (Vic):

PART 1 — NON-ESSENTIAL MASS GATHERINGS

The purpose of this Part is to prohibit non-essential mass gatherings.

Directions

1. A person who owns, controls or operates **premises** in the State of Victoria must not allow a **mass gathering** to occur on the premises between noon on 16 March 2020 and midnight on 13 April 2020.
2. A person must not organise a mass gathering on premises in the State of Victoria between noon on 16 March 2020 and midnight on 13 April 2020.
3. A person must not attend a mass gathering on premises in the State of Victoria between noon on 16 March 2020 and midnight on 13 April 2020.

Definitions

For the purposes of the directions in paragraphs 1,2 and 3:

4. **Premises** has the same meaning as in s 3 of the *Public Health and Wellbeing Act 2008* (Vic).
5. A **mass gathering** is any gathering of five hundred (500) or more persons in a single undivided space at the same time, whether in an indoor or outdoor space, but does **not** include a gathering:
    a. at an airport that is necessary for the normal business of the airport;
    b. for the purposes of or related to public transportation, including in vehicles or at public transportation facilities such as stations, platforms and stops;
    c. at a medical or health service facility that is necessary for the normal business of the facilities;
    d. for the purposes of emergency services;
    e. at a disability or aged care facility that is necessary for the normal business of the facility;
    f. at a prison, correctional facility, youth justice centre or other place of custody;
    g. at a court or tribunal;
    h. at Parliament for the purpose of its normal operations;
    i. at a food market, supermarket, grocery store, retail store, shopping centre that is necessary for the normal business of those premises;
    j. at an office building, factory or construction site that is necessary for the normal operation of those premises;

k. at a school, university, educational institution or childcare facility that is necessary for the normal business of the facility;

l. at a hotel or motel that is necessary for the normal operation of accommodation services;

m. at a place where five hundred (500) or more persons may be present for the purposes of transiting through the place; or

Example: Federation Square or Bourke Street Mall.

n. specified as exempt from this direction by the Chief Health Officer in writing or delivered by an operator who has a social distancing policy approved in writing by the Chief Health Officer.

6. For the purposes of paragraph 5(k), a school event that involves members of the community in addition to staff and students is deemed not necessary for the normal business of the facility.

Note: The intended effect of paragraph 6 is that a school event that involves members of the community in addition to staff and students will be a mass gathering if it involves a gathering of five hundred (500) or more persons in a single undivided space at the same time. School events include assemblies, sporting events or parent-teacher events.

Note: the exclusions identified in paragraph 5 will be reviewed on a day to day basis and further directions are expected to be issued to remove some of the current exclusions.

PART 2 — SELF-QUARANTINE FOLLOWING OVERSEAS TRAVEL

Direction

7. Except in those circumstances identified in paragraph 8 below, a person who arrives at an airport in Victoria on a flight that originated from a place outside Australia, or on a connecting flight from a flight that originated from a place outside Australia:

a. must travel from the airport to a premises that is suitable for the person to reside in for a period of 14 days;

b. except in exceptional circumstances, must reside in that premises for the period beginning on the day of arrival and ending at midnight on the fourteenth (14^{th}) day after arrival;

c. must not leave the premises, except:

i. for the purposes of obtaining medical care or medical supplies;

ii. in any other emergency situation;

iii. in circumstances where it is possible to avoid close contact with other persons; and

d. must not permit any other person to enter the premises unless that other person usually lives at the premises, or the other person is also complying with this direction for the same 14 day period, or for medical or emergency purposes.

8. A person is not required to comply with the direction in paragraph 7 if the person is:

a. a member of the flight crew;

b. a citizen or permanent resident of a Pacific Island; or

c. a person intending to live indefinitely on a Pacific Island and who is travelling through an airport in Victoria in transit to the Pacific Island.

PENALTIES

Section 203 of the *Public Health and Wellbeing Act 2008* (Vic) provides:

Compliance with direction or other requirement

(1) A person must not refuse or fail to comply with a direction given to the person, or a requirement made of the person, in the exercise of a power under an authorisation given under section 199.

Penalty: In the case of a natural person, 120 penalty units.

In the case of a body corporate, 600 penalty units.

(2) A person is not guilty of an offence against subsection (1) if the person had a reasonable excuse for refusing or failing to comply with the direction or requirement.

.....

Brett Sutton
Chief Health Officer

16 / 3 /2020

Direction from Deputy Chief Health Officer (Communicable Disease) in accordance with emergency powers arising from declared state of emergency

Airport arrivals

Public Health and Wellbeing Act 2008 (Vic)
Section 200

I, Dr Annaliese van Diemen, Deputy Chief Health Officer (Communicable Disease), consider it reasonably necessary to protect public health to give the following directions pursuant to ss 200(1)(b) and (d) of the *Public Health and Wellbeing Act 2008* (Vic):

Preamble

1. This direction replaces Part 2 of the "Direction from Chief Health Officer in accordance with emergency powers arising from declared state of emergency" made on 16 March 2020 pursuant to ss 200(1)(b) and (d) of the *Public Health and Wellbeing Act 2008* (Vic).
2. The purpose of this direction is to make provision for the self-quarantine of persons arriving in Victoria on a flight from a place outside Australia in order to limit the spread of Novel Coronavirus 2019 (2019-nCoV).

Citation

3. This direction may be referred to as the **Airport Arrivals Direction**.

Direction

4. Subject to paragraph 5, a person who arrives between 5pm on 18 March 2020 and midnight on 13 April 2020 at an airport in Victoria on a flight that originated from a place outside Australia, or on a connecting flight from a flight that originated from a place outside Australia:
   a. must travel from the airport to a premises that is suitable for the person to reside in for a period of 14 days;
   b. except in exceptional circumstances, must reside in that premises for the period beginning on the day of arrival and ending at midnight on the fourteenth (14^{th}) day after arrival;
   c. must not leave the premises, except:
      i. for the purposes of obtaining medical care or medical supplies;
      ii. in any other emergency situation;
      iii. in circumstances where it is possible to avoid close contact with other persons; and
   d. must not permit any other person to enter the premises unless that other person usually lives at the premises, or the other person is also complying with this direction for the same 14 day period, or for medical or emergency purposes.
5. A person is not required to comply with the direction in paragraph 4 if the person is:
   a. a member of the flight crew;
   b. a citizen or permanent resident of a Pacific Island, or a person intending to live

indefinitely on a Pacific Island, who is travelling through an airport in Victoria in transit to the Pacific Island.

PENALTIES

Section 203 of the *Public Health and Wellbeing Act 2008* (Vic) provides:

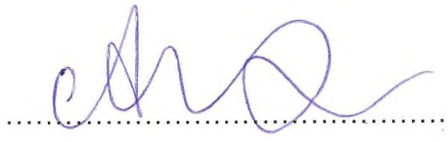
Compliance with direction or other requirement

(1) A person must not refuse or fail to comply with a direction given to the person, or a requirement made of the person, in the exercise of a power under an authorisation given under section 199.

Penalty: In the case of a natural person, 120 penalty units.

In the case of a body corporate, 600 penalty units.

(2) A person is not guilty of an offence against subsection (1) if the person had a reasonable excuse for refusing or failing to comply with the direction or requirement.



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Dr Annaliese van Diemen

Deputy Chief Health Officer (Communicable Disease), as authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the *Public Health and Wellbeing Act 2008* (Vic).

18 March 2020

DIRECTION AND DETENTION NOTICE

Public Health and Wellbeing Act 2008 (Vic)

Section 200

1 Reason for this Notice

(1) You have arrived in Victoria from overseas, on or after midnight on 28 March 2020.

(2) 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.

(3) 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.

(4) 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.

(5) 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.

(6) 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.

(7) 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.

2 Place and time of detention

(1) You will be detained at:

Hotel: _____ *(to be completed at place of arrival)*

Room No: _____ *(to be completed on arrival at hotel)*

(2) You will be detained until: _____ on ____of _____2020.

3 Directions — transport to hotel

(1) 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.

(2) 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.

4 Conditions of your detention

(1) **You must not leave the room in any circumstances**, unless:

(a) you have been granted permission to do so:

(i) for the purposes of attending a medical facility to receive medical care; or

(ii) where it is reasonably necessary for your physical or mental health; or

(iii) on compassionate grounds; or

(b) there is an emergency situation.

(2) **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).

(3) Except for authorised people, the only other people allowed in your room are people who are being detained in the same room as you.

(4) 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.

(5) 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.

5 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.

6 Offence and penalty

(1) 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.

(2) The current penalty for an individual is $19,826.40.

Name of Authorised Officer: Dr Annaliese van Diemen

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

Incident Action Plan

Novel Coronavirus 2019/20

Incident name	2019-nCoV public health incident
Plan number	1
Date	2 February 2020
Approved by	REDACTED

Priorities (2 February 2020)

As of 1700 on 1 February 2020,

- Victoria has 4 confirmed cases and 12 suspected cases who are currently being tested. Australia has 9 confirmed cases.
- Globally there have been 11,374 cases and 259 deaths.
- 7153 cases have been reported from Hubei province and 4068 cases in 32 other provinces of China.
- On 1 February, the case definition was expanded to declare all of mainland China as an at-risk area. Travel warnings have been raised to level 4 (do not travel) and restrictions have been placed on travel from mainland China to Australia.

An Incident Management Team (IMT) meeting was held at 1000 on 2 February. The action list can be seen in Appendix B. The full action list can be seen at TRIM reference: HHSD/20/40246

The IMT structure is as follows. See appendix A for a diagrammatic representation and other positions not listed below.

Position	Name	Email	Mobile
Incident controller	REDACTED	REDACTED	REDACTED
Deputy IC	Finn Romanes	REDACTED	
Operations	REDACTED	REDACTED	
Intelligence	REDACTED	REDACTED	
Planning	REDACTED	REDACTED	
Logistics	REDACTED	REDACTED	
Public information	REDACTED	REDACTED	
Media	REDACTED	REDACTED	

Other relevant positions

- Chief Health Officer: Brett Sutton - REDACTED
- Deputy Chief Health Officer (Communicable Diseases) REDACTED

Governance

The department is actively contributing to a nationally integrated and coordinated response to the outbreak via existing legal frameworks (including the *Biosecurity Act 2015*) and governance structures including Australian Health Protection Principal Committee (AHPPC), Communicable Diseases Network of Australia (CDNA). A DHHS Health Protection Incident Management Team is in place to coordinate the public health response. Integration with emergency management arrangements is being worked through to capitalise on broader functions and arrangements which may support the response

Mission: To contain the 2019-nCoV infection and respond to and minimise the impact of the virus on the health and well-being of Victorians.

Objectives	Strategies	Responsibility
To establish an Incident Management Team structure and governance arrangements which can be scaled and varied so as proportionate to the consequences and needs of the incident at any time.	1. Utilisation of existing systems plans and arrangements where relevant including application of AIIMS, the State Health Emergency Response Plan, Emergency Response Plan for Communicable Disease Incidents of National Significance: National Arrangements May 2018, giving consideration to the application of the Australian Health Management Plan for Pandemic Influenza. 2. Consistent focus on resourcing to increase capacity of the incident management team – access to surge staff and considering additional roles and functions which may be required at any stage, including regular consideration to escalation under the State Health Emergency Response Plan if required. 3. Effective use of emergency management liaison, and other program areas to support activity and communications required for effective response.	Incident Controller Chief Health Officer Deputy Secretary, RHPEM
Case and contact management (Rapid identification, testing and isolation of cases to reduce transmission to household and community contacts).	1. Rapid identification of cases requiring testing, and efficient approval for testing of cases 2. Contact tracing and monitoring for confirmed cases. 3. Coordinated and timely flow of information between the department and VIDRL; VIDRL participation in Incident Management Team meetings, and regular sharing of information including the provision of lists of samples being tested by VIDRL and immediate contact with department when results are available. 4. Support VIDRL to increase testing (surge) capacity, and ongoing consideration to other potential approaches to testing/case identification.	Operations
Clinical and epidemiological characterisation of cases, to inform case definition, clinical guidance, incident management, treatment and public advice.	1. Clinical and epidemiological analysis, including the provision of up-to-date line lists, epidemic curves and other analysis to support case definition, risk identification and projections.	Intelligence
Working with other jurisdictions to support national and international coordination and consistency in response.	1. Participation in regular AHPPC meetings (CHO). 2. Participation in daily (or more frequent if appropriate) CDNA meetings - Deputy CHO (Communicable Disease).	CHO Deputy CHO (Communicable Disease)/ Incident controller

Timely, accurate and appropriate information about the incident to key government and department stakeholders.	1. The provision of daily updates to ministers offices & departmental executive through situation reports. 2. Updates to ministers' offices and key departmental executive when a new case is confirmed, or where new intelligence/updates of significance. 3. Stakeholder mapping to be undertaken.	Incident Controller Planning
Ensure the health service capability for response and minimising risk of transmission in healthcare environments.	1. Regular engagement with Ambulance Victoria to ensure effective pre-hospital capability. 2. Provision of support and guidance to medical practitioners via the Communicable Disease 1800 phone line 3. Development and release of a Health Care Guide for health services and other education materials 4. Regularly communicate updates and identify any emerging risks relating to health services (operational and clinical services). 5. Mapping of current health sector capacity and potential need, specific to treatment of 2019 n-CoV (particularly specialist equipment, services & consumables). Planning to increase capacity for response if required. 6. Engagement of Health Sector Resilience Network to support preparedness and contribute to the sustainability of services. 7. Distribution of p2 face masks to general practitioners (via Primary Health Networks) and health services.	Incident Controller Planning Public Information Logistics
Supporting the health, safety and wellbeing of Incident Management team and staff responding to the incident.	1. Development of updated guidance for call takers – to deal with difficult (including highly emotive callers) 2. Consideration to staff sessions for call takers - introduction to psychological first aid. 3. Increasing ease of access to Employee Assistance Program & collateral. 4. Regular IMT briefings and debriefings with staff.	Incident Controller (with support of EMB) 5. All IMT functional unit leads.
Provision of clear, accurate and timely public information to the Victorian community	1. Development of Incident/Strategic Communications Plan 2. Activation of a public hotline (1800 675 398) operated through Nurse-on-call for queries from the community in relation to 2019-nCoV – 24/7 operations. Analysis of incoming calls to inform IMT actions and FAQs. 3. Daily (updated more frequently as required) key messages, distributed through the Emergency Management Joint Public Information Committee. 4. Regular Chief Health Officer Alerts & media conferences. 5. Activity to ensure all materials and products CALD friendly, ensure access to translators for incoming calls & media. 6. Activation of web page on DHHS website dedicated to 2019-nCoV 7. Ongoing social media monitoring	Public Information Officer
Ensure any risks and consequences for the department's clients and services are rapidly identified and effective strategies are implemented for preparedness and response.	1. Regular distribution of advice and updates through department program areas. 2. Ensure process is in place for early identification of any cases or contact tracing – i.e. cases or contacts who are departmental clients or attached to departmental services.	Incident Controller Operations

Strategic risk and consequence planning for a public health emergency, should it be realised.	1. Develop draft state risk and consequence plan to identify and allow for planning and preparedness for escalation of the incident to a public health emergency. Consideration to including broader impacts for the community, such as psychosocial & economic issues, business continuity, resourcing and supply chain impacts.	Planning

Administration

Individuals are responsible for logging activity and tracking their additional hours worked.

Documents will be stored in subfolders under WORK/19/136 in TRIM.

Daily IMT meetings will be conducted at 1000hrs.
A daily Situation Report will be distributed at 1600hrs.
A daily Incident Action Plan will be distributed at 1100hrs (1 hour after the IMT)

Safety

The health, safety and wellbeing of all staff involved is to be managed throughout the duration of the incident through employing the following strategies.

- Rosters are used effectively to manage staff fatigue
- Staff being encouraged to take regular breaks
- Surge staff engaged where possible, for roles based on their prior training and experience
- Critical Incident debriefing the identification of an issue which has, or is likely to have a significant impact on staff

Ready access to Employee Assistance Program services for staff.

Risk assessment

The situation report as of 1600 on 1 February 2020 is attached in Appendix A. Situation reports are being updated daily.

At this time, the risk assessment is focused on the level of risk in geographic areas and the associated policy implication.

As of 1 February 2020,

- Any person returning from mainland China (i.e. not including Hong Kong, Macau or Taiwan) is considered at **high** risk.
    - The risk classification for mainland China was raised on 1 February based on increased case incidence and evidence of ongoing transmission in Chinese provinces outside of Hubei (see Appendix C for detailed explanation).
- There is no other declared area of geographic risk. Any person returning from other parts of Asia or the rest of the world are considered to be at **low** risk UNLESS they have been in contact with a known or suspected case of 2019-n-CoV.
- Any person who has been in close contact with a confirmed case of 2019-nCoV is considered to be at **high** risk.

Based on these risk assessments, the departments current advice is that

- Returned travellers who have been in mainland China are being advised to self-isolate in their home and avoid public settings until after 14 days after leaving Hubei Province, other than when seeking individual medical care.
- Anyone who has been in close contact with a confirmed case of 2019 n-CoV should also stay at home and avoid public settings until 14 days after their last contact.

Risk classifications have further implications for the management of suspected cases, contacts. These will be outlined in the 'Risk Management' section.

As of 29 January 2020, 2019-nCoV became a notifiable condition under the *Public Health and Wellbeing Regulations 2019* and is required to be notified by medical practitioners and pathology services as soon as practicable.

The following case definitions are in place as of 1 February 2020

1. Confirmed case

A person tested for 2019-nCoV at the Victorian Infectious Diseases Reference Laboratory and found to have 2019-nCoV infection.

2. Suspected case

Both clinical and epidemiological criteria need to be met for a person to be classified as a suspected case.

Clinical criteria:
acute respiratory infection (shortness of breath or cough or sore throat) with/without fever
AND
Epidemiological criteria:
A history of being in mainland China or having close contact with a confirmed case of 2019-nCoV in the 14 days prior to symptom onset.*

Notes:
**Mainland China excludes Hong Kong, Macau and Taiwan.*
A casual contact with compatible symptoms, after discussion with the department, may be classified as a suspected case and tested for novel coronavirus.

Risk management

The following principles of risk management are based on the latest evidence. Approach will evolve as new evidence emerges. The internal protocol for 2019-nCoV is available here.

Case management

- Cases are defined as above. The current estimated incubation period is 14 days and the infectious period is from 48 hours prior to symptom onset to 24 hours after symptoms resolve.
- The clinical management of cases is the responsibility of the treating clinician. Patient management is largely supportive and there is no specific chemoprophylaxis available for cases. Guidance for health professionals is available here.
- Where transfer is required by Ambulance Victoria, the department must inform treating clinicians that the department will organise transfer. The department is to call the State Health Commander on REDACTED and provide relevant information.
- Patients should be isolated, whether at home or in hospitals until at least 24 hours after symptoms resolve.

Laboratory management

- The Victorian Infectious Diseases Reference Laboratory (VIDRL) will undertake testing for 2019-nCoV in Victorian patients.
- The department has determined that no testing should be requested of VIDRL without prior notification to the department and unless there is approval for testing.
- The department will request that clinicians take
    - Respiratory specimens for coronavirus PCR/2019-nCoV PCR – nasopharyngeal and throat swab in ambulatory patients and sputum (if produced) and/or endotracheal aspirate or bronchoalveolar lavage AND
    - Blood (serum) for storage for serology at a later date.

Contact management

- Contacts may be classified as 'Close' or 'Casual'.
- Close contacts are required to self-isolate during the 14 days after the last unprotected contact with a potentially infectious case. Any close contact who develops symptoms consistent with nCoV will be managed as a 'Suspected' case.
- Casual contacts can attend public settings but should self-monitor for illness for 14 days after the last unprotected contact with the infectious case. Casual contacts who develop consistent symptoms will be assessed on a case-by-case basis to determine the need for testing.

Infection prevention and control

- The department recommends droplet and contact precautions for healthcare workers assessing suspected cases and confirmed cases of 2019-nCoV infection. If available, airborne precautions can

also be used.
- This advice extends to family members, visitors, other health care workers and any other individuals in contact with the suspected or confirmed case.
- The department, through Primary Health Networks, has distributed P2 face masks to general practitioners

Risk communication

A series of materials have been made available for health professionals, members of the public and other stakeholders. These can be found here.

The latest Chief Health Officer alert from 31 January 2020 is here.

The following numbers are active, central phone numbers
- Members of the public with concerns can contact DHHS on 1800 675 398
- Health professionals can contact DHHS on 1300 651 160
- A number will be disseminated for health service executives to liaise with DHHS on non-clinical, operational matters

Attachments

A. Situation report
B. Action list
C. Log of significant policy changes
D. Incident Management Team members
E. Communication lists

FOR OFFICIAL USE ONLY

Incident name	Novel coronavirus (2019-nCoV) 2019 - China				
Situation report number	8	Incident level	Public Health Incident	Date	01/02/2020 1600

Situation overview

- The following relates to the international situation:
  - As at 1 February 2020 1500hrs, 11,374 confirmed cases and 259 deaths have been reported globally.
  - 153 cases have been identified outside mainland China in 25 countries.
  - There is now evidence of human-to-human transmission outside of Hubei Province.
  - WHO Emergency Committee met on 30 January 2020 (31 January 2020 AEST) and declared a Public Health Emergency of International Concern (PHEIC).
- The following relates to confirmed cases in Victoria:
  - Case 1 was diagnosed on 25 January 2020. The case is a RE visitor from Wuhan, China, REDACTE years, who is stable and being isolated in hospital.
  - Case 2 was diagnosed on 28 January 2020. The case is a RED Melbourne resident REDACTED who returned from Wuhan to Melbourne on 20 January 2020. The case initially self-isolated but was admitted to hospital on 31 January 2020.
  - Case 3 was diagnosed on 30 January 2020. The case is a RED visitor from Wuhan, China, REDACTE RED The case did not visit any public settings between arrival in Australia and symptom onset a week later. The case was admitted to Royal Melbourne Hospital.
  - Case 4 was diagnosed on 31 January 2020. This person is a REDACTED REDACTED There are no contacts or public exposure sites associated with this case. She has is selt-isolating at home.
  - There are two settings where confirmed cases have created settings where casual contacts are now being monitored:
    - Sunday 19 January 2020, 9am: Flight REDA from Guangzhou to Melbourne;
    - Sunday 26 January 2020, 5.30-7pm: REDACTED Glen Waverley.
- The following relates to interstate confirmed cases:
  - Four cases have been confirmed in NSW; three with recent travel to Wuhan and a fourth with direct contact with a confirmed case in Wuhan.
  - Two cases have been diagnosed in Queensland.
- The following relates to critical activity within the Victorian public health response:
  - DHHS has formed an Incident Management Team to coordinate the public health and sector response.
  - A rapid change to the Public Health and Wellbeing Act 2008 Regulations (2019) was made to make 2019-nCoV notifiable.
  - The Communicable Disease Prevention and Control Unit (DHHS) continues to receive a large volume of calls relating to the 2019-nCoV (from medical practitioners, educational institutions and the public).
  - A public hotline 1800 675 398 has been commenced through nurse on call, staffed by registered nurses and will run 24 hours per day.
  - The IMT is working closely with CDNA colleagues to review current epidemiological information and respond accordingly.

Victoria Case Summary (14:00, 1 February 2020)	
CONFIRMED cases	**4 confirmed Victorian cases**
SUSPECTED cases	**12 people are currently being tested**
Suspected cases rejected following	**65**

negative test result			
Total number of people tested negative		**149 – includes 65 suspected cases above and an additional 84 individuals tested as a precaution**	
		Confirmed cases	**Suspected cases**
Total		4	12
Sex; n (%)	Male	2 (50%)	5 (42%)
	Female	2 (50%)	5 (42%)
	Unknown	-	2 (17%)
Median age years		52.5	32.5
Hospitalised		3 (75%)	0 (0%)
Travel to Hubei Province within 14 days of symptom onset		4 (100%)	8 (67%)

Epidemiology Summary	

International	• Internationally, as of 1 February 2020 1200, there have been 11,374 confirmed cases of 2019-nCoV and 259 deaths reported.
	• Of the confirmed cases approximately:
	  ○ 7,153 cases have been reported from Hubei province (including Wuhan City), China
	  ○ 4,068 cases have been reported in 32 other provinces of China
	• The case fatality rate is estimated at around 2%, and around 20% of confirmed cases appear to have severe respiratory infection requiring hospitalisation.

National	• As of 1500hrs, 1 February 2020, nationally there have been nine confirmed cases in Australia, four in Victoria, four in New South Wales and two in Queensland. • Several cases have met the suspected cases definition in other jurisdictions and are being tested.

State Response and Control Measures	

Public Health Response	• The Health Protection Branch has formed an Incident Management Team to coordinate the public health and health sector response.
	• The Infection Clinical Network of Safer Care Victoria is providing advice to the department.
	• The current focus of the public health response is on containment of the novel CoV infection. This includes:
	  ○ rapid identification, treatment and isolation of cases to reduce transmission to household and community contacts;
	  ○ clinical and epidemiological characterisation of cases;
	  ○ minimising risk of transmission in healthcare environments.
	• Confirmed and suspected case definitions have been developed and will be refined as further intelligence becomes available about clinical and epidemiological features of cases.
	• Nearly 600 calls were received in 4 days 28/1-31/1, to the Communicable disease notification line 1300 160 651 – over five times the normal call volume.
	• The incident management team is working closely with the Department of Education (Vic), the National Incident Room and all other states and territories as issues arise
	• A rapid change to the Public Health and Wellbeing Act 2008 Regulations (2019) was made to make 2019-nCoV notifiable.
	• Information has been provided to the Department of Education and Training to provide advice on students who have been to China or who may have had contact with 2019 nCoV cases and to universities to share with staff and students.
	• Surge staffing has been identified and staff are being trained to support the response.

	• P2 masks are being distributed to GP practices through Primary Health Networks. By 31 January 2020, 90,000 masks had been received by PHNs for onward distribution to practices. **Testing** • All cases that meet the suspected case definition are approved for testing. The Victorian Infectious Diseases Reference Laboratory (VIDRL) is testing all specimens.
	Contact tracing and monitoring for confirmed cases (1500 1 February 2020) **Case 1 -** • There are four household contacts identified with the first case. All are being monitored daily and asked about fever or respiratory symptoms. All are reported to be well. • There have been 475 people (contacts) identified as passengers on the same flight as the confirmed case. Of these, 17 have been identified as close contacts (i.e. passengers seated within close proximity to the case as per standard contact tracing guidelines). Of these, details have been made available to Victoria for four contacts; three of which have been successfully contacted. All are reportedly well. One of these contacts is a REDACTED student who has been advised to exclude from school for 14 days post exposure (2 February 2020). DET have been notified of this student. • An additional 208 Victorian contacts for whom we have contact details (sourced via incoming passenger cards) have been contacted. **Case 2 -** • For the second confirmed case, there were five close family contacts all of whom have been contacted by the department. All are well. Several casual contacts from REDACTED have been provided with casual contact information. **Case 3 –** • There are 2 close family contacts REDACTED both of which have been contacted by the department and who are self-isolating. A GP who did not wear PPE when collecting the swab has been excluded from work for 14 days. Case 4 – • There are no contacts associated with this case. **Queensland case –** • A QLD confirmed case spent part of their infectious period in Melbourne before flying to Gold Coast REDACTED January 2020. DHHS has received details of the case's movements in Victoria and no contact tracing is required.
Hospital reports	Whist some hospitals have reported a slightly busier ED and calls for advice and testing (Royal Melbourne, Box Hill and other Eastern sites), demand has been managed. A process for quantitative updates is currently being formalised.
Media and Communications	**National Agencies** • Victoria is actively engaged in preparedness and response activities with interstate colleagues, Communicable Disease Network of Australia and the National Incident Room. **Health Services and Health Practitioners** • Chief Health Officer Alerts were published or updated on 10, 24, 25, 29, and 31 January 2020. • *'2019 Novel coronavirus (2019-nCoV) Guideline for health services and general practitioners'* has been developed and is available to support healthcare services and GPs. This has been updated with new policies regarding exclusion, infection prevention and the case definition. • A supporting *'Quick reference guide'* is also available for healthcare practitioners this was updated on 30 January 2020. • Posters for general practice and emergency department waiting rooms have been developed and are available for download on the website in English and Chinese. A further general poster for public areas such as bus stations and tourism offices is being developed. **Public** • A public hotline has been commenced through nurse on call, staffed by registered nurses running 24 hours per day. • A specific novel coronavirus webpage has been developed *https://www.dhhs.vic.gov.au/novelcoronavirus* with specific pages housing information for

	the general public; GPs; educational settings and the media. An audit of this website is underway to ensure accuracy and currency. • Extensive social media posts have been made from the departmental sites and translated. CHO videos and one translated video have been removed from view pending content review. **Media** • A media release went out on 1 February announcing the 4th confirmed case • The Chief Health Officer, Brett Sutton, continues to engage extensively with media including ABC Breakfast radio regarding WHO's decision to declare a PHEIC, an interview with the Herald Sun for a feature story tomorrow, and an interview with 3AW's Saturday Nights that will feature 7-8pm 1 February 2020. • The media and communications team are in daily contact with other relevant Victorian Government communication teams to prioritise and coordinate messaging and communications.

National and International Response Overview	
National Response measures	**Communicable Disease Network of Australia (CDNA)** • A CDNA working group has been convened to ensure a coordinated national response to the novel coronavirus. The Deputy Chief Health Officer (Communicable Disease) is a member of this group. The group are meeting daily or more frequently as needed. **Australian Health Protection Principal Committee (AHPPC)** • AHPPC first met on 20 January 2020 to discuss the national response and continues to meet regularly. • AHPPC met on 1 February 2020 and is providing advice to the Prime Minister and first ministers in relation to increasing risk associated with mainland China (excluding Hong Kong, Macau, Taiwan). **Border measures** • 'Human coronavirus with pandemic potential' was added as a Listed Human Disease (LHD) under the Biosecurity Act 2015 on 21 January 2020, enabling use of enhanced border measures. • The United States is now restricting access to entry for Chinese nationals. • DFAT have updated a Smart Traveller travel advisory to "do not travel" for Hubei Province. The advice for the rest of China remains at "exercise normal safety precautions". • Biosecurity Officers are meeting all flights from China to assess any ill passengers and to provide information about 2019 nCoV.
International Response measures	• WHO Emergency Committee met on 30 January 2020 (31 January 2020 AEST) and declared a Public Health Emergency of International Concern (PHEIC). • Entry screening is being conducted in 11 countries, including those bordering China as well as Canada and the US. China has commenced exit screening of travellers. • Public transport into and out of Wuhan has been suspended and citizens asked not to leave Wuhan and to wear masks in public places.

The next situation report will be issued at: 1700hrs, 02/02/2020, Authorised by: Dr Finn Romanes, Incident Controller

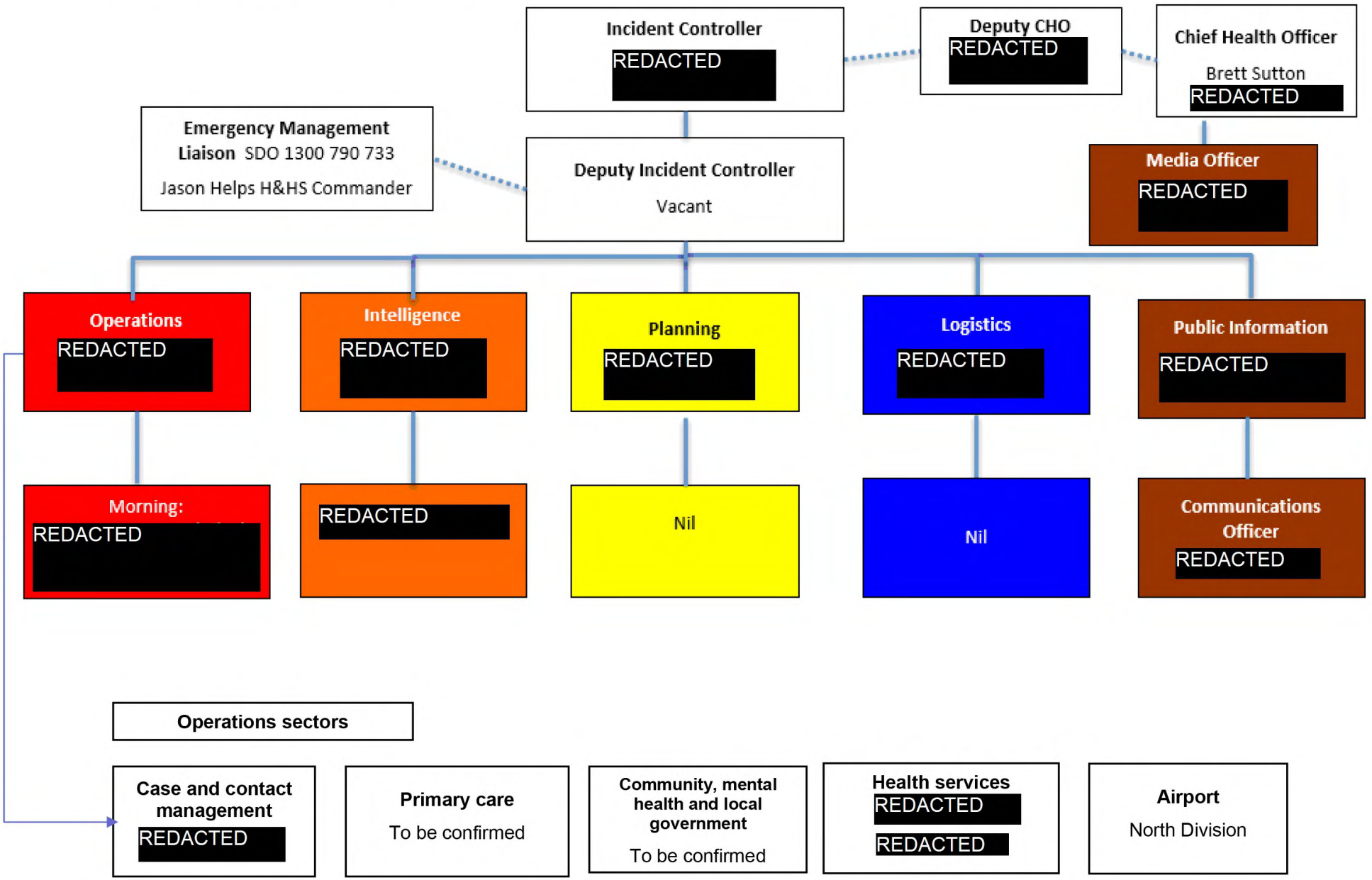
Appendix B: Action list (2 February 2020)

Functional area	Person responsible	Actions
Governance	REDACTED	To continue discussion on draft sectoring
Intelligence		Provide SitRep for dissemination by 4pm
		Note: Update provided on global epi. WHO has provided sitrep. Advised that asymptomatic transmission is rare. Also report first instance of 3rd generation transmission.
Operations		Note: update provided on case and contact management. Ongoing daily contact with cases/contacts. Four confirmed cases at this time. Testing results for suspected cases will return around 4-6pm each day.
Planning		Provide IAP for dissemination
		To act as liaison with airport sector and provide guidance materials for team working there.
PIO		To update GP quick reference guide and other pending materials
		To update CHO alert
		Note: several updates made to online materials and other collateral yesterday based on Commonwealth announcement.
Logistics		Working to expedite getting admin staff
		Exploring other surge possibilities (e.g. nursing staff)
		To work with EMB/Jason Helps on arrangements if there is any shift to SEMC and any changes to structure

Appendix C: Log of significant policy changes

Date	Policy change	Rationale	Approved by
1 Feb 2020	Case definition expanded to include the entire Chinese mainland as a 'declared' area. Testing and exclusion guidelines have been updated to reflect this.	Assessment of epidemiological evidence on 1 February 2020 indicated: • Ongoing transmission in Hubei Province, China, with 7,153 confirmed cases and 249 deaths as of 1 February 2020. • Increasing identification of confirmed cases in provinces of mainland China outside Hubei Province, as evidence by over 300 confirmed cases in four provinces which are Zhejiang (537 cases), Guangdong (436 cases), Henan (352 cases) and Hunan (332 cases). • Across multiple provinces of China there is now evidence of human to human transmission, with rates of new cases that are similar to case notifications in Hubei Province prior to 24 January 2020. • Early epidemiological modelling indicates transmission is likely occurring across mainland China, and it will be exceedingly difficult to limit spread to specific provinces. • There is an increasing risk of transmission to people who are present in mainland China, beyond Hubei Province, and thus a risk of illness in those people if they leave China. • The spread of novel coronavirus has increased across mainland China over the last few days. • There is evidence of human to human transmission outside Hubei Province. • As a result, the suspected case definition has been expanded to include people who have a respiratory illness who have been in mainland China in the 14 days prior to onset of illness. • Further, as a precaution, people who have been in mainland China (excluding Hong Kong, Macau and Taiwan) are advised to self-isolate if they were in mainland China on or after 1 February 2020, when this risk was identified to have significantly increased.	Finn Romanes

Appendix D: Incident Management Team



Appendix E: Communication lists

SitRep distribution list (updated from HHSD/20/54237)

Name	Position	Email address
Andrea Spiteri	Director, Emergency Management Branch	REDACTED
Andrew Crow	Director, Rural and Regional Health	REDACTED
Andrew Hockley	Chief Communications Officer, Strategy and Planning	
REDACTED	Acting Manager, Health Protection Branch	
REDACTED	Manager, Investigation and Response, Health Protection Branch	
	Principal Epidemiologist BBV/STI, Health Protection Branch	
	Manager, Operational Capability, Emergency Management Branch	
Angie Bone	Deputy Chief Health Officer (Environment), Health Protection Branch	
Annaliese van Diemen	Deputy Chief Health Officer (Communicable Disease), Health Protection Branch	
Brett Sutton	Victorian Chief Health Officer, Health Protection Branch	
Finn Romanes	Public Health Physician (Communicable Disease), Health Protection Branch	
REDACTED	VIDRL Registrar, The Peter Doherty Institute for Infection and Immunity	
REDACTED	Infectious Diseases and Microbiology Registrar, Health Protection Branch	
Graeme Walker	Senior Communications and Media Adviser	
Helen Mason	Health Services Policy and Commissioning	
REDACTED	Office of the Premier Victoria	
Jason Helps	Dep Director, Emergency Management Branch	
REDACTED	Senior Project Officer, Health Protection Branch	
REDACTED	Acting Director, Emergency Management Branch	
REDACTED	Ministerial Chief of Staff, Department of Premier and Cabinet	
	West Region Emergency Management and Health Protection	
Kym Peake	Secretary, Department of Health and Human Services	
REDACTED	Assistant Director, Communications and Media	
Louise Galloway	Director, Health & Wellbeing	
REDACTED	Executive Assistant Communicable Disease, Health Protection Branch	
Melissa Skilbeck	Deputy Secretary, Regulation, Health Protection and Emergency Management	
REDACTED	Communications Manager Public Health, Communications and Media	
Merrin Bamert	Southern Region Emergency Management and Health Protection	
Michael Mefflin	Northern Region Emergency Management and Health Protection	
REDACTED	Senior Media and Communications Adviser,	
Rob Hudson	Media Director Health and Ambulance	
Ryan Heath	Director (A/g), Health & Wellbeing Division	

REDACTED	Director, Emergency Management and Health Protection, East Division	REDACTED @dhhs.vic.gov.au
SEMC	State Emergency Management Centre	semc@dhhs.vic.gov.au
REDACTED	Principal Epidemiologist, Health Protection Branch	REDACTED @dhhs.vic.gov.au
REDACTED	Deputy Secretary, Health and Wellbeing	REDACTED @dhhs.vic.gov.au
REDACTED	Senior Communications and Media Adviser	REDACTED @dhhs.vic.gov.au
REDACTED	Head of Communications, Communications and Media	REDACTED @dhhs.vic.gov.au

Significant stakeholder distribution list (pre-notifications)
To be confirmed

'VIP' distribution list
To be confirmed

COVID-19

Outbreak Management Plan

Version 1.0

Approved by Chief Health Officer

5 June 2020

VICTORIA State Government | Health and Human Services

Contents

Executive Summary

Purpose

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

Context

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

Outbreak Management

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

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

Key Definitions

Outbreak of COVID-19

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

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

Linked cases

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

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

Transmission within one household does not ordinarily constitute an outbreak.

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

Other immediate control response cases

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

Acronyms and abbreviations

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

Glossary

Confirmed case	For COVID-19, a confirmed case is a person who tests positive to a validated SARS-CoV-2 nucleic acid test or has the virus identified by electron microscopy or viral culture
Contact	A person who has been in contact with a confirmed case during their infectious period. Contacts are typically defined as either close contacts or casual contacts
Close contact	A person who has had greater than 15 minutes face-to-face contact (cumulative) or who has shared a closed space for more than two hours with a confirmed case during their infectious period without recommended personal protective equipment (PPE)
Contact tracing	The process of identifying people who are close contacts of a case, and ensuring they are quarantined for the maximum incubation period (14 days) after last close contact with the case.
COVID-19	Coronavirus disease 2019 (the name of the disease). COVID-19 was initially referred to as “novel coronavirus” (2019-nCoV) and is sometimes referred to as just “coronavirus”
Critical Infrastructure and essential services	Defined as per the Infrastructure and Essential Services list held by Emergency Management Victoria (EMV)
Exposure site	A location or site to which an individual case or outbreak has been linked through attendance while infectious or during their acquisition period
Healthcare worker	Healthcare workers are people in close contact with patients or the patient space. For example, doctors and nurses and cleaners who enter the patient’s room or cubicle are included as healthcare workers. Staff who work in non-clinical areas who do not work with patients or enter patient rooms are not included as healthcare workers for this purpose.
Infectious period	The period during which an infected person can transmit an infectious agent to a susceptible person. Also known as the ‘communicable period’. The duration of the infectious period for COVID-19 is unknown. However, for the purposes of isolation and contact tracing, cases are considered to be infectious from 48 hours prior to the onset of symptoms, until they meet the criteria for release from isolation.
Isolation	The physical separation of ill people with a communicable disease (e.g. COVID-19) from those who are healthy.
Outbreak	The internationally accepted definition of an outbreak encompasses the occurrence of more cases of a disease than expected, or two or more linked cases. Tailored definitions for a COVID-19 outbreak are provided in this document.
Outbreak control squads	Multi-disciplinary public health teams formed to enable additional and rapid support at physical outbreak settings to facilitate outbreak control
Pandemic	Worldwide spread of a new disease

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

Governance

Overview

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

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

Roles and Responsibilities in an outbreak

Outbreak Management Team

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

Core members of an Outbreak Management Team

Outbreak Lead

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

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

Case and Contact Management Lead

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

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

Epidemiology Lead

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

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

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

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

DHHS Agency Commander (Representing the State Controller - Health)

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

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

State Joint Intelligence Lead (State Control Centre representative)

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

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

Communications and media lead

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

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

Outbreak Squad Coordinator

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

The Outbreak Squad Coordinator will:

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

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

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

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

Health and Wellbeing Division representative

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

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

- Commissioning Group – Metro or Regional
- Private Hospitals

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

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

Administrative Support Officer

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

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

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

Potential additional members of an Outbreak Management Team

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

Outbreak Briefings

The following meeting will take place as a regular briefing:

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

Key elements of the outbreak response

Identifying an outbreak

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

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

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

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

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

Problem Assessment Group (PAG)

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

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

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

The PAG should determine:

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

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

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

Initial Notification

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

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

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

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

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

Outbreak Management Team

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

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

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

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

An initial outbreak meeting agenda is in Appendix 4.

Outbreak Squads

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

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

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

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

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

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

Daily Activities

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

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

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

Points of Escalation

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

Tier 1

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

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

Tier 2

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

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

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

Closure of an outbreak

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

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

Outbreaks in Sensitive Settings

Sensitive Settings

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

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

The following are considered sensitive settings:

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

See Reference materials for further guidance on sensitive settings

Outbreak Briefings and Reports

Summary of outbreak briefings, plans and reports

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

Business rules for distribution of outbreak reports and data requests

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

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

Evaluation

Key Performance Indicators (KPIs)

Following the decision to establish an Outbreak Management Team:

Within 2 hours

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

Within 12 hours– 50 Lonsdale St

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

Within 24 hours –50 Lonsdale St and site visit requirements

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

Within 48 hours – on site actions

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

Closure of the outbreak

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

Reference Documents/Guidelines

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

Factsheets

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

System Requirements

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

Appendix 1 – Outbreak Control Squads

Public Health Outbreak Control Squads

Role and focus

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

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

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

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

The squads will work within each OMT.

Pre-deployment briefing

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

Roles and responsibilities

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

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

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

Informing the outbreak setting of squad deployment

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

Documentation

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

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

Appendix 2 – Use of Genomics

Use of Genomics

Microbiological Diagnostic Unit (MDU) Public Health Laboratory

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

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

MDU epidemiologists and bioinformaticians will:

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

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

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

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

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

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

- Protocol documents
- Meeting minutes

- Genomic data requests
- Genomic reports

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

Appendix 3 – Outbreak Management Plan template

Purpose

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

Governance

Outbreak Management team

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

Outbreak Management Team meeting dates

Situation

[Insert overview of the situation]

Epidemiological and clinical investigation

COVID-19 in Victoria

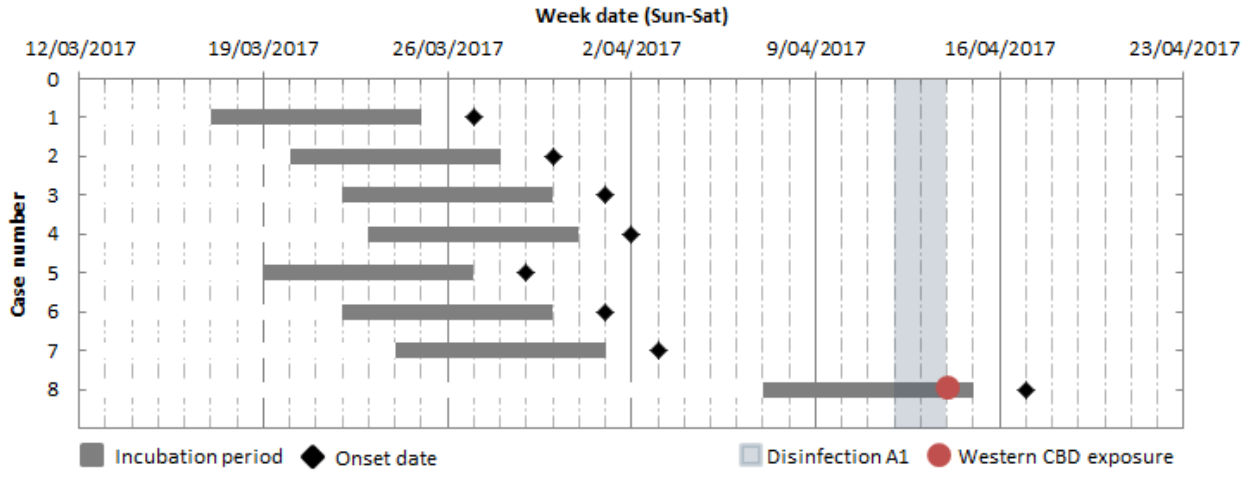
[Insert background epidemiology]

Epicurve

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

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

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



Case definitions

Current department case definition

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

Outbreak case definitions

Confirmed case – outbreak

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

Suspected case – outbreak

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

Person under investigation – outbreak

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

Rejected case

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

Case follow-up

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

Case finding

[Describe active case finding activities]

Case summary

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

Line list

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

Environmental investigation

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

Hypothesis

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

Control measures

[Describe any control measures taken]

Stakeholder mapping

[List identified stakeholders]

Risk communication

Key events

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

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

Communication with exposed settings

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

Chief Health Officer Alert

[Link to CHO alert if developed and issued]

Key messages – health professionals

[Develop and record key messages]

Key messages – general public

Develop and record key messages]

Outbreak Management Team meeting actions list

Action	Due date	Responsible person

Timeline of outbreak

Date	Action

Appendix 4 – Initial Outbreak Management Team Agenda

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

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

Appendix 5 – Health Services and Outbreaks

Health Services potential roles in outbreaks

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

State Health Incident Management Team Meeting Minutes

Date: 1 April 2020

Time and date	1100-1200 1 April 2020 – SHIMT #1
Chairperson	State Controller - Health
Location	Teams
Invitees	State Controller – Health – Andrea Spiteri Chief Health Officer – Brett Sutton State Health Coordinator – Euan Wallace Public Health Command – Simon Crouch, REDACTED State Health Commander (Ambulance Victoria) – REDACTED Health Planning (Project Management Office) – Denise Ferrier, REDACTED Deputy State Health Coordinator (minute taker) - REDACTED
Apologies	Helen Mason
Purpose	To confirm escalation of the COVID-19 public health emergency and set the priorities for the State Health Incident Management Team under the State Health Emergency Response Plan

Item	Description	Presenter
1.	Welcome & role of SHIMT AS welcomed attendees, acknowledged traditional owners and introduced the agenda for the meeting. AS acknowledged that some SHIMT roles have been undertaken by the Departmental Incident Management Team to date, but the time has come to have a formal SHIMT in support of the Public Health Incident Management Team. A range of planning has been undertaken across the department, government and other organisations, so the aim of the SHIMT is to bring everyone up to speed on key activities underway. AS acknowledged the presence of the Health Services Pandemic Leadership Team (PLT), consisting of CEOs of a number of metropolitan, regional and rural health services, including Ambulance Victoria CEO, Primary Health Networks (PHNs) and a number of peak	Chair

	organisations, chaired by DHHS Secretary. The SHIMT must work through how the SHIMT and the PLT function effectively together. The Health Emergency Management Stakeholder Reference Group (HEMSRG) is also meeting in relation to the pandemic – this has a broader membership including Adult Retrieval Victoria (ARV), Pharmacy Guild, Aged Care, private hospitals and the Field Emergency Medical Officer (FEMO) program. SHIMT members should give thought as to how that group may be used in the pandemic planning and response.	
2.	Update: • Chief Health Officer: ○ Current situation – 968 confirmed cases, 51 increase on yesterday. Daily increases averaging 70-80 per day (range of 50-110) since last week. Previously, increases of 20-25% were observed, with a reduction to approximately 10% daily increases following implementation of control measures. Whilst this is promising, this still represents a move from doubling every 3-4 days to doubling every 7 days, so could still result in approx. 16,000 patients in a month, so there is still work required to control spread. The implementation of enforced quarantine for travellers is expected to reduce the instance of travel-related secondary contacts, along with the implementation of immediate testing of quarantined travellers upon onset of symptoms. Ongoing physical distancing is necessary to manage community transmission chains. Approx. 35 cases have been identified with no link to a confirmed case or to international travel; the actual numbers in the community must be much greater. It is expected that a proportion of health care workers who have been infected must have been exposed by patients who were unrecognised. A couple of weeks are necessary to determine how social distancing can manage the risk. The reduction of international arrivals and associated testing is expected to free up testing capacity for further cohorts that are currently not being tested. ○ Key concerns: PPE supply – there is a need to consider health care worker exposures. 130 health care workers are in furlough at the Alfred due to COVID-19 cases on the ward that were initially unrecognised. A number of staff and other patients were infected. This demonstrates how unrecognised cases and prolonged transmission in healthcare settings can compromise health services. Tens of millions of PPE items are on the way, and millions of items are landing each day nationally, but we're using a lot and need to balance current need and protection of healthcare workers with the potential catastrophic result of running out of PPE as the pandemic peaks. EW: It would be useful to profile infected health care	

workers to identify the cohorts that are at most risk, with recognition of the fact that most cases are travellers and have not had a workplace exposure. This would aid in managing anxieties around PPE provision. As soon as system is ready, all health care workers should wear basic PPE all the time, and reserve higher level PPE (eg P2 masks) for higher risk cohorts.
DF: This issue is high on hospital CEO agendas to identify and mitigate risks for staff at greatest risk, so even if such a profile was unable to be publicised, hospitals could use it to implement local risk mitigation solutions.
Action: Identify the health care worker profiles with greatest incidences of COVID-19 infections – Public Health Command

- BS: Another key issue – the state's testing capacity is strained, with around 40 days' worth of reagents available. Some limiting factors exist around the types of materials needed for testing. Developments around point of care tests and rapid diagnostic tests will be useful for early identification of cases and triaging patients away from emergency departments and other health settings if they test negative. Some tests are already approved by TGA but are of questionable utility; others are before TGA for potential registration that look more promising but currently unclear how scalable they are. The laboratory networks are engaged in assessing validity of such tests.

- Public Health Command
  - Testing and case definition: Limited testing supplies but testing numbers are down due to restrictive case definition prioritising returned travellers. Changes to case definition today expands out to high-risk groups with public facing roles and those working with vulnerable populations. Police will be included in expanded testing – the rationale is they are seeing people still during the general lockdown. Won't massively increase testing requirements. Manageable within current stock levels.
  - Instigated a screening program to test 20% of clinic attendees who otherwise wouldn't meet testing criteria and are getting some positive returns from these presentations, indicating a degree of community transmission.
  - There has been a massive scale-up of case & contact management, capturing cases and contacts. Up to 500 people are working on the public health response. Things are now settling down and effective processes are running. Redundancies now in place to support work.
  - Encouraging SHIMT to maintain physical distancing. The nature of our work is that we have to be here but

should practice spreading out and giving distance wherever possible.

- Ambulance Victoria
    - ESTA have implemented epidemiological screening questions protocol based on current case definition. Provides alert to crew of anyone who might meet case definition.
    - Social distancing is taking place where possible within AV. All critical teams have been locked down, including Operations Centres, secondary triage and referral teams, the Emergency Management Unit, and rostering groups to preserve them and ensure they are isolated from the rest of the organisation and community. Those critical groups have also been surged to provide extra workforce capability.
    - Workload – 180 calls per day meeting case definition in some way. About 70 come through with some form of respiratory disorder on 000. Patient care records now have a grouping for all COVID cases. Incidents peaked on the weekend with 102 cases identified by paramedics as meeting case definition. 80 cases were identified yesterday.
    - Issues: PPE guidelines for application by paramedics. The issue of accessing PPE has been resolved. Clinical changes to resuscitation and nebulising practices have occurred to minimise aerosol-generating procedures. Cancelled GoodSAM (community members responding to cardiac arrest). A risk assessment meeting will occur to turn the system back on for health professionals, St John Ambulance etc who may have PPE.
    - Other measures in place to shore up ambulance availability include: modifications to leave, brought forward recruiting (120 staff in 4-6 weeks), the possibility of another 150 staff recruited depending on funding, bringing in university students and volunteer / sessional community officers. Upgrading contracts with existing non-emergency contractors and potentially bringing more contractors in.
    - Working with ESTA for alternative dispatch grid to divert more cases to secondary triage and preserve fleet for immediate life threat and higher acuity only.
    - AV's escalation is currently at Orange.
    - Holding regular state-wide teleconferences with senior staff, daily videos for staff.
    - EW: The Clinical Leadership Expert Group (CLEG) has a working group looking at patient hand-overs from AV to hospital, attempting to minimise high-risk patient movements through busy areas. Invitation to bring to CLEG's attention if some services are challenging to deal with in this regard.

RE Will discuss further online as some variability has

been noted. AV are happy to work with CLEG to bed in improved practices in this area.

- Health Planning
  - DF – The departmental health structure includes the PLT as the decision-making group for the health sector, and CLEG in association from a clinical perspective. The Project Management Office (PMO) has been set up as a coordinating structure across all areas of metro and rural service planning and within the organisation of DHHS to pull things together.
  - Structure of PMO – DF as exec lead, REDA and REDA as leads for PMO. 5 units underneath: Information and governance, data and information (working on what data needs are emerging, collecting data, setting up to answer questions on impacts as they emerge), comms (internal and external, working on secure portal for health services), health service planning (liaison points into existing branches – metro performance, rural performance, mental health, community heath and primary care, ACCHOs, dental), models of care (how to cohort patients, ICU pathways etc), pathology, procurement / logistics. Tapping into teams outside the PMO as necessary, with the PMO is coordinating body.
    EW: A challenge exists around the PPE task force and the ICU coordination piece approved by the PLT – these are frontline items that require operationalisation as well as coordination. How is the PMO setup to respond to the changing needs of these areas in an agile way?
    DF: The PMO has clarity in its role to coordinate the groups that are responsible for operationalising work. The PMO is being responsive to the issues and moving the clusters of the planning stream to the areas where they're needed, to solve a problem and move onto the next. Shouldn't lose the opportunity to build on and leverage frontline changes to the system that might be worth retaining. The PMO is also looking for those opportunities and capturing intelligence.
    AS: We need to work through the coordination needs across the whole of the health sector, and when very active coordination to the sector during response is required, need to consider how we move from a PMO to an operational structure.
  - Key issues: PPE – lots of action around procurement, ordering and logistics – the risk is recognised. The broader team has done work around securing private hospital contracts which are close to delivery to access private capacity. Work out of the Health and Human Services Building Authority includes installing beds at closed hospitals. Team working on workforce recruitment and retention – trying to recruit staff, launched a portal for people to register interest in returning to the workforce (expecting announcements

	today). In the background looking at what happens for non-ICU essential health services e.g. obstetrics, dialysis etc as we gear up ICU capacity	

3.	SHERP escalation process
	• Refer to Appendix A of the agenda / minutes
	• There is a requirement to minute the escalation assessment in the State Health Emergency Response Plan (SHERP), and review at each meeting.
	• All attendees agreed with the following assessment:
	  ○ Incident scale: Very large
	  ○ Consequence: Critical
	  ○ Impact assessment: Severe
	  ○ **SHERP escalation: Level 3 incident**
	• The Victorian Health Response Plan stage of the response is Stage 2 (Targeted Action), with elements of Stage 1.
	• This emergency is a Class 2 emergency under Victoria's Emergency Management Arrangements.
		Chair

4.	Other business • AS: SHERP references Code Brown as a notification process for relatively sudden-onset emergencies, or emergencies that are starting to come onto the radar but have not arrived yet. Due to significant escalation across the health sector, seeking feedback about the timing, triggers and outcomes from Code Browns. SC: Advised further consideration required – the decision should be based on what Code Brown activation achieves that is different to what is currently happening. Consideration needed as to how it will change and improve response. Expect local arrangements are most likely already active. EW: Code Brown relates to ability of the health sector to manage patient load in the moment. We are currently in the preparation phase, Code Brown is likely to be triggered by overwhelming demand or a complete inability for hospitals to accommodate the needs of patients (most likely ICU), or massive loss of workforce requiring a system-wide response. RE It would be helpful to have a single point of contact at operational level – such as a hospital commander – in place. Some hospitals do without having activated Code Brown. Agree with other comments, no need for a huge surge right now as referenced in Code Brown, but it would be helpful for health services to implement an IMT or at least have arrangements in place for a nominated hospital commander as a single point of contact for problem resolution at a system level. In terms of activating staff and associated arrangements, don't believe it is necessary at this point. EW: Agree with REDA – important that hospitals have command structures in place and a single operational contact point. When we need activation, we'll need rapid activation. DF: This is a discussion occurring in the PLT. There is a sense that a hospital command structure outside the realm of Code Brown could be helpful, and the PLT could assess whether this is happening, and how it could be made to happen.	All

	AS: Aware of activity underway in PLT in this regard, but wanted to ensure it was raised in the SHIMT given its relationship to the State Health Emergency Response Arrangements. **Action: Circulate the PLT paper out of session relating to hospital command and incident management arrangements** – AS	
5.	Frequency of meetings • Next meeting to be scheduled on Monday 6 March, time to be determined. • Feedback encouraged on required frequency of meetings.	Chair
6.	Confirmation of actions and close of meeting	Chair

Appendix A

SHERP Escalation Process (see pp.32-35 of SHERP)

SCALE – The extent of impact, or potential impact, on the community's health.

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

Assessment: ☐ Small ☐ Medium ☐ Large ☐ Very Large

CONSEQUENCE – Severity, or likely severity, of health consequences for the community.

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

Assessment: ☐ Minor ☐ Moderate ☐ Significant ☐ Critical

HEALTH IMPACT ASSESSMENT (Scale & Consequence)

		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

Health Impact Assessment: ☐ Low ☐ Medium ☐ Major ☐ Severe

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.

FURTHER CONSIDERATIONS (move one or more spaces to the right in health impact assessment 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

(Adjusted) Health Impact Assessment: ☐ Low ☐ Medium ☐ Major ☐ Severe

[If there are any changes in the health impact assessment outcome, describe the reasons for the change here]

RESPONSE DETERMINATION

DEPARTMENTAL RESPONSE
Low health impact Resolved locally with support from the Regional Health Coordinator and/or Regional Health Commander as required
Medium-Major health impact Establish a Health Incident Management Team (State or Regional or combined) with support from DHHS State and/or Divisional Operations teams and the AEOC as required
Major-Severe health impact Establish a State Health Incident Management Team with support from State and Divisional Operations teams and the AEOC as required For Class 2 emergencies: Appoint a State Controller

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

Assessment:

Incident level: ☐ Level 1 ☐ Level 2 ☐ Level 3

Departmental response: *[Briefly describe the response structure of the department here]*

RE: Hotel Quarantine [SEC=OFFICIAL]

From: "Pam Williams (DHHS)" [redacted]
To: "Merrin Bamert (DHHS)" [redacted], "Brett Sutton (DHHS)" <[redacted]
Date: Sun, 21 Jun 2020 10:24:44 +1000

Thanks also (I twin with Merrin in the role of Commander, Operation Soteria).
Three points:

- We will begin temperature and symptom testing at commencement of every shift for all staff in hotels and send home those with symptoms and fever – with the emphasis on driving the message home to security staff. This is obviously a limited tool but it can be backed up with swab testing across the workforce in a rolling program. The details will be worked through with security companies in a number of meetings tomorrow.
- The payment of staff for time off work at ordinary rates is not a small cost and there is no such thing as ordinary work in the security industry. This is very much the gig economy we are dealing with.
- Support Brett's point re the nature of the security workforce. We are engaging a Behavioural insights team to look at improving the understanding and take-up of PH messages and to using different approaches to security through use of other workforces and technology, recognising that we have had no people who have left quarantine in a hotel without permission (with almost 18,000 through the program).

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: Merrin Bamert (DHHS) <[redacted]>
Sent: Sunday, 21 June 2020 10:11 AM
To: Brett Sutton (DHHS) <[redacted]
[redacted]>
Cc: Pam Williams (DHHS) <[redacted]>
Subject: Re: Hotel Quarantine [SEC=OFFICIAL]

Thanks both

We are also looking at alternative workforce models
To security or those more akin to infection control measures, PCA, hospital orderlies etc, in addition to the increased training and oversight of security staff.

Merrin Bamert
Commander, Operation Soteria
Director, Emergency Management, Population Health and Health Protection, South Division

---

From: Brett Sutton (DHHS) <[redacted]>
Sent: Sunday, June 21, 2020 10:06:12 AM
To: MURPHY, Brendan [redacted]
Cc: Merrin Bamert (DHHS) [redacted]hhs.vic.gov.au>
Subject: Re: Hotel Quarantine [SEC=OFFICIAL]

Thanks [redacted]. Merrin - in copy - is overseeing this operation and I'm sure will touch base as required. I think Aspen, in particular, could strengthen the program but its security staffing that is our main risk at the moment. I might also raise routine symptomatic testing of these staff with AHPPC today.

Brett

Get Outlook for iOS

From: REDACTED
Sent: Saturday, June 20, 2020 11:46:27 AM
To: Brett Sutton (DHHS) <REDACTED
Subject: RE: Hotel Quarantine [SEC=OFFICIAL]

If you needed a short term surge workforce in the meantime, Aspen or even ADF could help at very short notice

REDACTED
Australian Government Chief Medical Officer

From: Brett Sutton (DHHS)REDACTED
Date: Saturday, 20 Jun 2020, 10:34 am
To:REDACTED, Annaliese Van Diemen (DHHS)
REDACTED
Subject: Re: Hotel Quarantine [SEC=OFFICIAL]

ThanksREDACT. We've got good training and IPC supervision but the workforce is the wrong cohort. Talking to DJPR about better options. And might consider regular PCR tests for security staff.

Brett

Get Outlook for iOS

From: REDACTED
Sent: Saturday, June 20, 2020 10:13:51 AM
To: Brett Sutton (DHHS) REDACTED; Annaliese Van Diemen (DHHS)
REDACTED
Subject: FW: Hotel Quarantine [SEC=OFFICIAL]

The other thing I was wondering is whether there is anything we can do to help in your enhancement of infection control in the quarantine hotels. Obviously with the recent breaches you are doing detailed reviews of the infection control practices but with the rising incidence of positive returned travellers, do we need to do more. Use PPE more extensively, up the training and supervision, etc. etc.
We have used Aspen Medical to come into aged care homes as a surge workforce and to provide infection control expertise
They are readily available.
We are very keen to help in any way

REDACTED
Australian Government Chief Medical Officer

From:REDACTED
Date: Friday, 19 Jun 2020, 8:26 pm
To:REDACTED
REDACTED Brett.SuttonREDACTED
REDACTED

REDACTED, 'Annaliese Van
Diemen (DHHSREDACTED

Subject: Hotel Quarantine [SEC=OFFICIAL]

Been reflecting on the quarantine breaches we have had and the issue raised by Annaliese today, where a hotel worker continued to work while symptomatic and didn't identify because of fear of income loss. Is it possible to write into the hotel quarantine contracts a provision that any hotel or security worker who has to quarantine (as a contact) or isolate (for COVID + status) would be paid their "normal weekly hours" for the two week period. It would be a minor expense but would fix this as an issue?
Thoughts

REDACTED
Australian Government Chief Medical Officer

"Important: This transmission is intended only for the use of the addressee and may contain confidential or legally privileged information. If you are not the intended recipient, you are notified that any use or dissemination of this communication is strictly prohibited. If you receive this transmission in error please notify the author immediately and delete all copies of this transmission."

DIRECTION AND DETENTION NOTICE

Public Health and Wellbeing Act 2008 (Vic)
Section 200

1 Reason for this Notice

(1) You have arrived in Victoria from overseas, on or after 11:59:00pm on 1 July 2020.

(2) A state of emergency exists in Victoria 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.

(3) 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 a high risk of infection and are significant contributors to the spread of COVID-19 throughout Victoria.

(4) 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, having regard to the medical advice, that detention 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.

(5) **You will be detained for a further period of 10 days from the end of the detention period** specified in clause 2 below if you refuse to be tested for COVID-19 on the request of an Authorised Officer. This detention will be required because, having regard to the medical advice, this further detention 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.

(6) You must comply with the directions in clause 3 below because they are reasonably necessary to protect public health, in accordance with section 200(1)(d) of the Act.

(7) 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.

2 Place and time of detention

(1) You will be detained at:

Hotel: _____ *(to be completed at place of arrival)*

Room No: _____ *(to be completed on arrival at hotel)*

(2) You will be detained until: _____ on ____of _____2020, subject to clause 1(5).

(to be completed at place of arrival)

3 Directions — transport to hotel

(1) 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.

(2) 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.

4 Conditions of your detention

(1) **You must not leave the room in any circumstances**, unless:

(a) you have been granted permission to do so:

(i) for the purposes of attending a medical facility to receive medical care; or

(ii) where it is reasonably necessary for your physical or mental health; or

(iii) on compassionate grounds; or

(iv) for the purpose of visiting a patient in hospital where permitted to do so under the **Hospital Visitor Directions (No 7);** or

(b) there is an emergency situation.

(2) **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).

(3) Except for authorised people, the only other people allowed in your room are people who are being detained in the same room as you.

(4) 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.

(5) 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.

5 Review of your detention

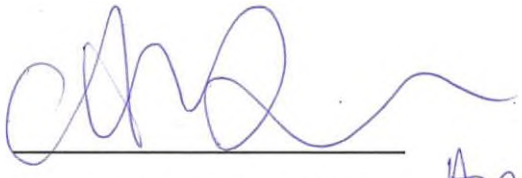
Your detention will be reviewed at least once every 24 hours for the period that you are in detention, in order to determine whether your detention continues to be reasonably necessary to eliminate or reduce a serious risk to public health.

Note: This review is required by section 200(6) of the Act.

6 Offence and penalty

(1) 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.

(2) The current penalty for an individual is $19,826.40.



Name of Authorised Officer: Annaliese van Diemen

As authorised to exercise emergency powers by the Chief Health Officer under section 199(2)(a) of the Act.

RE: CONFIDENTIAL: New Outbreak - Rydges, Swanston St

From: "Brett Sutton (DHHS)" <REDACTED

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

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

Date: Tue, 26 May 2020 20:28:12 +1000

Thanks Simon – I think there's no rationale to inform residents other than if there has been exposure of if there is proactive media planned.

Brett

Adj Clin Prof Brett Sutton MBBS MPHTM FAFPHM FRSPH FACTM MFTM
Victorian Chief Health Officer
Victorian Chief Human Biosecurity Officer
Regulation, Health Protection & Emergency Management
Department of Health & Human Services | 14 / 50 Lonsdale St
REDACTED e. REDACTED
health.vic.gov.au/public-health/chief-health-officer
twitter.com/VictorianCHO

Please note that I work from home on Thursdays and am contactable on the numbers above.

From: Simon Crouch (DHHS) <REDACTED>
Sent: Tuesday, 26 May 2020 8:10 PM
To: Finn Romanes (DHHS) <REDACTED; Brett Sutton (DHHS) <REDACTED
Cc: REDACTED>; Pam Williams (DHHS) REDACTED Jason Helps (DHHS) <REDACTED; SCC-Vic (State Intel Manager) <sccvic.stateintelmgr@scc.vic.gov.au>; REDACTED <REDACTED>; Kira Leeb (DHHS) REDACTED REDACTED REDACTED REDACTED REDACTED Sarah McGuinness (DHHS) REDACTED REDACTED; press (DHHS) <press@dhhs.vic.gov.au>; DHHS EmergencyCommunications (DHHS) <em.comms@dhhs.vic.gov.au>; Kym Peake (DHHS) REDACTED Jacinda de Witts (DHHS) <REDACTED Annalise Bamford (DHHS) REDACTED Melissa Skilbeck (DHHS) REDACTED
Subject: CONFIDENTIAL: New Outbreak - Rydges, Swanston St

Dear Finn and Brett

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

household)

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

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

At this stage there are no identified close contacts at work.
There are 5 household close contacts REDACTED All are currently well and in home quarantine.

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

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

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

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

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

Thanks
Simon

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

Rydges hotel - Two new COVID-19 cases

To: "Kym Peake (DHHS)" REDACTED "Annalise Bamford (DHHS)" REDACTED "Brett Sutton (DHHS)" REDACTED "Finn Romanes (DHHS)" REDACTED REDACTED

Cc: "Jacinda de Witts (DHHS)" REDACTED, "Nick Chiam (DHHS)" REDACTED, "Sarah McGuinness (DHHS)" REDACTED, "press (DHHS)" <press@dhhs.vic.gov.au>

Date: Fri, 29 May 2020 17:57:36 +1000

Dear colleagues,

Today we have been notified of a further **two** COVID-19 cases in security staff at the Rydges hotel. In total, **four** staff have now been identified as part of this cluster.

	Case 1	Case 2	Case 3	Case 4
Age/gender	REDACTED			
Symptoms?	Yes	Yes	No	No
Symptom onset date	25/05/2020	25/05/2020	Asymptomatic	Asymptomatic
Current location	Isolating at REDACTED	Isolating at home	Hotel accommodation arrangements in process	Isolating at home
Work role	REDACTED			
Last worked at Rydges	REDACTED			
Swab date	25th May	26th May	27th May	27th May
Testing location	REDACTED			
Notification date	26th May	27th May	29th May	29th May

We are in contact with the security company to get full rosters for the above workers, however currently we know that
Case 1 works as REDACTED
Case 2 works on
Case 3 works on
Case 4 works on

All deny close contact with other workers during their shifts.

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

- REDACTED involvement in cleaning duties, including the lift used to transport positive patients
- Use of masks and gloves in security staff who have self-instigated PPE use with non-standard (e.g. porous gloves) and without adequate training in hand hygiene and PPE use. PPE use had not been recommended for security staff who did not have direct contact with cases.
- Lack of routine cleaning & disinfection with agents that have antiviral activity in areas of hotel where staff work (cleaning products used in common areas & lifts are household

variety products)
- No reported contact with confirmed cases.

Actions already undertaken
- Cases and household
  - All cases isolated
  - Further social and household contacts isolated
- Other hotel staff (security, hotel staff, medical and nursing staff, DHHS staff)
  - Liaison with security agency, hotel, nursing and medical services including Alfred hospital
  - All staff who have been on-site for 30 minutes or more since 11th May have been asked to undergo testing for COVID
    - 133 (82%) staff have tested -ve
    - 4 positive
    - (further clarity being sought of exact number of pending results – some staff have been tested elsewhere)
    - Total staff number 162 (including 41 security staff)
- Outbreak response squad
  - Assessment visit, provision of infection control education particularly to security staff, cleaning advice, review of infection control processes
- Full commercial bioclean of common and high touch areas areas

Following discussion with the Public Health Commander and Chief Health Officer,
Additional next steps
- Cohorting of staff - all staff who have worked at the hotel from 11th May will be asked not to work at other sites
- Any security staff member who has had an overlapping shift with any of the cases during their infectious period will be considered close contacts (quarantined). (Noting one case interview is still underway.)
- Commercial cleaning to be urgently implemented at the hotel to ensure regular appropriate cleaning of common areas (eg. lifts) and high touch surfaces
- Ongoing support and education of security staff regarding appropriate hand hygiene, infection control measures and PPE use (if necessary)
- Ongoing support to hotel from outbreak response squad
- Reactive media lines to be updated

Kind regards

REDACTED

REDACTED
Deputy Public Health Commander COVID-19 (Case, Contact and Outbreak Management)
Senior Medical Advisor
Health Protection Branch | Regulation, Health Protection and Emergency Management Division
Department of Health and Human Services | 50 Lonsdale Street, Melbourne Victoria 3000
REDACTED REDACTED
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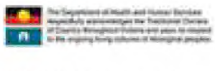
Follow the Chief Health Officer on Twitter @VictorianCHO



Stamford Plaza complex case - OMT

From: "Simon Crouch (DHHS)" REDACTED

To: "Annaliese Van Diemen (DHHS)" REDACTED

Cc: "Brett Sutton (DHHS)" REDACTED REDACTED REDACTED @dhhs.vic.gov.au>, "Jason Helps (DHHS)" REDACTED REDACTED REDACTED "REDACTED "press (DHHS)" <press@dhhs.vic.gov.au>, REDACTED "Merrin Bamert (DHHS)" REDACTED "Pam Williams (DHHS)" REDACTED @dhhs.vic.gov.au>, REDACTED REDACTED "Braedan Hogan (DHHS)" REDACTED "Andrea Spiteri (DHHS)" REDACTED DHHS EmergencyCommunications (DHHS)" <em.comms@dhhs.vic.gov.au>, REDACTED REDACTED REDACTED REDACTED

Date: Tue, 16 Jun 2020 22:58:35 +1000

Dear Annaliese

Situation
We were notified this evening of a case who is a security guard at the Stamford Plaza Hotel – one of the Operation Soteria Hotels

Background
The case became unwell on 15 June and presented for testing REDACTED the same day – the result was notified on 16 June and the case represented to ED at REDACTED He has been admitted overnight.

The case has worked as a security guard at the Stamford Plaza during his infectious period on RED REDACT June. He also worked most days during his acquisition period.
The case reports that a work colleague became unwell a few days ago and has been off work.
REDACTED

An OMT meeting was convened this evening – Merrin Bamert, Jason Helps, REDACTED REDA REDACTE REDACTED and REDACTED attended.

- Additional information was provided from the Outbreak Control Squad about IPC concerns at the Stamford Plaza following a visit today. This included concerns around PPE use when escorting residents outside. There have been a number of positive cases detected at the Stamford in recent days.
- An incident was reported at the weekend as a large number of security guards were identified undertaking their handover in a small room with very poor physical distancing. This incident coincides with the date that the case worked.

Assessment
The likely acquisition source for this case is from a positive guest at the Stamford Plaza – either directly, via a contaminated environment or from an as yet unidentified staff case.

Actions
The OMT agreed to the following immediate actions:

1. Full clean of the hotel as soon as possible tomorrow – it was agreed that only staff who have worked in the past three days will be allowed on site to supervise the clean in order to minimise any ongoing risk. Following the clean all staff who have worked since 7 June will be stood down in the first instance and only new staff will be allowed to staff the hotel. This period will be reviewed tomorrow. Merrin Bamert to obtain all staff lists and rosters for this period. All identified close contacts of the case will be quarantined.
2. Arrange testing for all staff who have worked since 1 June – REDACTED to support this

tomorrow.
3. Provide a letter for all staff who have worked at the hotel since 1 June – Simon Crouch to provide letter to Merrin Bamert for further dissemination. The letter will need to go to all DJPR staff, all DHHS staff, all hotel staff, all nursing/medical staff and all security staff.
4. The outbreak squad will revisit the hotel tomorrow –REDACTED to arrange.
5. Merrin Bamert to inform DJPR tonight.
6. Braedon Hogan to contact REDACTED to inform them of the housing commission link (but no further actions required at this stage).
7. Media lines to be prepared.
8. Communications for residents of the hotel to be developed in the morning (to go out before any media)
9. Further investigation of the case, his movements, close contacts and exposures tomorrow.

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

Thanks
Simon

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

Stamford Hotel outbreak update

From: "Annaliese Van Diemen (DHHS)" [redacted]

To: "Brett Sutton (DHHS)" [redacted] "Annalise Bamford (DHHS)" [redacted] "Jacinda de Witts (DHHS)" [redacted] "Melissa Skilbeck (DHHS)" [redacted] "Andrea Spiteri (DHHS)" [redacted]

Cc: [redacted] "Simon Crouch (DHHS)" [redacted] "Finn Romanes (DHHS)" [redacted] "Merrin Bamert (DHHS)" [redacted] "Pam Williams (DHHS)" [redacted]

Date: Thu, 18 Jun 2020 20:42:09 +1000

Good evening all,

A quick update to close the loop on conversations this evening regarding the Stamford Hotel and Hallam family outbreaks.

Initial status today:

- Single case detected in a security guard at Stamford Hotel, uncertain source, all staff requested to be tested who had worked from June 1 and a large number quarantined due to close contact with infected security guard
- [redacted] family outbreak – initially detected through [redacted] who was symptomatic. Contact tracing and further testing has revealed that [redacted] all linked to this case

This afternoon the team received further staffing lists from the security company as part of contact tracing for the first Stamford security guard. Through this process it was discovered that the [redacted] family outbreak is a security guard at Stamford, and worked for six days whilst infectious (two pre-symptomatic, four symptomatic). Further checks have determined that [redacted] denied any paid employment and stated very minimal contact outside of home duties on interview. The [redacted] is now quite unwell and in HDU at Dandenong hospital. The [redacted] is stable, but remains intubated in ICU at RCH.

A further four Stamford security guards have been notified as positive to date this evening.

Actions this evening:

- All staff who have worked from 8 June are required to go into immediate quarantine – initial text message now and follow up phone calls tomorrow
- All staff from June 1 were already being tested – a number of results still pending
- Operation Soteria team working to find a solution to either re-staff the hotel or evacuate passengers
- Media team aware and preparing reactive lines + lines for tomorrow
- Contact tracing of the further four guards has commenced
- RCH and Monash have been made aware that there is a link to the Stamford and there may be further media coverage tomorrow.

This will be updated in the outbreak reports this evening, however given high profile of the case wanted to ensure you all have the information at hand.

Please let me know if there are further questions.

Kind Regards

Annaliese

Dr Annaliese van Diemen MBBS BMedSc MPH FRACGP FAFPHM
Public Health Commander- COVID-19 Department Incident Management Team

Deputy Chief Health Officer (Communicable Disease)
Regulation, Health Protection & Emergency Management
Department of Health & Human Services | 14 / 50 Lonsdale St
REDACTED
health.vic.gov.au/public-health

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.

Outbreak summaries - 3 June

From: Simon Crouch (DHHS) REDACTED

To: Annaliese Van Diemen (DHHS) REDACTED Brett Sutton (DHHS) REDACTED

Cc: Jacinda de Witts (DHHS) REDACTED Annalise Bamford (DHHS) REDACTED Kym Peake (DHHS) REDACTED Kira Leeb (DHHS) REDACTED Terry Symonds (DHHS) REDACTED sccvic.stateintelmgr@scc.vic.gov.au, Jason Helps (DHHS) REDACTED, Andrea Spiteri (DHHS) REDACTED Katherine Ong (DHHS) REDACTED Simon Crouch (DHHS) REDACTED Sarah McGuinness (DHHS) REDACTED covid-19projectmanagementoffice (DHHS) <covid-19projectmanagementoffice@dhhs.vic.gov.au>, Melissa Skilbeck (DHHS) REDACTED

Date: Wed, 03 Jun 2020 20:31:47 +1000

Dear Annaliese and Brett

Please see today's outbreak summaries below. There are no new outbreaks and no new cases linked to these outbreaks.

THIS EMAIL MAY CONTAIN SENSITIVE PATIENT AND EXPOSURE SITE INFORMATION AND IS NOT FOR FURTHER DISTRIBUTION.

REDACTED **Family Cluster**

- * A total of 13 cases have been associated with one large family group comprising four households and their contacts. REDACTED
- * The IPC squad has visited all four households associated with this family group on RE May and reported on adequacy of isolation, IPC measures and any other welfare needs.
- * One of the families have been provided with alternative accommodation as they were unable to adequately isolate in their usual dwelling.
- * Another family group with R infected people have been provided with alternative accommodation, so that those cleared from isolation are able to separate from those who continue to be infectious.
- * The first case was reported on RE May with comorbidities who was admitted to hospital and ICU. This case is improving and the treating team are aiming for a potential discharge on Friday.
- * RED family members were diagnosed on RE May. On RE May a case was identified in a close contact from a different household and subsequent screening has identified R further household cases as of R May.
- *R family members who are currently "close contacts" in one of the houses have developed symptoms and testing has occurred today.
- * These cases attended or worked in their infectious periods at a number of sensitive settings and a workplace:

- [redacted] one case attended on 26 May during their infectious period
  - * Around 66 [redacted] identified as close contacts (including 5 [redacted] from [redacted] and 1 [redacted]). All are in quarantine and will undergo return to [redacted] testing. Return to [redacted] testing has been communicated to the [redacted] and is being organised to occur through Sunshine Hospital.
  - * [redacted] aware
  - * Outbreak response squad visit. Clean occurred.
  - * Advised that [redacted] has re-opened today (1 June)
- [redacted] one case attended on 26 May during their infectious period (asymptomatic)
  - *[redacted] aware
  - * Students in year [redacted] class all considered close contacts (21 students, and 6 staff). All are in quarantine and will undergo return to school testing. Return to school testing has been communicated to the school and is being organised through Sunshine Hospital.
  - *[redacted] staff members were symptomatic and have been tested – results both negative
  - * Outbreak response squad visit. Clean occurred.
  - * Expecting school to open on Wednesday
- [redacted] **Laverton**
  - * Workplace of **three** family members (2 of 3 +ve; 1 -ve)
  - * Both confirmed cases worked [redacted] May while infectious
  - * One confirmed case had extensive contact with workers across the site
  - * Around 21 close contacts identified. Further 8 staff identified but not close contacts (were working from home). Potential for index case to have acquired COVID-19 from this site, so all staff (21 close contacts and 8 additional staff) have been tested – results pending.
  - * Site closed. Deep clean undertaken. Outbreak response squad have visited. Return to work testing will be undertaken.
  - * Worksafe aware
  - * EPA aware
    - [redacted] **Hospital** [redacted] **Hospital**
      - Two cases attended [redacted] Hospital and [redacted] Hospital 15-18 May. One was a patient, the other [redacted] husband.
      - Infectious periods from 15 and 16 May.
      - Exposure sites during infectious period: [redacted] hospital ED, ambulance transfer to [redacted] [redacted] hospital theatre and ward.
      - [redacted] Health IPC aware and commencing contact tracing (noting more than 14 days have elapsed since initial exposure).
      - No close contacts identified from [redacted] Hospital (appropriate PPE used). 16 close contacts identified through [redacted] Hospital – all in quarantine and have been tested. 11 results are negative, 5 are pending.
- * A pop up testing clinic has opened in [redacted] with targeted promotion of symptomatic testing to local communities, school communities.
- * Liaison with local Pasifika community via DPC and local government. Round table with community leaders took place this week

[redacted]

- * One case has been identified in a staff member at this residential aged care facility.
- * The case worked for one day while infectious. However they worked multiple shifts during their acquisition period.
- * Six staff members and 18 residents have been identified as close contacts. All residents on the ward where the case worked are being classified as close contacts. Further contact tracing of visitors and external close contacts is under way.
- * A member of the department outbreak control squad and a Commonwealth clinical first responder visited the site on 2 June to perform an assessment and provide training and support. The facility is being supported with supplies of PPE.
- * Testing for all staff (131) and residents (97) was undertaken on 2 and 3 June. 107 of the 131 staff and all 97 residents have tested negative. The remaining 20 staff will be tested on 4 June.
- * The day 11 testing date for residents and staff who are close contacts of cases 2 and 3 is

being organised for 7 June.

Rydges

- * 12 cases have been linked to this outbreak – 7 are staff who work REDACTED at Rydges on Swanston. 1 REDA staff, 5 security staff and 1 REDACTED e. Five are household close contacts
- * A commercial clean of relevant areas of the hotel has occurred.
- * All staff cases worked REDACTE at Rydges on Swanston, overlapping on R May.
- * One staff case is asymptomatic, the other 6 have symptom onset dates ranging from 24 to 29 May (3 have the same symptom onset date = 25 May)
- * Current hypothesis is that the hotel is the source of infection, either from environmental contamination in the week prior to 25 May, or possibly from an unrecognised case(s) or known hotel case; at this stage it is not possible to definitively determine.
- * It is likely that environmental risk has been attenuated following a deep clean of the premises on 28 May.
- * All staff who attended the site between 11 and 28 May asked to seek testing for COVID-19.
- * As of 30 May, any staff member who attended the Rydges on Swanston Hotel for 30 minutes or more during the period 18 May to midday on 28 May inclusive is now being asked to **self-quarantine for 14 days** since their last visit to the hotel.
- * Education and training on appropriate PPE by outbreak squad nurses (particular focus on security staff who have been wearing non-approved porous gloves)
- * All staff close contacts will be required to be re-tested prior to completing their 14 day quarantine period.
- * Due to difficulties in staffing the Rydges, alternative accommodation was sought. Residents have been moved today to a different hotel in the CBD. Department outbreak control squad nurses have visited this hotel and are providing training and support to enable the lifting of restrictions. It is expected that following training of security staff today (3 June) that restrictions can be lifted tomorrow (4 June)
- * Genomics has identified that case 1 clusters with a family of returned travellers who have stayed at the hotel. Genomics on case 2 has identified that it also clusters with case 1.
- * This outbreak is active and under investigation. There is no projected closure date.

REDACTED

- * Three confirmed case have been linked to this outbreak in an aged care facility (1 resident and 2 staff)
- * Symptom onset for case 1 was 16 May. The case was admitted to the REDACTED on RE May following a fall. They have met clearance criteria. They will remain at the REDACTED
- * The facility advised that a resident with symptoms of a respiratory illness died on the RE May. This was considered a suspected case as testing was not performed and the body has since REDACTED. Their family contacts were placed in quarantine but have now all tested negative.
- * As of 20 May, all residents in the same wing as the index case (17), and staff that worked in that wing from 14 to 17 May (21) are considered close contacts and are being quarantined. These staff will return to work on 2 June. The department has also identified 7 other close contacts including 5 family members and 2 healthcare workers.
- * All 87 residents and 103 staff have received negative results from initial testing.
- * Testing was arranged for a further 7 staff members. Of these staff members, two have returned positive results. Both were asymptomatic at the time of testing, one case has since developed symptoms. The department is working closely with the facility to ensure appropriate measures are being put in place. Including quarantine of all residents.
- * Repeat testing for all staff and residents was undertaken on 26 - 28 May. All permanent staff and residents (85 residents, 105 staff) have tested negative. There are some results from agency and contract staff which are pending.
- * PPE training was conducted on 21 May by outbreak squads, IPC site visits occurred 26, 27 and 28 May.
- * Another round of testing for all residents, staff and contractors is planned for Friday 5 June and will guide outbreak closure planning.
- * This outbreak is active and under investigation. There is no projected closure date.

REDACTED

- * There are two confirmed cases in residents of this aged care facility. Case 1 – symptom onset 17 May; case 2 – asymptomatic (test positive 23 May)
- * All staff at the site have undergone an initial round of testing with negative results. A second round of staff testing has also been performed – one staff member is yet to be tested (returning from leave on 4 June); two have pending results, and the remainder have tested negative.
- * All but one of the residents have been tested. The resident who has not been tested has REDACTED has consistently refused testing. Both cases live in separate areas of the facility. The resident who has not been tested lives in a separate area of the facility to both cases.
- * Following an infection control assessment by Alfred Health, case 2 has been moved back into their residence. There had been concerns regarding RED mental health and wellbeing while isolating in the REDACTED The department has outlined specific requirements for case 2 to be safely isolated REDACTED
- * Case 1 has received 2 x negative swabs and is now cleared.
- * Clearance testing for case 2 will commence on Thursday 4 June. Day 11 testing for close contacts of case 2 (6 residents, 14 staff) will also be conducted on 4 June
- * Staffing support is being provided by the Commonwealth
- * This outbreak is active and under investigation. Projected release date for REDACTED REDACTED case 2 resides is early next week, if clearance testing for residents and staff is negative and everyone remains asymptomatic.

Public Health and Wellbeing Act 2008

Instrument of authorisation under section 199

Interpretation

In this instrument:

Act means the *Public Health and Wellbeing Act 2008*.

Chief Health Officer means the person appointed as Chief Health Officer under section 20 of the Act.

emergency powers means the powers set out in section 200 of the Act.

Minister means the Minister of the Crown administering section 198 of the Act.

public health risk powers means the powers set out in section 190 of the Act.

serious risk to public health has the meaning set out in section 3 of the Act.

state of emergency means a state of emergency declared under section 198 of the Act.

Description

A state of emergency was declared in Victoria on 16 March 2020 for a period of four weeks. The state of emergency was extended, effective at midnight on 13 April 2020, to remain in force until midnight on 11 May 2020.

On 13 April 2020, I made an authorisation under Division 3 of Part 10 of the Act to authorise specified authorised officers to exercise public health risk powers and emergency powers for the purpose of eliminating or reducing the serious risk to public health during the state of emergency. That authorisation commenced on midnight 13 April 2020 and was stated to remain in force until midnight on 11 May 2020.

Since 13 April 2020, I have made a series of additional authorisations under Division 3 of Part 10 of the Act. Each of those additional authorisations was stated to remain in force until midnight on 11 May 2020. I refer to the authorisation of 13 April 2020 and these additional authorisations as the **existing authorisations**.

On 11 May 2020, the Minister, under s 198(7)(c) of the Act, extended the state of emergency with that extension taking effect at midnight on 11 May 2020 and being stated to remain in force until 11:59:00 PM on 31 May 2020.

As the state of emergency will extend beyond 11 May 2020, this instrument, under s 201(4) of the Act, extends the period for which the existing authorisations continue in force so that the authorised officers authorised under the existing authorisations may continue to exercise public health risk powers and emergency powers for the purpose of eliminating or reducing the serious risk to public health during the state of emergency as extended.

Further, if the state of emergency is extended beyond 31 May 2020 under s 198(7)(c) of the Act, that will be because the Minister, following the processes specified in s 198 (including, in practice, taking the Chief Health Officer's advice) considers that a serious risk to public health continues to arise from Novel Coronavirus 2019 (**2019-nCoV**). If this occurs, it will be necessary for authorised officers to continue to exercise public health risk powers and emergency powers and to do so without a break in continuity. This instrument therefore, under s 201(4) of the Act, also extends the period of time for which the existing authorisations continue in force so that it continues in force as long as the state of emergency exists.

Authorisation

I, **Adjunct Clinical Professor Brett Sutton, Chief Health Officer of Department of Health and Human Services,** under s 201(4) of the Act, extend the period of time of the authorisation given by me under each of the existing authorisations under s 199 in Part 10, Division 3 of the Act so that each:

- continues in force until 11:59:00 PM on 31 May 2020; and
- if the state of emergency is extended beyond 31 May 2020 under s 198 of the Act, continues in force as long as the state of emergency exists.

I believe it is necessary to continue the existing authorisations in order to eliminate or reduce a serious risk to public health, being the risk arising from 2019-nCoV throughout the State of Victoria. I also believe that, if the state of emergency is extended beyond 31 May 2020, it will be necessary for the existing authorisations to continue to eliminate or reduce a serious risk to public health, being the risk arising from 2019-nCoV throughout the State of Victoria, a risk that will have been found to continue to exist in order for the state of emergency to be further extended.

The authorisation, as extended:

- Authorises the officers in column 2 of the Schedule to each of the existing authorisations, being authorised officers appointed by the Secretary of the Department of Health and Human Services (or her delegate) under s 30 of the Act, to exercise any of the public health risk powers and emergency powers.
- Has no restrictions or limitations as to which of the public health risk powers or emergency powers may be exercised under the authorisation.
- For the purposes of clarity, column 2 of the attached Schedule identifies each of the authorised officers to which this instrument applies.

Commencement

This instrument commences at midnight on 11 May 2020 and continues in force until 11:59:00 PM on 31 May 2020, except if the state of emergency is extended beyond 31 May 2020 in which contingency it continues in force as long as the state of emergency exists.

Signed at **Melbourne** in the **State of Victoria**
This 11th day of May 2020
Time: 17:30

Adjunct Clinical Professor Brett Sutton
Chief Health Officer
Department of Health and Human Services

Schedule

Source of power:	*Public Health and Wellbeing Act 2008*
Holder of power/function:	Chief Health Officer
Authority type:	Authorisation

Public health risk powers and emergency powers

COLUMN 1 Statutory provision	COLUMN 2 Authorised officers		COLUMN 3 Limitations/ restrictions
Section 199 of the Act	The following authorised officers that have been appointed by the Secretary (or her duly appointed delegate):		
	REDACTED • Angela (Angie) Bone REDACTED • Annaliese Van Diemen REDACTED • Anthony Kolmus REDACTED • Finn Romanes REDACTED	REDACTED • Daniel (Danny) Csutoros REDACTED	N/A

COLUMN 1 Statutory provision	COLUMN 2 Authorised officers	COLUMN 3 Limitations/ restrictions
Section 199 of the Act	The following authorised officers that have been appointed by the Secretary (or her duly appointed delegate): REDACTED REDACTED • Meena Naidu REDACTED • Murray Smith REDACTED	

COLUMN 1 Statutory provision	COLUMN 2 Authorised officers	COLUMN 3 Limitations/ restrictions
Section 199 of the Act	The following authorised officers that have been appointed by the Secretary (or her duly appointed delegate): REDACTED REDACTED • Simon Crouch REDACTED	

COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan

Confidential and internal draft plan

4 April 2020 – 17:00

Contents

Background

In Victoria, the term ‘physical distancing’ will be used, in preference to the term ‘social distancing’.

A recent summary of the value of social distancing in relation to the COVID-19 emergency was given as:

“Social distancing is one of the key measures currently being utilised to contribute to Australia’s ability to severely limit transmission of COVID-19. This reduces the burden of disease in the community, and importantly, will ensure healthcare capacity is not overwhelmed at any given time. The health sector must continue to undertake its core functions, as well as maintain the capacity to support those with COVID-19 who require more intensive care.

The overarching goal of our recommendations is to slow the spread of the virus and flatten the epidemic curve. We all have both a community and individual responsibility to maintain social distancing and minimise interactions in order to protect the people we love. The aim is a population response, to reduce transmission to protect vulnerable populations.”

Purpose

This plan intends to:

- Provide clarity to all parts of the Department of Health and Human Services’ (the department’s) physical distancing response to coronavirus disease 2019 (COVID-19);
- Describe the strategy and protocols for the physical distancing response;
- Describe the compliance and enforcement policy for all directions, including mandatory detention policy;
- Inform internal and external communications collateral around physical distancing.

Scope

In scope for this policy are:

- Physical distancing interventions in Victoria;
- Quarantine and isolation interventions in Victoria implemented for any reason.

Authorising environment

Chief Health Officer and Deputy Chief Health Officer

Under a state of emergency declared by the Victorian Government, he Chief Health Officer and Deputy Chief Health Officer have exercised powers to make a range of Directions that reflect physical distancing controls in Victoria, as described in Annexes to this plan.

Emergency Management Commissioner and State Controller

State Controller (Class 2) is appointed to coordinate the overall response, working within the emergency management arrangements.

National Cabinet

National Cabinet for COVID-19 has released statements of policy on social distancing (physical distancing). These are reported to have been based on advice from the Australian Health Protection Principal Committee (AHPPC). The AHPPC releases its advice in statements which are published online.

Victoria Police

Advice has been sought from Legal Services as to the role of Victoria Police. As of 31 March 2020, Victoria Police will undertake a greater role in managing compliance in the community including issuing of infringement notices. As a result, the role of DHHS authorised officers in specific support to Victoria Police around compliance checks will

reduce as Victoria Police have a range of powers considered sufficient to investigate, including to issue infringements and fines.

Governance of physical distancing policy within the DIMT

A Physical Distancing Cell will be chaired by the Deputy Public Health Commander – Planning, on behalf of the Deputy Chief Health Officer (Public Health Commander). This will include:

- a communications lead;
- an enforcement and compliance lead, and
- an evidence and policy lead.

Policy on control measures for physical distancing

AHPPC recommendations to National Cabinet

Statements by AHPPC

The Australian Health Protection Principal Committee (AHPPC) have made a number of statements on the matter of physical distancing (social distancing). These are available at TRIM location HHSF/20/7891, and on the web at https://www.health.gov.au/news/latest-statement-from-the-australian-health-protection-principal-committee-ahppc-on-coronavirus-covid-19-0

The most recent AHPPC statement was 30 March 2020.

National requirements from National Cabinet

The National Cabinet has made announcements through the Prime Minister, including a statement relating to social distancing on 24 March and as recently as 30 March 2020.

Legal directions under emergency powers in Victoria

Directions work within legal services

A team within the department's Legal Services Branch has been established, including order to draft Directions under the state of emergency, for the Chief Health Officer and Deputy Chief Health Officer. The Legal Services Branch is not available to provide third party legal advice on Directions and their compliance or otherwise.

Process for creating Directions

The process involves a number of steps, some of which are iterative as the policy underlying the Direction is developed.

These steps include – but are not limited to –

- Policy area develops a need for a Direction under the state of emergency;
- Legal services commence work to create instructions;
- Secretary finalises required directions content to Legal Services;
- Legal Services instructs parliamentary counsel to draft instructions;
- Final check undertaken with Chief Health Officer or Deputy Chief Health Officer;
- Direction is signed;
- Direction is published on the webpage;
- A communications approach is initiated, including a press release and frequently asked questions.

Critical step in creation of Directions

The Deputy Chief Health Officer has identified a minimum requirement for an evidence-informed policy rationale to be recorded prior to the issuing of directions, and that this evidence-informed rationale extends beyond the general observation of a state of emergency having been declared. Such a short evidence summary could be produced by the Intelligence function.

Directions

At the current time, Directions and detention orders are generally signed by Dr Annaliese van Diemen (Deputy Chief Health Officer) as authorised by the Chief Health Officer.

Consideration is being given to expanding the list of authorised officers who can sign directions to include other Senior Medical Advisors within the response who are Authorised Officers.

List of Directions

The following 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:

- *Direction on airport arrivals (Annex 1) – 18 March 2020 (revoked 30 March 2020 - still displayed for reference);*
- *Direction on cruise ships docking (Annex 2) – 19 March 2020 (revoked 30 March 2020 - still displayed for reference);*
- Direction on aged care (Annex 4) – 21 March 2020;
- Direction on hospital visitors (Annex 6) – 23 March 2020;
- Direction on isolation (diagnosis) – 25 March 2020;
- Direction on revocation of airport arrivals and cruise ship directions – 28 March 2020;
- Direction on detention notice – Undated (first posted 28 March 2020);
- Direction on stay at home – 30 March 2020;
- Direction on restricted activity – 30 March 2020.

Summary of legally required actions in Victoria with a focus on physical distancing

The Directions in place are available online, and at the TRIM location HHSF/20/7901.

The summary of the key requirements in all seven active directions, across four themes, is below (linking to the Direction itself for more detail).

Directions on visitors to aged care facilities – 21 March 2020

- Prevents entering or visiting aged care facilities unless goods and services are necessary, and if the person meets criteria for a suspected case or is ill or is not up to date with vaccination or is under 16;
- Some exemptions including employee, care and support, end of life visit.

Directions on hospital visitors – 23 March 2020

- Prohibits non-essential visits to hospitals, including for categories of patients, workers and visitors;
- Exceptions include patients. Exemptions can be granted.
- Prohibits non-essential business operation from noon on 23 March 2020, including for pubs, hotels, gyms,

Directions on isolation – 25 March 2020

- Prohibits movement out of isolation until a person is not longer required to be in isolation by DHHS but allows a person not in their home to go directly there after diagnosis.

Direction – detention notice – 27 March 2020

- Orders 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 specified room in a hotel, with only limited reasons wherein leaving the room can be allowed.

Direction on stay at home – 30 March 2020

- Restricts the way by which people can leave their home making an effective requirement to stay at home except in certain circumstances, restricts gatherings to two people in most instances with some exceptions.

Direction on restricted activity – 30 March 2020.

- Expands restrictions on certain businesses and undertakings put in place as part of non-essential activities restrictions, for example to include playgrounds.

Directions that have been revoked

The following Directions have been issued but have been revoked. Information is included for reference.

Direction on airport arrivals -18 March 2020

- *Anyone who arrives at an airport in Victoria on a flight that originated from a place outside Australia, or on a connecting flight from a flight that originated from a place outside Australia must self-quarantine for 14 days after arrival, if arrived after 5pm on 18 March 2020;*
- *Sets rules on being in quarantine – cannot leave home except in an emergency and cannot allow people to enter unless they live there.*

Directions on cruise ship docking – 19 March 2020

- *Anyone who disembarks at a port in Victoria from an international cruise ship or an Australian cruise ship (which is on a voyage from a port outside Australian territory) must self-quarantine for 14 days after arrival.*
- *Allows for some exceptions (goes interstate directly, or to hospital).*

Directions on mass gatherings – 21 March 2020

- *Non-essential mass gatherings are prohibited (not allowed to be organised, allowed or attended). A mass gathering means:*
  - *A gathering of five hundred or more persons in a single undivided outdoor space at the same time;*
  - *A gathering of one hundred (100) or more persons in a single undivided indoor space at the same time.*
- *In addition, the total number of persons present in the indoor space at the same time does not exceed the number calculated by dividing the total area (measured in square metres) of the indoor space by 4, meaning a limit of one person per four square metres (2x2m).*
- *Many specified exemptions, including for some forms of transport, schools, prisons, Parliament or where CHO or DCHO issue an exemption.*

Directions on non-essential business closure – 23 March 2020

- *Prohibits non-essential business operation from noon on 23 March 2020, including for pubs, hotels, gyms, places of worship, other specified businesses;*
- *No exemptions process is specified – it is an inclusive list.*

Directions on prohibited gatherings – 25 March 2020

- *Non-essential gatherings are prohibited from midnight on 25 March 2020 – not to be organised, allowed or attended.*
- *Adds two additional prohibited mass gatherings which are social sport gatherings and weddings and funerals.*
- *Specifies a density quotient, with examples.*
- *A mass gathering means:*
  - *A gathering of five hundred or more persons in a single undivided outdoor space at the same time;*
  - *A gathering of one hundred (100) or more persons in a single undivided indoor space at the same time.*
- *Many specified exemptions, including social sport gatherings (two or more people), weddings, and funerals (no more than 10 people – indoors or outdoors), some forms of transport, schools, prisons, Parliament or where CHO or DCHO issue an exemption.*
- *Allows for exemptions to be asked for and granted.*

Directions on non-essential activities – 25 March 2020

- *Prohibits categories of non-essential activity;*
- *Adds requirement for signage, cleaning and disinfection on businesses that remain open;*
- *Includes prohibition on licensed premises, personal training facilities, outdoor personal training limited to ten persons, entertainment facilities, non-essential retail facilities, food and drink facilities, accommodation facilities, swimming pools, animal facilities, auctions;*
- *Exceptions include essential public services such as food banks, wedding venues, recording of performances, time-limited haircuts, delivery of goods, densely packed markets (density rule), food and drink facilities in certain places (hospitals for example); some types of accommodation facility.*

Announced stages of restrictions in Victoria

Stage 1 restrictions

Victoria announced 'stage 1 restrictions' on 22 March 2020 and 23 March 2020 and implemented effective midday 23 March 2020. These included:

- Bringing school holidays forward to commence starting on Tuesday 24 March;
- Ceasing non-essential business activity including:
  - pubs, bars or clubs, or hotels (other than to operate a bottleshop, take-away meals or accommodation),
  - gyms,
  - indoor sporting centres,
  - the casino,
  - cinemas,
  - nightclubs or entertainment venues of any kind,
  - restaurants or cafes, other than to the extent that it provides takeaway meals or a meal delivery service
  - places of worship, other than for the purposes of a wedding or funeral.

https://www.premier.vic.gov.au/statement-from-the-premier-32/

https://www.premier.vic.gov.au/statement-from-the-premier-33/

https://www.premier.vic.gov.au/wp-content/uploads/2020/03/200323-Statement-From-The-Premier-1.pdf (this includes a copy of the Deputy Chief Health Officer direction)

Stage 2 restrictions

Stage 2 restrictions were announced on 25 March 2020. Further to the stage 1 restrictions, these further restrictions include:

- Ceasing operation of:
  - Recreation facilities (indoor and recreation facilities, personal training facilities, community centres and halls, libraries, galleries and museums, youth centres and play centres (other than for essential public services);
  - Entertainment facilities (in addition to entertainment facilities already covered in stage 1, stage 2 added theatres, music and concert halls, auditoriums, arenas, stadiums, convention centres, arcades, amusement parks, gambling businesses, brothels, sex on premises venues, and strip clubs);
  - Non-essential retail facilities (beauty and personal care, auction houses, market stalls - other than for the provision of food and drink and subject to density provisions);
  - Food and drink facilities (in addition to stage 1, stage 2 added fast food stores, cafeteria's and canteens, and food courts) but maintaining the ability to provide take away;
  - Camping grounds and caravan parks;
  - Swimming pools (other than private pools not for communal use);
  - Animal facilities (zoos including petting zoos, wildlife centres, aquariums or animal farms not for food production);

  - Real estate auctions (other than remotely) and inspections (other than by appointment);
- Introduced a density quotient for retail facilities of 1 per 4m2 and increased cleaning requirements;
- Introduced a restriction social sport gatherings;
- Limited attendees at weddings (5 people) and funerals (10 people).

Prohibits operation of non-essential businesses and undertakings to slow spread. Cafes and food courts must stop providing table service, but may continue to offer delivery and takeaway. Cafes and canteens may continue to operate at: hospitals, care homes and schools, prisons, military bases, workplaces (though only as a takeaway service). Auction houses, real estate auctions and open house inspections, non-food markets, beauty and personal care services.

https://www.premier.vic.gov.au/wp-content/uploads/2020/03/200325-Statement-From-The-Premier-1.pdf

Stage 3 restrictions

These restrictions came into effect at midnight on 30 March 2020, and are:

- Gatherings are restricted to no more than two people except for members of your immediate household and for work or education purposes;
- Requirement to stay home will become enforceable;
- Playgrounds, skate parks and outdoor gyms will also close;
- There are only four reasons to be out:
  - Shopping for what you need – food and essential supplies;
  - Medical, care or compassionate needs;
  - Exercise in compliance with the public gathering requirements;
  - Work and study if you can't work or learn remotely;
- Moratorium on evictions introduced;
- Rules for weddings (no more than five people to attend) and funerals (no more than ten people can attend).

Essential services and non-essential services

A listing of the Victorian classification of essential compared to non-essential is under development.

Summary of strong recommendations in Victoria on physical distancing (should) – top lines

In addition to Directions, the Chief Health Officer provides a number of strong recommendations around physical distancing that are considered critical for suppressing any transmission of COVID-19 in Victoria at the current time.

The top lines at the present time are:

- Play your part and do the right thing or Victorians will die.
- Wash your hands.
- Cough into your elbow.
- Keep your distance from other people. Keep 1.5 metres between yourself and others
- Stay at home.
- If you can stay home, you must stay home.
- Stay in your own house and do not go to someone else's house.
- If you don't need to go out, don't go out.
- Do not go out if you are sick except to seek medical care.
- Shop for what you need, when you need it – do not go shopping unless you have to.
- If you can work from home, you should work from home.
- If you go to work, you must follow all the social distancing rules.
- Keep a distance of 1.5 metres is between yourself and others.
- Stop shaking hands, hugging or kissing as a greeting.

- Work from home where possible.
- If you have had close contact with a confirmed case of COVID-19 in the previous 14 days you must self-isolate and must not participate in community gatherings including community sport.
- Stay home if you are sick and don't expose others. If you are unwell with flu-like symptoms, do not go outside your property or home, do not go to work, school or shops unless it is essential – for example to seek medical care.
- Do not travel interstate, overseas or take a cruise. Avoid unnecessary travel.
- Everyone should avoid crowds if possible. If you must be in a crowd, keep the time short.

Policy development and decision-making

Evidence for physical distancing policies

Physical distancing between people aims to minimise interactions between people to limit the opportunities for disease to spread from an infected person to an un-infected person. Measures to bring about physical distancing amongst populations have been utilised in previous efforts to control influenza epidemics and pandemics.

Observational and modelling studies have provided evidence to help guide the use of physical distancing measures for influenza. Although these can provide some insight into how we might expect physical distancing to influence the progression of the COVID-19 pandemic, COVID-19 has its own disease characteristics which will influence the impact of physical distancing measures.

Evidence of the impact of social distancing is beginning to emerge from countries in which the epidemic commenced earlier than in Australia, particularly China. Additionally, modelling studies using information on the epidemiological features of COVID-19 are estimating the impact of different physical distancing measures.

To ensure that Victoria's approach to physical distancing is informed by the best-available evidence, an evidence summary will be produced and updated as new results emerge from the global scientific community. The current summary of evidence for physical distancing is at **Appendix 2**. This will be updated regularly.

International and national comparisons

Reports outlining the physical distancing interventions in place in other Australian states and internationally will be developed and updated on an ongoing basis. These will be updated weekly in the first instance, however the current summary of comparisons for physical distancing is at **Appendix 6**.

Evaluation of physical distancing policies

A range of measures to evaluate the efficacy of all interventions will be developed. In the first instance, these measures will include those suggested by the AHPPC:

- Evidence for efficacy of strengthened border measures/ travel advisories: reduction in the number of imported cases detected over time;
- Evidence of efficacy of the reduction in non-essential gatherings and mixing group sizes: reduction in the average number of secondary infections per case, based on contact tracing;
- Evidence for the combined efficacy of case finding and contact quarantine measures augmented by social distancing: reduction in the rate of growth of locally acquired infected cases;
- Evidence for the effectiveness of isolation: time from symptom onset to isolation.

The Intelligence function will develop a framework for monitoring and advising on progress with the effectiveness of physical distancing interventions in Victoria, to inform understanding of the Chief Health Officer and other colleagues, including decision-makers.

Next steps for physical distancing interventions

Scenario modelling and factors determining scaling back of physical distancing will be considered and incorporated in this section of the Plan.

Initial draft considerations relating to scaling back physical distancing interventions have considered – but not determined – whether factors like those listed below might prompt consideration.

Factors might include situations where:

- Societal tolerance of physical distancing measures is breached, or
- a vaccine is available and is being implemented, or
- underlying immunity (‘herd immunity’) is above a certain level (which is more than 70%, or calculated as 1/Ro, based on current reproductive number of around 2.4-2.7), or
- transmission will lead to manageable illness within an agreed intensive care unit capacity level, or
- transmission has been interrupted, mitigated, or stopped for a certain period.

Compliance and enforcement for physical distancing

Purpose of this section

The purpose of this compliance protocol is to set out the compliance approach in relation to Deputy Chief Health Officer (D/CHO) directions under *Public Health and Wellbeing Act 2008* (PHWA).

Scope of compliance and enforcement

The scope of enforcement and compliance activity will include persons and situations listed below:

- People under quarantine for any reason, including travel or close contact;
- People under isolation for any reason, including suspected cases and confirmed cases;
- Mass gatherings and any matter relating to any Direction relating to physical distancing, including visitation restrictions.

Chain of command for enforcement and compliance

It has been agreed with the Chief Health Officer and Deputy Chief Health Officer that the chain of command for matters relating to physical distancing (especially and including enforcement and compliance actions) interventions – in particular the compliance and enforcement activities relating to directions - is:

- Chief Health Officer to
- Public Health Commander to
- Deputy Public Health Commander (Planning) to
- Director Health and Human Services Regulation and Reform to
- Manager Environmental Health Regulation and Compliance to (where necessary -
- Victoria Police).

Strategy for compliance and enforcement

Intended outcome of compliance and enforcement activity

The outcomes being sought are to reduce the transmission COVID-19 through a range of interventions, including: quarantine for 14 days of those returning from overseas, isolation of those suspected to have or confirmed to have COVID-19, application of restrictions on non-essential mass gatherings, restricted entry into aged care facilities where vulnerable populations reside and closure of non-essential business. Actions should focus on achieving outcomes, be risk-based and minimise transmission risks in the Victorian community.

Strategy for focus of compliance and enforcement activity

The focus of activity will be on:

- Implementation of a mandatory detention program for new arrivals from overseas;
- Spot checks by Victoria Police of people who should be in quarantine or isolation;
- Mass gathering compliance and enforcement by Victoria Police.

These priorities will change, and likely expand into specific and more targeted risk-based compliance for highest-risk individuals in quarantine or isolation.

The department will consider enhanced monitoring arrangements and consider indicating to Victoria Police that other methods are considered, such as tracking of individuals through mobile phones, or random sampling calls to mobile phones of individuals if agreed. These methods are not yet formally under consideration.

Approach to compliance and enforcement – prioritisation framework for compliance activities

This will be based on a risk framework, based on public health risk.

An initial frame for Victoria Police was provided on 25 March 2020 and was:

- Cases diagnosed after midnight tonight.
- Passengers who have disclosed country visited in one of the higher risk countries? Which ones?
- Random selection of age cohorts from passenger list (of those who arrived less than 14 days ago) so that we can start to gauge which cohorts are the most likely to not comply.
- Pubs/clubs etc. (should be fairly easy to gauge with overnight crews.)
- Any allegations received from DHHS or VicPol Police Assistance Line.
- Selection of commercial premises mentioned in latest direction.

The proposed new preliminary order for focus of compliance and enforcement based on a public health risk assessment is (highest priority is first) from 26 March 2020 and updated 1 April 2020:

- Returned travellers from overseas who are in mandatory quarantine;
- Returned travellers from overseas who have indicated they do not intend to adhere to quarantine (self-isolation);
- Mass gatherings that are underway where there is alleged non-compliance with Directions;
- Cruise ships where there is potential or alleged non-compliance with Directions;
- Non-essential businesses where there is potential or alleged non-compliance with Directions;
- Confirmed cases who indicate they do not intend to isolate or are suspected not to be isolating;
- Known close contacts who indicate they do not intend to isolate or are suspected not to be isolating;
- Individuals where there is a report that a person is not adherent to quarantine or isolation;
- All other confirmed cases in relation to isolation Direction;
- All other close contacts;
- Prohibited gatherings (other than mass gatherings) that are underway or alleged non-compliance with Directions;
- Non-essential activities that are alleged to be non-compliant with Directions.

The Director of health and Human Services Regulation and Reform will communicate these priorities as a control agency advice to Victoria Police on a daily basis or as updated.

Linking members of the public to compliance action by Victoria Police

Linking occurs by:

- Callers may select the social distancing advice line between 8am and 8pm at DHHS by calling 1800 675 398 and selecting option 2.
- Callers may speak to Victoria Police by calling 1800 675 398 and selecting option 4.
- Callers who come through to any other line should be referred to the 1800 675 398 line and advised to select option 4.
- Members of the public are encouraged to call the phone line, rather than emailing their concerns.
- If concerns are emailed from the public about compliance with directions excluding those that are about close contacts and confirmed cases, the email should be forwarded to the Victoria Police complaints inbox, which is COVID-19.vicpol@dhhs.vic.gov.au

Department of Health and Human Services Liaison to Victoria Police

The department has established a roster of Emergency Management Liaison Officers at the State Control Centre, associated with the Police Operations Centre. The roster for the EMLO is on the board at the State Emergency Management Centre.

The EMLO is provided with the details of the DHHS oncall Authorised Officer each day to pass onto the Victoria Police SPOC for the overnight periods when the EMLO position is unstaffed.

Department of Health and Human Services initiation of compliance activity

If concerns are emailed from the public about compliance by close contacts and confirmed cases, the Operations Officer should oversee an investigation by the case and contact management team. If the case and contact management team assess that compliance action is required, they should contact the DHHS EMLO on the roster to agree how Victoria Police can assist, and may need to email details to the COVID-19 Victoria Police DHHS email address, which is COVID-19.vicpol@dhhs.vic.gov.au

Peer influence, education and community awareness to guide approach

It is anticipated that there will be high levels of voluntary compliance by those impacted by the Directions. This is due to high levels of community awareness, strong community support for measures to prevent transmission of COVID-19.

Exercising a Direction and considerations of enforcement

DHHS authorised officers are empowered to direct a person to comply with a D/CHO Direction (exercising the emergency powers). Victoria Police can assist an authorised officer to exercise a direction. Victoria Police are now undertaking a range of actions, including enforcement actions such as infringements.

Consideration of enforcement action, such as a prosecution under the PHWA, should generally only be pursued where there is a deliberate intention to not comply and/or repeated failure to comply with a direction.

Victoria Police COVID 19 Taskforce Sentinel

A Victoria Police taskforce of 500 officers will promote and assess compliance with directions and perform spot-checks, such as visiting those who have recently returned from overseas. The taskforce is coordinated through the Police Operations Centre. Information for spot checks can be provided directly to through Victoria Police SPOC.

Victoria Police support to DHHS compliance activity

Victoria Police (VicPol) will support DHHS to respond to allegations of non-compliance with the directions. This includes:

- receiving reports of non-compliance with directions through the Victoria Police Assistance Line (1800 675 398 – option 4);
- seeking to influence compliance and address non-compliance through spot checks, reiterating obligations, providing education and issuing infringements;
- where required, assisting DHHS authorised officers to provide a direction to a member/s of the public.

Contacting the Victoria Police Special Operations Centre

Victoria Police Special Operations Centre private number REDACTED if a senior officer in DHHS needs to contact the SPOC directly for an urgent reason.

The DHHS EMLO to Victoria Police is available through a roster in the SEMC.

Infringements

On 28 March 2030, the Public Health and Wellbeing Regulations 2019 were amended to create four new infringement offences to strengthen enforcement specifically around the emergency and public health risk powers. These are:

- hinder or obstruct an authorised officer exercising a power without reasonable excuse (5 penalty units);
- refuse or fail to comply with a direction by CHO to provide information made under s.188(10 without a reasonable excuse (10 penalty units for natural person and 30 penalty units for body corporate);
- 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);
- refuse or fail to comply with a direction, or a requirement made of, a person in the exercise of a powers under a authorisation (10 penalty units for natural person and 60 penalty units for body corporate).

Data management to support compliance and enforcement

Department obtaining data on travellers for compliance

Authorised officers are responsible for uploading information to the business system which will then inform an upload to PHESS so that all persons in mandatory detention are recorded in PHESS for compliance and monitoring and surveillance purposes. This upload will occur under the accountability of the Director of Health Regulation and Reform. Final arrangements being confirmed

Provision of data on agreed priority groups to Victoria Police for enforcement and compliance purposes

On the direction of the Chief Health Officer, the Intelligence Officer has established a secure data portal for DHHS-Victoria Police data secure data sharing and provided a limited number of named Victoria Police officers in the COVID-19 response access. Information is being uploaded from Isolation Declaration Cards to a spreadsheet and then provided to the Intelligence Officer, who are then providing that information to Victoria Police for compliance purposes by a secure portal, on a daily basis. In conjunction with the priorities for compliance, Victoria Police can then take directed action. An information sharing agreement is under development.

Twice each day, the Intelligence Officer or delegate will upload the following to the data portal:

- Instructions on the use of the data;
- All active close contacts;
- All non-recovered confirmed cases;
- All new arrivals via scanned and uploaded Isolation Declaration Cards.

In coming days, data will be widened to include other groups if authorised by the Chief Health Officer. Further work is required to formally provide information on other categories for priority compliance activity

Specific procedures to support compliance and enforcement

Personal protective equipment for authorised officers is provided though the PPE Taskforce and the Equipment and Consumables Sector of the response. This plan will specify source.

Digital platforms to aid contact tracing and enforcement and compliance

The department will be implementing a new contact system to send daily health monitoring SMS messages to close contacts of confirmed COVID-19 cases and recently returned travellers who must isolate for fourteen days.

This system will use an Australian based system called Whispr to send messages to contacts in the department's public health monitoring systems.

People who receive these messages will be required to check in daily to:

- Confirm that they are in quarantine
- Whether they are well or experiencing COVID-19 symptoms
- Whether they have been tested and waiting for results.

Close contacts and returned travellers who are not isolating will be flagged by the system and can be further followed up as required.

This system became active from 26 March 2020.

Further work is underway to explore other systems for automating case and contact tracing.

Management of advice and exemption requests not relating to mandatory quarantine

There is no exemption clause in the Restricted Activity Direction (formerly Essential Services Direction). There is an area where exemptions occur which is in clause 11 of the Hospital Visitor Direction.

Exemptions can only be considered when there is a provision within the Direction to allow an exemption to be considered.

The Directions and Detention order give rise, broadly, to three kinds of request for advice or consideration by individuals and the public –

- Permission to leave detention requests from people in detention in Victoria;
- Exceptional circumstances requests for people seeking to not be ordered into detention (who have not yet arrived in Victoria from overseas); and
- All other requests for advice in relation to Victoria's Directions (including exemption requests for certain parts of Directions).

Only this last category will be dealt with in this part of the Plan (all other requests for advice in relation to Victoria's Directions). The other two categories will be dealt with in the Mandatory Quarantine section of this Plan.

To be specific, requests in relation to the mandatory quarantine (detention) orders or permission to leave (for people in detention) should be rapidly reviewed by staff in the call centre function if they occur, and there should generally be a presumption that these requests are forwarded immediately (within two hours) to the COVID-19.vicpol@dhhs.vic.gov.au email address for review by an Authorised Officer working directly to the Compliance Lead, as these are a high priority category of requests. The Authorised Officer will then follow the process outlined in a subsequent section of this Plan.

Process for seeking advice or requesting exemptions in relation to the Hospital Visitor Direction or other Direction

The Authorised Officer should provide advice to the requestor consistent with the *COVID -19 DHHS Physical Distancing Plan* and the Directions that are in force. The Plan is an internal document and is not for provision to members of the public. Instructions in the Directions should generally be emphasised.

Further information and consultation for an exemption relating to a direction can be undertaken by calling 1800 675 398.

The process is:

- Members of the public can submit requests to the COVID Directions inbox, including in relation to asking for advice on directions, requesting an exemption in relation to the Hospitals Visitor Direction (although that is unlikely) or in relation to asking to not have a detention order applied, or requesting a grant of leave (permission) from detention;
- Requests for advice (or Hospital Visitor exemptions) that are considered are logged on the secure MS Teams site established by Legal Services in a manner that can be audited and reviewed by any party in this compliance chain;
- The Director of Health Protection and Emergency Management who oversees the inbox and team managing this process assesses the merits of the individual proposal – including through delegates - and applies judgment as to whether advice should be provided verbally or whether advice is appropriate in writing to resolve the request, noting legal advice can be sought at any time;
- Requests are then assigned into three categories –
  - Priority 1 requests – where there is a same day urgency and importance is high;
  - Priority 2 requests – where there is complexity, lower urgency and / or medium urgency;
  - Priority 3 requests – where the authorised officer has determined that advice is given by the call centre function or staff with no further action, preferably verbally or in some rarer cases in writing;
- For priority 3 requests or where the call centre lead determines the matter is clear, if advice in writing is deemed appropriate, a written response should generally only be provided using an agreed template response, as it is preferable that advice is generally verbal in relation to directions (**Appendix 6**);
- For priority 2 requests and only where the call centre lead needs further advice, these should be batched and provided as a set of emails including a recommendation in each to an informal panel of the Deputy Public Health Commander, Compliance Lead and Legal Services to be convened every 24 hours if needed;

- For priority 1 requests, the call centre lead should email through details and a recommendation and call the Authorised Officer working directly to the Compliance Lead and discuss, and can initiate calls to the Compliance Lead at the time;
- If a request is deemed reasonable to meet, the Compliance Lead submits the proposal to the Deputy Public Health Commander Planning with a recommendation, and may call the Deputy PHC Planning to discuss and alert the DPHC to the request, including legal service advice as needed;
- The Deputy Public Health Commander assesses the recommendation and then recommends the outcome required by the Public Health Commander;
- The Public Health Commander communicates the outcome and the Compliance Lead is authorised to enact the outcome.
- Police will then be advised where any exemption is are granted by the Public Health Commander via the COVID-19.vicpol@dhhs.vic.gov.au that have relevance for enforcement and compliance by Victoria Police.

The Authorised Officer should then notify the requestor in writing the outcome of the decision of the Public Health Commander.

Formal documentation placed into the TRIM folder by the Deputy Public Health Commander or a tasking officer.

An audit of requests to check responses will be undertaken in due course, including a review of how advice was communicated publicly, if at all.

Protocols for investigating and managing potential breaches of Directions

Information is included here for reference, as Victoria Police have assumed a more independent role as to undertaking compliance and enforcement activity, with strategic direction as to highest risk groups.

Action to achieve compliance and address non-compliance

Following advice that Victoria Police can enforce directions, from 30 March 2020 Victoria Police is the primary agency responsible for investigating allegations of non-compliance and undertaking enforcement action, including the issuing of infringement notices.

Prior to this advice, existing arrangements involved referring alleged breaches to Victoria Police for investigation. If needed, Victoria Police would request DHHS authorised officer action and assistance, such as for issuing a direction.

Victoria Police may contact the DHHS Emergency Management Liaison officer seeking advice or clarification of particular circumstances

Reporting and evaluation of compliance and enforcement

The department proposes a range of checks or surveys of individuals who are directed to be in quarantine or isolation, including checks or surveys, and key metrics for evaluation. More detail will be developed in due course. Victoria Police provide a daily report on enforcement and compliance activity.

Plan for people returning from overseas to Victoria

Background to the mandatory quarantine (detention) intervention

A mandatory quarantine (detention) approach was introduced by creation of a policy that a detention order would be used for all people arriving from overseas into Victoria from midnight on Saturday 28 March 2020. An example detention order is available at https://www.dhhs.vic.gov.au/state-emergency

The objectives of the plan 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 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 an authorised officer during the period of detention;
  - A requirement to fairly and reasonably assess any request for permission to leave the hotel room / detention.

Governance and oversight of the mandatory quarantine (detention) intervention

Lead roles

The Chief Health Officer and Deputy Chief Health Officer have instituted a policy, in keeping with a conclusion from National Cabinet, that leads to issuance of detention orders for people returned from overseas.

The following lead roles are involved in the oversight of the mandatory detention intervention:

- Deputy Chief Health Officer – decision to issue a detention notice or not;
- Deputy Public Health Commander Planning – initial advice to DCHO/PHC on requests where a decision is needed whether to grant leave (permission);
- Director Health Regulation and Reform – is the Compliance Lead, for compliance and enforcement activity including authorised officer workforce – including the issuing and modification of detention orders (for example including moving a person from one room to another);
- Deputy State Health Coordinator – lead for healthcare provision to persons in detention;
- Director Health Protection and Emergency Management – lead for welfare and implementation of healthcare provision to persons in detention;
- Department of Health and Human Services Commander – lead for logistics for provision of mandatory detention involving transport and accommodation.

Information management for people in mandatory detention

A business system is being developed by BTIM to assist with the management of the healthcare and welfare for people included in this intervention.

That system articulates with the PHESS database through a common link key.

Critical information about people in mandatory detention will be uploaded to PHESS at two points in the day as a download from the business system to be used.

To be determined: the master source of who has exited the airport in mandatory detention.

To be completed: the build of the business system to support welfare and health needs of people in mandatory detention.

The Enforcement and Compliance section will ensure identities and basic compliance information of all persons in detention are entered onto PHESS through the twice daily upload process from the completed business system.

As a parallel system, Isolation Declaration Card (IDCs) are collected at the airport and batched and sent to an Australia Post call centre. The data is entered into a spreadsheet and sent to DHHS for cross entry into PHESS. This process takes approximately 24 hours. This can then be reconciled with any passenger list or people in detention list.

Enforcement and Compliance Command for Mandatory Quarantine

Deliverables of the enforcement and compliance function

The Director of Health Regulation and Compliance role 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 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.

DHHS 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 CHO. This authorisation under s.199 has an applicable end date; relevant AOs must be aware of this date. CHO has not authorised council Environmental Health Officers to exercise emergency powers

Any AO that is unsure as to whether they been authorised under s.199 should contact administrative staff in the DHHS Health Protection Branch prior to enforcing compliance with the Direction and Detention Notice.

Exercising this power imposes several obligations on DHHS authorised officers including:

- producing their identity card for inspection prior to exercising a power under the PHWA
- before the person is subject to detention, explaining the reason why it is necessary to detain the person
- if it is not practicable to explain the reason why it is necessary to detain the person, doing so as soon as practicable
- before exercising any emergency powers, warning the person that refusal or failure to comply without reasonable excuse, is an offence
- facilitating any reasonable request for communication made by a person subject to detention
- reviewing, every 24 hours, whether continued detention of the person is reasonably necessary to eliminate or reduce a serious risk to health
- giving written notice to the Chief Health Officer (CHO) 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.

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.

Following receipt of a notice, the CHO must inform the Minister as soon as reasonably practicable.

** DHHS Authorised Officer under the PHWA that has been authorised for the purposes of the emergency order.*

Required authorised officer actions at the airport

The lead for this situation is the Compliance Lead through a lead Authorised Officer.

DHHS Authorised Officers*:

- declare they are an Authorised Officer and show AO card [s.166] **(mandatory AO obligation)**
- must provide a copy of the 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) and:
  - explain the reasons for detention [s. 200(2)] **(mandatory AO obligation)**
  - warn the person that refusal or failure to comply with a reasonable excuse is an offence and that penalties may apply [s. 200(4)] **(mandatory AO obligation)**
- ensure the Direction and Detention Notice:
  - contains the hotel name at which the person will be detained
  - states the name/s of the person being detained
- record issue and receipt of the notice through a scanned photograph and enter into business system
- if necessary, facilitate a translator to explain the reasons for detention
- facilitate any reasonable request for communication, such as a phone call or email [s. 200(5)] **(mandatory AO obligation)**
- provide a fact sheet about detention (what the detainee can and can't do, who to contact for further information)
- record any actions taken in writing, including the above mandatory obligations, use of translator and any associated issues.
- use the list of arriving passengers to check off the provision of information to each arrival. This will help ensure all arrivals have been provided the information in the Direction and Detention Notice.
- check the vehicle transporting detainees is safe (in accordance with the review of transport arrangements procedure)

If it is not practicable to explain the reason for detention prior to subjecting the person to detention, the AO must do so as soon as practicable. This may be at the hotel, however every effort should be made to provide the reason at the airport [s. 200(3)] **(mandatory AO obligation)**.

*DHHS Authorised Officer under the PHWA that has been authorised for the purposes of the emergency order.

Authorised Officer review of transport arrangements

AO should consider the following:

- All persons must have been issued a direction and detention notice to board transport
- Is there adequate physical distance between driver and detainees?
- If not wait for another suitable vehicle to be arranged by the hotel.
- Has the vehicle been sanitised prior to anyone boarding? If not then vehicle must be cleaned in accordance with DHHS advice (business sector tab).
- Ensure the driver required to wear PPE?
- Are the persons subject to detention wearing face masks? (Refer to Airport and transit process)
- Are there pens/welfare check survey forms available for each detainee to complete enroute or at the hotel?

People who are unwell at the airport

The lead for this situation is the Human Biosecurity Officer on behalf of the Deputy Chief Health Officer (Communicable Disease).

Any person who is unwell at the airport will be assessed by a DHHS staff member and biosecurity officer at the airport. After discussion with the human biosecurity officer, if it is determined that the person meets the criteria as a suspected case, the following actions should take place:

- The human biosecurity officer should organise an ambulance transfer to the Royal Melbourne Hospital or Royal Children's Hospital for testing and assessment;
- The authorised officer from DHHS at the airport should log the person as requiring mandatory quarantine at a specified hotel and then should follow-up with the hospital to update on whether the person has been found to be negative, so a transfer by (patient transfer/ambulance/ maxi taxi etc) can be organised to return to the hotel.
- If the person is unwell and requires admission, they should be admitted and the Compliance Lead informed;
- If the person is well enough to be discharged they should return to the hotel through an arrangement by the authorised officer, (comments as above) and be placed in a COVID-19 floor if positive, or in a general part of the hotel if tested negative for COVID-19.

Requirement for review each day

- DHHS AO must – at least once every 24 hours – review whether the continued detention of the person is reasonably necessary to protect public health [s. 200(6)] **(mandatory AO obligation).**
- DHHS AO will undertake an electronic review of detainment arrangements by viewing a Business system. This includes reviewing:
  - the date and time of the previous review (to ensure it occurs at least once every 24 hours)
  - number of detainees present at the hotel
  - duration each detainee has been in detention for, to ensure that the 14-day detention period is adhered to
  - being cleared of COVID-19 results while in detention, which may be rationale for discontinuing detention
  - determining whether continued detention of each detainee is reasonably necessary to eliminate or reduce a serious risk to health
  - any other issues that have arisen.

To inform decision-making, a DHHS AO must:

- consider that the person is a returned overseas traveller who is subject to a notice and that they are obliged to comply with detainment
- 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
- note the date of entry in Australia and when the notice was given
- consider any other relevant compliance and welfare issues the AO[1] becomes aware of, such as:
  - 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
  - being cleared of COVID-19 results while in detention
  - any other material risks to the person
- record the outcomes of their review (high level notes) for each detained person (for each 24-hour period) in the agreed business system database. This spreadsheet allows ongoing assessment of each detainee and consideration of their entire detention history. This will be linked to and uploaded to PHESS.

To ascertain any medical, health or welfare issues, AO will need to liaise with on-site nurses and welfare staff (are there other people on-site an AO can liaise with to obtain this information).

Additional roles of the AO

- AOs should check that security are doing some floor walks on the floors to ascertain longer-term needs and possible breaches
- AO going onto the floors with persons subject to detention must wear gloves and masks. There should be P2 masks for AO's at the hotels (in addition to the surgical masks).

- AO should provide a handover to the incoming AO to get an update of any problems or special arrangements. For example, some people are permitted to attend cancer therapy at Peter Mac etc.
- AO responsible for uploading information to the business system which will then inform an upload to PHESS so that all persons in mandatory detention are recorded in PHESS for compliance and monitoring and surveillance purposes.

Charter of Human Rights considerations in decision-making making process

AO should consider the Charter of Humans Rights when exercising emergency powers and reviewing a person's detention every 24 hours, namely:

- **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 detainees from humiliation and not subjecting detainees 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 detainees and storing it securely
- **Right to protection of families and children –** This includes taking steps to protect facility and children and providing supports services to parents, children and those with a disability
- **Property rights –** This includes ensuring a detainee's property 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 detainees with humanity

Mandatory reporting (mandatory AO obligation)

A DHHS AO must give written notice to the Chief Health Officer as soon as is reasonably practicable 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.

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.

To streamline, the reporting process will involve a daily briefing to the CHO of new persons subject to detention and a database of persons subject to detention. The database will specify whether detention is being continued and the basis for this decision.

The CHO is required to advise the Minister for Health of any notice [s. 200(9)].

Grant of leave from the place of detention

This is a different legal test to that which applies after the notice is issued. It relates solely to the granting of leave (permission) and requires a different process and set of considerations.

The detention notice provides for a 24-hour review (which is required by legislation) to assess whether ongoing detention is needed, and, in addition, a person may be permitted to leave their hotel room on certain grounds, including compassionate grounds.

Any arrangements for approved leave would need to meet public health (and human rights) requirements. It will be important that the authorised officer balances the needs of the person and public health risk. For example, if the person needs immediate medical care, public health risks need to be managed appropriately, but the expectation is that the leave would automatically be granted. This would be more nuanced and complex when the request is

made on compassionate grounds where there is a question about how public health risks might be managed. However, again, human rights need to be considered closely.

Potential mechanisms for grant of leave from detention

Noting that there are broadly two mechanisms available to the authorised officer on behalf of the Compliance Lead / Public Health Commander to release a person from mandatory detention:

- The daily review by the authorised officer could find that detention is no longer required (with agreement of the Compliance Lead), or
- There could be permission given by the authorised officer (with agreement of the Compliance Lead) that a person has permission to leave the room in which they are detained.

The Public Health Commander could determine that detention should be served in an alternative location to a hotel, by writing a detention order to that effect.

Potential reasons for permission to grant leave from detention

There is a policy direction from the Deputy Chief Health Officer that permission to leave mandatory detention should be exceptional and always based on an individual review of circumstances.

In the following circumstances there could be consideration of permission grant after an application to the Deputy Chief Health Officer however this will require permission:

- A person who has a medical treatment in a hospital;
- A person who has recovered from confirmed COVID-19 infection and is released from isolation;
- An unaccompanied minor (in some circumstances – see below);
- Instances where a person has a reasonably necessary requirement for physical or mental health or compassionate grounds to leave the room, as per the detention notice.

Note that the last category is highly subjective. This means it is the expectation of the authorising environment that exemption applications on those grounds are made on exceptional circumstances.

Process for considering requests for permission to leave or not have detention applied

It is critical that any procedure allows for authorised officers to be nimble and able to respond to differing and dynamic circumstances impacting people who are detained, so that the detention does not become arbitrary. The process outlined here reflects their ability to make critical decisions impacting people in a timely manner.

Matters discussed with Legal Services on this matter should copy in REDACTED and [redacted]

Considerations

Any arrangements for approved leave would need to meet public health (and human rights) requirements. It will be important that the authorised officer balances the needs of the person and public health risk. For example, if the person needs immediate medical care, public health risks need to be managed appropriately, but the expectation is that the leave would automatically be granted. This would be more nuanced and complex when the request is made on compassionate grounds where there is a question about how public health risks might be managed. However, again, human rights need to be considered closely.

Requests in relation to the mandatory quarantine (detention) orders or permission to leave (for people in detention) should be rapidly reviewed by staff in the call centre function, and should always be funnelled through the COVID Directions inbox. That will allow that inbox to be a complete repository of all categories of requests for permission, exceptional circumstances requests and advice / exemption requests.

There should then be a presumption that these requests are forwarded immediately (within two hours) to COVID-19.vicpol@dhhs.vic.gov.au for review by an Authorised Officer working directly to the Director lead for compliance and enforcement, as these are a high priority category of request.

Temporary leave from the place of detention (Detention notice)

There are four circumstances in which permission may be granted:

1. **For the purpose of attending a medical facility to receive medical care**

- D/CHO or Public Health Commander will consider circumstances determine if permission is granted. See *Policy on permissions and application of mandatory detention*. AO must be informed so they are aware.
- In particular circumstances, an on-site nurse may need to determine if medical care is required and how urgent that care may be. DHHS AO officers and on-site nurse may wish to discuss the person's medical needs with their manager, on-site nurse and the Director, Regulation and Compliance officer to assist in determining urgency and whether temporary leave is needed
- Where possible, on-site nurses should attempt to provide the needed medical supplies.

2. **Where it is reasonably necessary for physical or mental health; or**

See policy on permissions and application of mandatory detention

- D/CHO or Public Health Commander will consider circumstances to determine if permission is granted. See *Policy on permissions and application of mandatory detention.*AO must be informed so they are aware.
- If approval is granted:
  - the AO must be notified
  - persons subject to detention are not permitted to enter any other building that is not their (self-isolating) premises
  - persons subject to detention should always be accompanied by an on-site nurse, DHHS authorised officer, security staff or a Victoria Police officer, and social distancing principles should be adhered to
- a register of persons subject to detention should be utilised to determine which detainees are temporarily outside their premises at any one time.

3. **On compassionate grounds;**

- D/CHO or Public Health Commander will consider circumstances to determine if permission is granted. *See Policy on permissions and application of mandatory detention*
- The AO must be notified if a detainee has been granted permission to temporarily leave their room and under what circumstances.

4. **Emergency situations must also be considered.**

- DHHS authorised officers 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 detainees
- if deemed that numerous detainees need to leave the premises due to an emergency, a common assembly point external to the premises should be utilised; detainees should be accompanied at all times by a DHHS authorised officer or a Victoria Police officer, and infection control and social distancing principles should be adhered to
- the accompanying DHHS authorised officer or a Victoria Police officer should ensure that all relevant detainees are present at the assembly point by way of a register of detainees.

<u>The process for a person not yet in detention is:</u>

- Members of the public who wish to ask for detention not to be applied, or permission to be granted to leave, have the option of submitting a request in writing to the COVID Directions inbox;
- Authorised officers should also use the COVID Directions inbox to submit requests for detention not to be applied or permission to be assessed so that the COVID Directions inbox is a complete funnel for handling these requests;

- All requests for permission that are considered are logged on the secure MS Teams site established by Legal Services in a manner that can be audited and reviewed by any party in this compliance chain;
- The Director of Health Protection and Emergency Management (lead for COVID-19 Directions) who oversees the inbox and team managing this process assesses the merits of the individual proposal – including through delegates - and applies judgment as to whether the application should proceed to the next step. There is a policy view – outlined in this Plan – that exceptional circumstances are generally required for the Authorised Officer to NOT issue a notice of detention for an overseas arrival;
- If a request is determined to require to proceed, it should then be sent to COVID-19.vicpol@dhhs.vic.gov.au for review by the AO reporting directly to the Direct E+C;
- The Compliance Lead will seek legal advice and a discussion with the Deputy Public Health Commander urgently if required;
- The outcome will be recorded in writing and communicated back to the COVID Directions team and requestor in writing.

Policy on unaccompanied minors

Instances where an unaccompanied minor is captured by a detention order must be managed on a case by case basis.

In general, there is a presumption that there are no exemptions granted to mandatory quarantine. The issues in relation to mandatory quarantine of unaccompanied minors include: where this occurs, and with what adult supervision.

Preliminary legal advice is that the State could 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. These must include:

- AO has to check in regularly;
- Person can easily contact parent / guardian;
- Has adequate food;
- Remote education is facilitated.

A draft detention notice is being put together by Legal Services should this be required.

When an unaccompanied minor normally resides outside Victoria

It is proposed that where there is no clear alternative, an unaccompanied minor who normally resides outside of Victoria may be facilitated to undertake detention in their normal home state of residence, with appropriate risk management of any possible exposures to others on a domestic flight out of Victoria to that state. The department will need to be satisfied that the receiving state will take the person under 18 years and manage public health risks.

When an unaccompanied minor is normally resident in Victoria

It is proposed that an adult (who is not themselves a returned overseas traveller) who supervises a minor should join that minor at a place of detention. If that occurs, the adult should then remain with that person in quarantine although there is no legislative power to issue a direction to that adult to detain the adult.

If an unaccompanied minor who normally resides in Victoria is unable to be joined by a parent / guardian (for example because that parent / guardian has other caring duties and cannot thus join the minor in detention) then on a case by case basis, an assessment will be undertaken to identify whether detention is to be served in the home.

Whilst it may be acceptable for older children (16 – 18 year old) to be in quarantine without their parent(s) or guardian, it's likely to be unacceptable for younger children (12 or 13 years old or younger) and in that situation it's more appropriate to defer an alternative arrangement (i.e. parents join them in quarantine or quarantine at home).

If a child is quarantined at home with their parents, a detention notice should still be provided to the child and parents outlining the same requirements for children as if they were in quarantine in a hotel, together with the guidance about advice to close contacts in quarantine. Legal services will adapt notices for that purpose.

We'll need to ensure that authorised officers monitoring unaccompanied minors have current Working With Children Checks and understand their reporting requirements under the Reportable Conduct Scheme.

When a minor is detained at their home

If it is determined to be appropriate to detain a child at home after a risk assessment, the arrangement will involve:

- Issuing a detention order naming the specific home and / or parts of the home, and
- The detention order will be accompanied by advice on minimising risk of transmission to others in the home where the minor is detained (equivalent to advice to close contacts in quarantine); and
- An Authorised Officer will undertake a process to undertake a review each day in the manner required by the Act.

When an unaccompanied minor is detained in a hotel

If an unaccompanied minor is detained in a hotel without parents, a specific notice and process is below.

- A Detention Notice – Solo Children, is found at Appendix 7.
- A guideline for authorised officers in this respect is found at Appendix 8.

This is a more intensive process for the authorised officers, which is commensurate with the additional risk of quarantining a child because the child is subject to the care of the Chief Health Officer and department.

Working with Children Checks and Child Safe Standards

DHHS will work with Department of Justice and Community Safety to facilitate Working With Children Checks for Authorised Officers.

Escalation of issues

Should an AO become aware of any concern about a child, the AO must:

- contact DHHS welfare teams immediately
- contact after hours child protection team and Victoria police if AO thinks a child may be harmed

Release from mandatory quarantine (detention) after 14 days

The fourteen-day period is calculated from the day following arrival of the person in Australia and ends at midnight fourteen days later/

DHHS Authorised Officer prior to release should:

- review the case file and ensure the 14 day detention has been met.
- liaise with on-site nurse to check the detainee meets the following – i.e. no symptoms of COVID-19 infection;
- any physical checks of the room (damage, missing items, left items etc).

Supporting detainee to reach their preferred destination:

- DHHS organise for the detainee to be transported to their destination by completing a cab charge, Uber or appropriate mode of transport.
- Release from isolation criteria are as per current DHHS Victoria guidelines (based on the SoNG).

DHHS AO to update the business systems database with details of release.

Options to facilitate compliance

DHHS authorised officers should make every effort to inform the person of their obligations, facilitate communication if requested and explain the important rationale for the direction. The following graduated approach should guide an DHHS authorised officer:

- explain the important reasons for detention, that is this action is necessary to reduce the serious risk to public health **(mandatory obligation)**

- provide the person subject to detention with a fact sheet and give opportunity to understand the necessary action
- provide the person subject to detention opportunity to communicate with another person, including any request for a third-party communicator (such as translator), family member or friend (**mandatory obligation)**
- seek assistance from other enforcement agencies, such as Victoria Police, to explain the reason for detention and mitigate occupational health and safety concerns
- discuss matter with on-site nurse to ascertain if there are any medical issues that may require consideration or deviation from the intended course of action
- issue a verbal direction to comply with the Direction and Detention Notice
- advise that penalties may apply if persons do not comply with the Direction and Detention Notice
- recommend that Victoria Police issue an infringement notice if there is repeated refusal or failure to comply with a direction
- recommend Victoria Police physically detain the non-compliant individual for transfer to another site.

DHHS Authorised Officers should make contemporaneous notes where a person is uncooperative or breaches the direction.

Transfer of uncooperative detainee to secure accommodation (refer to Authorised Officer review of transport arrangements procedure)

It is recommended that a separate mode of transport is provided to uncooperative detainees to hotel or other for 14-day isolation.

Ensure appropriate safety measures are taken including child locks of doors and safety briefing for drivers etc.

Unauthorised departure from accommodation

If there is reason to believe a person subject to detention is not complying with the direction and detention notice, the DHHS authorised officer should:

- notify on-site security and hotel management
- organise a search of the facility
- consider seeking police assistance
- notify the Director, Regulatory Reform if the person subject to detention is not found

If the person is located, DHHS authorised officer should:

- 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
- assess possible breaches of infection control within the hotel and recommend cleaning
- consider issuing an official warning or infringement through Victoria Police
- reassess security arrangements
- report the matter to the Director, Regulation Reform.

DHHS Authorised Officers should make contemporaneous notes where a person is uncooperative or breaches a direction.

Occupational health and safety for Authorised Officers

See **Appendix 9** for Occupational health and Safety measures.

Logistics for Mandatory Quarantine

Deliverables of the logistics function

The Director of the Office of the Secretary in DJPR role is responsible for:

- contract management with accommodation providers;
- transport arrangements from the airport;
- material needs including food and drink.

Airport and transit process

The lead for this situation is the DHHS Authorised Officer.

Passengers pass through immigration, customs and enhanced health checks before being transferred to their hotel.

- Every passenger is temperature checked by a registered nurse (RN) contracted by DHHS.
- Every passenger is handed a copy of the direction and a detention notice by a DHHS Authorised Officer (AO) authorised under the emergency provisions of the *Public Health and Wellbeing Act 2008*.
- Every passenger is provided an information sheet by DHHS.
- Passengers are met by VicPol/Border Force and escorted to organised buses for transport to the hotel.
- Every passenger is given a single-use facemask to wear while in transit to their hotel room.
- Every passenger is given a welfare survey to fill out on the bus or at the hotel.

Health and welfare for Mandatory Quarantine

Deliverables of the health and welfare function

The Deputy State Health Coordinator role is responsible for:

- provision of healthcare to detainees;
- provision of welfare to detainees through the Director Health Protection and Emergency Management.

Potential threats to health and wellbeing of people in mandatory detention

Potential risks associated with detention of returned travellers for compulsory 14-day quarantine can broadly be divided in physical or mental health risks.

Physical risks	**Mental health risks**
Transmission/development of COVID-19	Family violence
Transmission of other infectious diseases	Depression
Other medical problems	Anxiety
Diet – poor/imbalanced diet, food allergies/intolerances, over-consumption	Social isolation/loneliness
Lack of exercise	Claustrophobia
Lack of fresh air	Drug and alcohol withdrawal
Smoking – nicotine withdrawal, risk of smoking within rooms/fire hazard	

Tiers of risk for persons in mandatory detention

- Residents will be triaged into three tiers of risk. The type of welfare check will depend on the tier the passenger falls into.

- For phone calls (tier 1 and tier 2), translators must be available as needed. Language requirements should be recorded on arrival at the hotel and provisions made as required.
- Automated text messages are sent to all passengers in tier 3 via Whispir.
- Residents may be moved between risk tiers throughout their quarantine period as need dictates.

Risk Tier	Risk factors	Welfare check type
Tier 1	Residents with suspected or confirmed COVID-19 Families with children < 18 years Passengers aged > 65 years Aboriginal and Torres Strait Islander peoples Residents with underlying comorbidities (e.g. respiratory or cardiac conditions)	Daily phone call
Tier 2	Those who indicate they require a phone call but do not have any other risk factors. Residents who are by themselves.	Phone call every second day
Tier 3	Low risk – everyone else.	Daily text message (via Whispir)

Arrival at hotel – check in

At hotel check-in:

- Detainee provides Direction and Detention Notice to hotel staff; hotel staff to write on the notice:
  - room number
  - the date that the person will be detained until (14 days after arrival at place of detention).
- Detainee provides completed Direction and Detention Notice to AO to confirm that the following details on the notice are correct:
  - the hotel name;
  - hotel room number and arrival date, time and room on notice;
  - the date that the person will be detained until (14 days after arrival at place of detention).
- AO must take a photo of the person's Direction and Detention Notice and enters this into database.
- Following any medical and welfare check of the person, AO to liaise with nurses to identify detainees with medical or special needs.
- AO to note detainees with medical or special needs, such as prescription and medical appointments.

Persons will be sent to their allocated room and informed that a person will contact them in the afternoon or next AO to make themselves known to the security supervisor onsite.

Welfare and health service provision

- Residents will have a welfare check (as specified below) each day.
- DHHS welfare officers conducting welfare checks phone and email covid-19.vicpol@dhhs.vic.gov.au and AO individually to alert AO of medical and welfare issue.
- Residents will be provided with a resident satisfaction survey to complete each week.
- Residents can seek review by the nurse 24 hours a day if required.
- 24 hour on-call medical support will be available for on call subject to demand. This will initially be provided by a Field Emergency Medical Officer, and subsequently through a locum general practice service.
- Medical care is organised by Deputy State Health Coordinator. Deliverables include:

  - Primary care assessments;
  - Prescription provision;
  - 24 hour access to a general practitioner;
  - 24 hour access to nursing assessment.
- It is advisable that where possible, individuals who are in detention are linked to receive telehealth care from their normal general practice provider.

Conduct of a welfare check

A welfare check will allow passengers to be assessed for medical and social issues, and concerns flagged and responded to. These issues include but are not limited to health, mental health, safety and family violence concerns. A welfare check will be conducted by a DHHS officer which is included as a script at **Appendix 5.**

Safety / mental health

If there are concerns about the safety or mental health of passengers, the process is as follows:

- The nurse will review via phone (or in person if required with appropriate PPE).
- If escalation is required, the nurse will contact the Anxiety Recovery Centre Victoria for psychosocial support.
- Mental health triage at RMH/the Alfred can be contacted as a back-up.
- If the person is acutely unwell or at serious risk, urgent ambulance should be arranged by calling 000.
- Daily welfare check phone calls should be implemented thereafter if not already implemented.

Family violence (FV)

If there are concerns about family violence / the safety of women and children, the process is as follows:

- Case worker is called to review via phone initially or in person if required (with appropriate PPE).
- A separate room may need to be organised to facilitate the review away from the other family members.
- If deemed necessary, separate rooms should be organised to separate the family members.
- Case worker to review again as required.

Alcohol and other drugs

If there are concerns about alcohol or other substance abuse or withdrawal:

- Consider nurse/medical review.
- Provide numbers for support services (listed below).
- Preference for provision of standard drinks to a limit rather than prescribing diazepam for alcohol withdrawal.
- Prescriptions – Schedule 8 prescriptions for drug-dependent patients can only be provided after discussion with the DHHS Medicines and Poisons Branch.

Diet

- Ensure a well-balanced diet with options provided for those with specific dietary requirements.
- Ensure access to essentials within the room (e.g. snacks, tea and coffee) to limit the amount of interactions/contact required with staff.
- Ensure access to additional food if required.

Exercise and fresh air

- If the room has a balcony, ensure the residents can access it for fresh air.
- Advise residents to open windows/balconies where possible for fresh air and ventilation.
- If it is possible for residents to go outside to take some exercise for organised/supervised short periods of time, this should be facilitated where possible. Residents should ensure physical distancing is practised during this period. Only well residents from the same room should be able to go out to exercise at the same time.

- Residents should be provided with resources for exercise routines and yoga/mediation that they can perform safely within their rooms.

Procedure for a detainee / 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.

The steps that must be taken by the detainee are:

- Confirm they are well;
- Confirm they have washed their hands immediately prior to leaving the room;
- Don a single-use facemask (surgical mask);
- Perform hand hygiene with alcohol-based handrub as they leave;
- Be reminded to – and then not touch any surfaces internal to the hotel on the way out;

The procedure for the security escort is:

- Don a mask;
- Undertake hand hygiene with an alcohol-based handrub or wash hands in soapy water;
- Be the person who touches all surfaces if required such as the lift button, handles;
- Maintain a distance (1.5 metres) from the person;

There is no requirement to wear gloves and this is not recommended, as many people forget to take them off and then contaminate surfaces. If gloves are worn, remove the gloves immediately after the person is back in their room and then wash your hands.

Social and communications

- All residents should have access to **free** wifi/internet where at all possible.
- All residents should have access to entertainment such as television and streaming services (e.g. Netflix).
- All residents should have access to communications so that they can keep in regular contact with family and friends throughout the quarantine period.
- Toys and equipment should be provided for small children if possible.

Care packages for people in detention

A public health risk assessment has been conducted that indicates that care packages, such as food or toys, can be delivered for provision to people in detention. The care package should be provided to the hotel reception or other party for conveyance to the person in detention and should not be directly handed to the person in quarantine by the person gifting the care package. Ensuring the package passes to the person in detention without misdirection or tampering is essential. There is no public health reason for an inspection of any care package.

Smoking policy for people in detention

As part of the emergency response to COVID-19, individuals have been confined within hotels while under quarantine. The movement of these people has been restricted to hotel rooms, without access to outdoor spaces, where they can smoke.

Current laws

Under the *Tobacco Act 1987* (Tobacco Act), smoking is prohibited in an ”enclosed workplace”, however, Section 5A (2) (g), provides an exemption for the personal sleeping or living areas of a premises providing accommodation to members of the public for a fee. This means that, while a hotel is considered an enclosed workplace, the hotel could allow the occupants of the rooms to smoke if they choose.

In many cases, hotels have implemented their own smoke-free policies in rooms as the smoke is likely to enter the centralised air conditioning systems resulting in occupants of other rooms and staff being exposed to the smoke. Smoke also remains on the surfaces of the room and permeates soft furnishings meaning that it remains in the

room and exposes staff cleaning the room to the remaining residual smoke. The Department of Health and Human Services supports and encourages hotels to designate their rooms smoke-free.

If smokers were to be permitted to leave their rooms for supervised cigarette breaks, they would need to be taken to an area that does not constitute an enclosed workplace. This might be a balcony, roof top or other outdoor area. This area should preferably be away from open windows, doors and air conditioning intake points.

COVID-19 and smoking

The World Health Organization (WHO) has advised that any kind of tobacco smoking is harmful to the bodily systems, including the cardiovascular and respiratory systems, and puts smokers at greater risk in the context of COVID-19. Information from China, where COVID-19 originated, showed that people with cardiovascular and respiratory conditions, including those caused by smoking, were at higher risk of developing severe COVID-19 symptoms and death.

The Victorian Chief Health Officer has recommended that quitting smoking reduces the health risks associated with COVID-19.

Other examples of restricting access to smoking

There are some precedents of people being confined to facilities where they are unable smoke. This includes mental health facilities, prisons and, if people are unable to leave, hospitals. In these circumstances, individuals are supported to manage cravings using pharmacotherapies such as nicotine replacement therapies.

Victoria's Charter of Human Rights and Responsibilities

Removing the ability to smoke would be compatible with the *Charter of Human Rights and Responsibilities Act 2006 (the Charter)*, as it would be for the purposes of protecting the right to life. Section 9 of the Charter states that “Every person has the right to life and to not have their life taken. The right to life includes a duty on government to take appropriate steps to protect the right to life.”

Options

Option 1: Provide support for smokers to quit or manage cravings (Recommended)

The preferred option, for both the benefit of the individual and broader community would be to support smokers to quit or manage withdrawal while confined to their hotel room. This would mean that smokers be supported to manage cravings while they are unable to smoke but would not be forced to quit.

This could be easily managed through the provision of approved nicotine replacement therapies (NRT), with meal deliveries, accompanied by counselling through the Quitline. Quit Victoria has recommended a box of patches and an intermittent form of NRT such as a spray. These items are available for purchase without a prescription from a range of retailers including pharmacies and some big supermarkets.

Other pharmacotherapies, like zyban or champix, would require a prescription from a GP and are designed to help people completely quit as opposed to a short-term measure for people who are forced to stop smoking abruptly. These medications can take a while to take effect and, with champix, the advice is to continue smoking until it starts to impact on your cravings which means that it would not be an appropriate option for the circumstances.

Addiction to cigarettes includes both nicotine dependence and a behavioural and emotional dependence, which is why counselling plus pharmacotherapy is required. Someone who is heavily addicted will crave a cigarette every 45-60 minutes.

Telephone counselling is available via the Quitline - 13 78 48

Even if someone doesn’t want to quit, Quitline can help them reduce the number of cigarettes they smoke.

People can also contact their regular general practitioner via telehealth.

Option 2: Relax no smoking restrictions for the hotel rooms

While it would be legally possible to enable people in quarantine to smoke in their rooms, this option is not recommended. This would have an adverse impact on hotels and their staff and goodwill in the circumstances. It

would also increase the health risks of individuals potentially already at risk of COVID-19.When sharing a room with children, smoking should not be allowed.

Option 3: Accompany individuals to leave the room to smoke

While it would be possible to create a smoking area for people wishing to smoke, such as in an outdoor drinking area attached to a bar or restaurant facility, this option is not recommended. Allowing people to leave their hotel rooms to smoke undermines the quarantine restrictions being put in place. The individuals would need to be accompanied by security guards and might need to travel floors via lifts to access an outdoor area or leave the building.

Even if we assume, that the hotel is not currently operating for other customers, movement in the hotel creates an increased risk for staff and a need for greater vigilance in cleaning and maintaining distance.

Current policy for smokers in mandatory quarantine

The following actions should occur –

- Nicotine Replacement Therapy should be promoted strongly for smokers;
- Smoking restrictions should remain in relation to the room;
- Only where absolutely necessary, and in exceptional circumstances, a person in mandatory quarantine could be granted permission to leave their room under specific circumstances, where public health risk is managed:
  - The Authorised Officer is aware and grants permission;
  - They are accompanied by security, who are provided PPE to wear;
  - They are instructed to – and follow the instruction – not to touch surfaces en-route to the smoking area and coming back;
  - They return immediately to their hotel room.

Other health and wellbeing issues

- All residents should be given the contact information for support services such as Lifeline at the beginning of their quarantine period (the information sheet they are provided with at the airport should also have these contact numbers).
- Residents should have access to fresh bedlinen and towels as required.
- Care packages may be permitted for delivery to residents under certain circumstances and subject to checks by AOs.
- Residents can be provided with up to three standard drinks per day if there is a risk of alcohol withdrawal (this is in preference to prescribing benzodiazepines for withdrawal).
- Other residents can also request alcoholic drinks as part of their food and drink provisions.
- Smoking breaks or NRT should be offered to all smokers if feasible.

Actions to detect and test for COVID-19 amongst people in mandatory detention

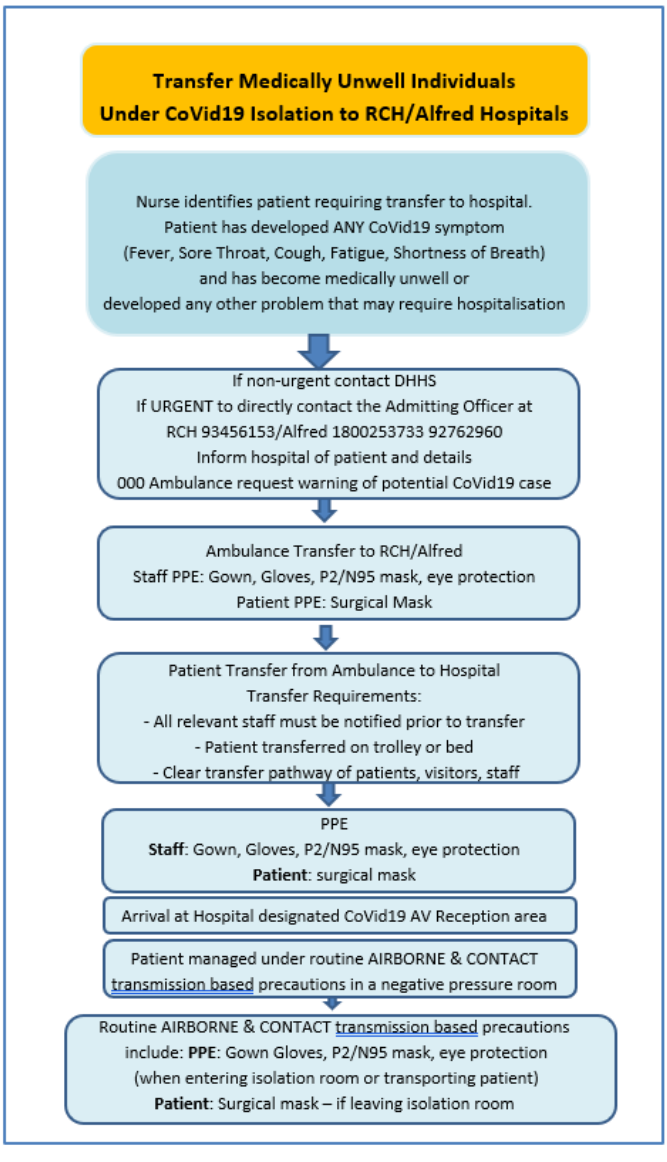
The following are the actions to enact this:

- Detainees will be asked daily (via phone or text) if they have symptoms consistent with COVID-19. These include but are not limited to fever, cough, shortness of breath and fatigue.
- The nurse onsite will be notified. The nurse will call the detainee (patient) and assess them over the phone. If face to face assessment is required, the nurse will assess them in the room with appropriate PPE.
- Security staff in PPE (masks and gloves) will accompany all nurses visiting hotel rooms. They will wait outside unless requested to enter by the nurses (full PPE is required to enter rooms).
- The nurse will assess the patient for symptoms of coronavirus. If deemed necessary, they will take swabs to test for COVID-19.
- If the patient is well enough, they can remain in quarantine at the hotel to await the test results. If they are sharing a room with another resident, they should be moved to a separate room if feasible and according to availability of rooms. If separation is not possible, they should practise physical distancing as far as is possible.

- If the test is positive and the patient is well, they can remain in quarantine at the hotel but should be moved to a separate section/floor of the hotel which is designated for confirmed cases. If they are sharing with other people, then arrangements such as a separate room or provision of PPE may be required, depending on the circumstances (for example it may not be feasible or appropriate to separate young children from parents).

Hospital transfer plan

- Passengers requiring hospital assessment/treatment for suspected or confirmed COVID-19 or other conditions, should be transferred to either the Royal Melbourne Hospital (RMH) or The Alfred Hospital, depending on proximity (**note children should be transferred to the Royal Children's Hospital**).
- If the hospital transfer is non-urgent, contact DHHS.
- If the hospital transfer is urgent, contact the Admitting Officer at RCH/RMH/the Alfred.
- Inform the hospital of patient and details.
- Call 000 to request ambulance and inform them that the passenger is a suspected (or confirmed) case of COVID-19.
- Staff should don full PPE and the passenger must wear a single-use surgical mask if tolerated.
- All relevant staff including AO must be notified prior to the transfer.
- AO must view appropriate authorisation.
- The passenger should be transferred on a trolley or bed from ambulance into the designated COVID-19 ambulance reception area.
- The patient should be managed under routine airborne and contact transmission-based precautions in a negative pressure room if available. The patient should wear a single-use surgical mask if leaving the isolation room.
- Ambulance services will list the hotels as an area of concern in case of independent calls and will ask on site staff to assess need for attendance in the case of low acuity calls.
- All residents who are: in high risk groups, unwell, breathless or hypoxic (O2 sats <95%) should be considered for hospital transfer.



Note P2 respirators are not required, but appear in this chart as an indicative mask, pending modification of this chart to reflect recommendation that a single use facemask is required.

Actions for confirmed cases of COVID-19 in people in mandatory detention

The following actions should be taken:

- Residents with confirmed COVID-19 should be accommodated / cohorted in a separate section/floor of the hotel, away from the non-COVID-19 infected passengers.

Personal protective equipment (PPE)

Staff who engage with monitoring or assisting persons in mandatory detention in person:

1. Apply standard infection prevention and control precautions at all times:
    a. maintain 1.5 metre distance
    b. wash your hands or use anti-bacterial agents frequently
    c. avoid touching your face.
2. Every situation requires a risk assessment that considers the context and client and actions required.

3. If you are not able to maintain a 1.5 metre distance and the person has symptoms (for example coughing) or is known to be a COVID-19 case use:
    a. fluid-resistant surgical mask (replace when moist or wet)
    b. eye protection
    c. disposable gloves.
4. If you need to be in a confined space (<1.5 metre) with a known COVID-19 case for more than 15 minutes, wear a single use facemask, eye protection and gloves.

Cleaning of rooms

Housekeeping services will not be provided routinely to residents. Fresh linen, towels and additional amenities can be left outside of rooms for residents to then collect. Biohazard bags can be left for residents to place dirty linen in and to leave outside their rooms for collection. Terminal cleaning is required on vacation of each room.

Reporting and evaluation on mandatory quarantine

A report will be prepared to summarise the activity of the program, and provided to the Deputy Chief Health Officer on a regular basis in confidence.

Communication and education

A communications plan for physical distancing is being developed to ensure the public receive timely, tailored and relevant advice on physical distancing measures.

The current collateral for the Victorian public and health sector to communicate on physical distancing requirements in Victoria includes items on the web and other locations:

Stay at home and restrictions:

- Coronavirus website homepage tile and webpage with detailed information on restrictions:
- www.dhhs.vic.gov.au/stay-home-and-restricted-activities-directions-frequently-asked-questions

Physical distancing and transmission reduction measures:

- Coronavirus website homepage tile and webpage with general information on physical distancing.
- www.dhhs.vic.gov.au/coronavirus-covid-19-transmission-reduction-measures
- Uploadable Victorian physical distancing document in keeping with that tile's web content, located at TRIM HHSD/20/142098

State of emergency and directions:

- Coronavirus website tile and webpage with PDFs of the signed Directions.
- www.dhhs.vic.gov.au/state-emergency

About coronavirus general information:

- Coronavirus website tile and webpage with general hygiene and physical distancing information.
- www.dhhs.vic.gov.au/victorian-public-coronavirus-disease-covid-19

Media (proactive and reactive):

- Daily interviews and press conferences by the Chief Health Officer, Premier, Minister for Health and Ambulance and the Public Health Commander
- Announcements will be made by the Premier/Minister/CHO at a media conference.
- A daily media release from the department will contain latest information on measures.

Social media posts on physical distancing

- Daily posts on DHHS and VicEmergency social media accounts.
- Live streams of press conferences on Facebook
- Social media FAQs for responding to community via social media channels

Videos on physical distancing

- Series of Chief Health Officer videos on self-isolation, quarantine and physical distancing

Appendix 1 - Standard emails and letter advice for compliance and enforcement

The following templates are generic and educative in nature. DHHS officers should adapt the tone and content according to risk and individual circumstances.

Airport arrivals

Dear (insert name),

As you may be aware, Victoria's Minister for Health has declared a state of emergency throughout Victoria in response to the coronavirus or COVID-19 situation. Following this declaration, Victoria's Deputy Chief Health Officer has exercised emergency powers under the *Public Health and Wellbeing Act 2008* to make a direction to eliminate or reduce the serious risk to public health posed by COVID-19.

We are contacting you as Department of Health and Human Services has received information that you may be not complying with the Airport Arrivals direction issued by Victoria's Deputy Chief Health Officer.

Please be aware that: a person who arrives between 5 pm on 18 March 2020 and midnight on 13 April 2020 at an airport in Victoria on a flight that originated from a place outside Australia, or on a connecting flight from a flight that originated from a place outside Australia:

- must travel from the airport to a premises that is suitable for you to reside in for 14days; and/or
- except in exceptional circumstances, must reside in a suitable premises for the period beginning on the day of your arrival and ending at midnight on the fourteenth (14th) day after arrival);
- must not leave the premises except:
  - for the purposes of obtaining medical care or medical supplies
  - in any other emergency situation circumstances where it is possible to avoid close contact with other persons; and
- must not permit any other person to enter the premises unless that other person usually lives at the premises, or the other person is also complying with this direction for the same 14 day period, or for medical or emergency purposes also complying with the CHO direction, or for medical or emergency purposes).

This email/letter seeks to inform you of your obligations. A copy of the direction and a fact sheet is attached to this email/letter.

Why it is important to comply with the Chief Health Officer's direction

The Victorian Government is very concerned about the serious, and potentially catastrophic, risk to public health arising from COVID-19 throughout Victoria.

Persons entering Victoria are at an increased risk of COVID-19. That is why a person entering Victoria from overseas must self-isolate for a period of 14 days in accordance with the Deputy Chief Health Officer's direction. Failure to self-isolate in accordance with the Deputy Chief Health Officer's direction may increase transmission of COVID 19 within our community.

All Victorians play an important role in minimising the impact of COVID-19. We strongly encourage you to comply with the CHO's direction and appreciate your co-cooperation.

Mass gatherings

Dear (insert name)

As you may be aware, Victoria's Minister for Health has declared a state of emergency throughout Victoria in response to the coronavirus or COVID-19 situation. Following this declaration, Victoria's Deputy Chief Health Officer has exercised emergency powers under the *Public Health and Wellbeing Act 2008* to make a direction to eliminate or reduce the serious risk to public health posed by COVID-19.

We are contacting you as Department of Health and Human Services has received information that you may be not complying with the Mass Gatherings direction issued by Victoria's Deputy Chief Health Officer.

Please be aware that:

- A person who owns, controls o operates premises in Victoria must not allow a mass gathering to occur on premises
- A person must not organise a mass gathering on premises in Victoria.

A mass gathering means:

- A gathering of five gendered (500) or more persons in a single undivided outdoor space at the same time; or
- A gathering of one hundred (100) or more persons in a single undivided indoor space at the same time.

A number of exclusions exist such as at an airport and a hotel, motel or other accommodation facility that is necessary for the normal operation of accommodation services.

This email/letter seeks to inform you of your obligations. A copy of the direction and a fact sheet is attached to this letter/email.

Why it is important to comply with the Deputy Chief Health Officer's direction

The Victorian Government is very concerned about the serious, and potentially catastrophic, risk to public health arising from COVID-19 throughout Victoria.

The restrictions are designed to limit transmission of COVID in places where there is high density of individuals in close proximity. This is because many individuals have been identified as being infected with COVID-19 and more cases are expected.

All Victorians play an important role in minimising the impact of COVID-19. We strongly encourage you to comply with the CHO's direction and appreciate your co-cooperation.

Appendix 2 – Evidence on physical distancing interventions for reducing impact of COVID-19

Last updated 27 March 2020

This document provides a review of evidence regarding the effectiveness of physical distancing interventions on the COVID-19 epidemic. As evidence is rapidly emerging this document may not contain all relevant available information. It also contains some references to reports and pre-prints that have not undergone peer-review. Therefore, caution should be taken in interpretation. Furthermore, as new evidence emerges the picture of the effectiveness will change. This document will be updated to reflect the changing evidence base.

Introduction

Physical distancing between people aims to minimise interactions between people to limit the opportunities for disease to spread from an infected person to an un-infected person. It is an example of a non-pharmaceutical intervention (NPI) that can be employed to control a disease outbreak. Measures to bring about physical distancing amongst populations have been utilised in previous efforts to control influenza epidemics and pandemics.

Observational and modelling studies have provided evidence to help guide the use of physical distancing measures for influenza. Although these can provide some insight into how we might expect physical distancing to influence the progression of the COVID-19 pandemic, COVID-19 has its own disease characteristics which will influence the impact of physical distancing measures. Evidence of the impact of social distancing is beginning to emerge from countries in which the epidemic commenced earlier than in Australia, particularly China. Additionally, modelling studies using information on the epidemiological features of COVID-19 are estimating the impact of different physical distancing measures.

This review consists of three parts:

- A review of the epidemiological features of COVID-19 and their implications for physical distancing in COVID-19
- A review of modelling analyses estimating the effects of physical distancing on the COVID-19 epidemic
- A review of evidence regarding physical distancing measures in the setting of pandemic influenza

1. Epidemiological features of COVID-19 that impact the effectiveness of physical distancing measures

1.1 Reproductive number

The basic reproductive number (R_0) is the number of individuals a single infected individual will infect in an otherwise fully susceptible population. This value will be influenced by features inherent to the pathogen, and characteristics of the population, such as population density and the nature and frequency of human-human interactions. As such, there is no single true value of R_0 for any disease, including COVID-19, as it will be influenced by population-specific factors.

Published estimates of R_0 for COVID-19 have ranged between 2.1 and 3.58. (1–6)

1.2 Modes of transmission

Early evidence suggests that SARS-CoV-2 (the virus that causes COVID-19) is primarily transmitted via respiratory droplets transmitted during close contact, and via fomites. (7) However, there is evidence of viral shedding in faeces (8) and viral persistence in aerosols (9,10), suggesting that aerosol and faecal-oral transmission may also occur. Transmission may also be possible via ocular surfaces. (11)

1.3 Timing of transmission

Analyses of viral shedding suggest that the time of peak viral load is early in the course of illness, around the time that symptoms develop, and that viral load then reduces over time. (10) The median duration of detected viral shedding of 191 patients in Wuhan was 20.0 days (IQR: 17.0-24.0 days) in survivors. (12) Importantly, these measurements of viral load cannot distinguish infectious from non-infectious virus. Although the two types of virus

are often correlated early in influenza, we cannot say for sure for whether the same holds for COVID-19 at this stage.

Evidence from case and cluster reports (13–15), and several epidemiological analyses (16–19) suggest that COVID-19 can be transmitted prior to the onset of symptoms.

1.4 Incubation period

An analysis of 55,924 laboratory-confirmed cases, found the mean incubation period was estimated to be 5.5 days. (7) Another analysis of 181 confirmed cases outside of Hubei Province found the mean incubation period to be 5.1 days (95% CI: 4.5-5.8 days). (20)

1.5 Duration of illness

An analysis of the clinical course of 52 critically ill adult patients with SARS-CoV-2 pneumonia who were admitted to the intensive care unit (ICU) of a Chinese hospital in late December 2019 and January 2020, found the median time from symptom onset to death was calculated to be 18 days. (21)

1.6 Demographic features of COVID-19

In general, COVID-19 causes a much more severe illness in older people, with case-fatality rates increasing with age, particularly for those aged 80 years and older. (7,22)

Children have thus far accounted for few cases of COVID-19 and are unlikely to have severe illness. (23) However, the role of children in transmission of COVID-19 remains unclear. In a pre-print analysis of household contacts of cases, it was found that children were infected at the same rate as older household contacts. (24) In the report of the WHO-China joint mission it was noted that children accounted for 2.4% of cases, that infected children had largely been identified through contact tracing, and there was no recollection of episodes of transmission from child to adult. (7)

1.7 Overview of the impact of key epidemiological features for physical distancing interventions

Key points arising from these epidemiological features are:

- COVID-19 is highly transmissible, and although close contact is more likely to result in transmission, transmission may be possible from minor contact, or through contact with infectious surfaces
- The COVID-19 epidemic in many areas is following exponential growth patterns, so case counts can be expected to rise rapidly
- As evidence suggests that people can transmit COVID-19 prior to the onset of symptoms, and because infectiousness appears to be highest at the time of symptom onset, isolating cases at the point of symptom onset may be inadequate to prevent transmission
- As there is a delay between infection and symptom onset and a delay between symptom onset and case detection, there will be a delay (of roughly 10 days) between implementation of an intervention and seeing its impact on case counts
- As there is a delay between symptom onset and death, there will be an even longer delay to seeing the impact of interventions on death rates (up to two weeks)
- The role of children in COVID-19 transmission remains unclear and would have significant implications for the effect of school closures on the epidemic

2. Modelling studies evaluating potential impact of physical distancing interventions for COVID-19

2.1 Modelling the impact of physical distancing interventions

This will be updated.

2.1.1 Imperial College report on non-pharmaceutical interventions

Ferguson et al of Imperial College published a report estimating the impact of a range of non-pharmaceutical interventions (physical distancing interventions) on the COVID-19 epidemic in the UK and the US. (26) Effects of different combinations of population-level interventions were reviewed. The report describes two alternative strategies: suppression and mitigation. It describes suppression as aiming to reduce the R value to less than 1, resulting in transmission ceasing in the population. Mitigation, however, aims to reduce the impact of the epidemic, whilst infection builds up in the community, rather than causing transmission to cease. Actions towards mitigation would include preventing infection amongst those most vulnerable to severe disease and slowing the rate of infection.

The report suggests that an approach of mitigation would result in the critical care capacity being overwhelmed many times over, resulting in hundreds of thousands of deaths. Only a combination of very strong measures taken together (including case isolation, household quarantine, general social distancing, school and university closure) is predicted to avoid critical care capacity being overwhelmed.

The report suggested that if suppression is being pursued, then earlier implementation is better, but if mitigation is being pursued then it is better to implement interventions closer to the peak of the epidemic. School closures were estimated to have a greater role on a suppression strategy, rather than mitigation. The modelling also suggested that relaxing the intervention whilst the population remained susceptible would result in a later, large peak that would also overwhelm critical care capacity, suggesting that policies may need to remain until a vaccine was available.

The report concluded that suppression seemed the only viable option, given that mitigation would result in health care capacity being overwhelmed many times over. However, they noted the uncertainty in whether a suppression approach could be achieved, as well as the uncertainty in modelling estimates.

2.1.2 Early modelling analysis from Australia

A modelling analysis, published as a pre-print, conducted by Australian researchers, Chang et al (27)suggested that the best intervention strategy is a combination of restriction on international arrivals to Australia, case isolation, and social distancing with at least 80-90% compliance for a duration of 13 weeks. They noted that compliance levels below this would lengthen the duration of required suppression measures. They also note that resurgence of disease is possible once interventions cease, and their analysis does not attempt to quantify the impact of measures beyond the 28-week horizon of analysis.

Another Australian pre-print analysis by Di Lauro et al (28) reviewed the optimal timing for “one shot interventions”, interventions that are assumed to only be able to implemented once in the course of an epidemic and for a finite time period. This suggested that optimal timing depended on the aim of the intervention; that to minimise the total number infected the intervention should start close to the epidemic peak to avoid rebound once the intervention is stopped, while to minimise the peak prevalence, it should start earlier, allowing two peaks of comparable size rather than one very large peak.

2.1.3 Modelling the impact of physical distancing interventions in China

Using a stochastic transmission model and publicly available data, Kucharski et al (29), estimated the effect of the distancing interventions introduced in China on the 23rd of January. the median daily reproduction number (Rt) in Wuhan declined from 2·35 (95% CI 1·15–4·77) 1 week before travel restrictions were introduced on Jan 23, 2020, to 1·05 (0·41–2·39) 1 week after.

An pre-print analysis by Lai et al (30) suggested that without the non-pharmaceutical intervention implemented in China (early detection and isolation of cases, travel restrictions and reduction of interpersonal interactions) the number of infections in Wuhan would have been many fold higher. They suggested that had the NPIs been conducted one week, two weeks, or three weeks earlier in China, cases could have been reduced by 66%, 86%, and 95%, respectively. They also suggested that social distancing interventions should be continued for the next few months to prevent case numbers increasing again after travel restrictions were lifted on February 17, 2020.

A pre-print analysis by Prem et al (31) reviewed the impact of China's interventions on social-mixing patterns and estimated the effects of different approaches to lifting the interventions. They suggested that control measures aimed at reducing social mixing can be effective in reducing the magnitude and delaying the epidemic peak. They suggested the interventions would have the most impact if continued until April, and if return to work was staggered. These results were sensitive to the duration of infectiousness and the infectiousness of children.

2.2 Modelling the potential impact of case isolation and contact tracing

An analysis by Hellewell et al (32) considered the possibility of controlling a COVID-19 outbreak with contact tracing and case isolation alone. Under some parameter assumptions it was possible to control the outbreak without the need for physical distancing measures. However, the probability of controlling the outbreak in this way decreased with an R0 of 2.5 or 3.5, when there was a larger initial infectious population, a longer delay to case detection and a larger proportion of pre-symptomatic transmission. The study concludes that "in most plausible outbreak scenarios, case isolation and contact tracing alone is insufficient to control outbreaks, and that in some scenarios even near perfect contact tracing will still be insufficient, and further interventions would be required to achieve control."

A pre-print analysis by Kretzschmar et al (33), suggests it is unlikely that case isolation and contact tracing alone could control a COVID-19 outbreak. They note that if delay between onset of infectiousness and isolation is more than 4 to 6 days, or the proportion of asymptomatic cases is greater than 40% the outbreak cannot be controlled even with perfect tracing. However, they note that contact tracing efforts can still be a valuable tool in mitigating the epidemic impact.

2.3 Modelling the impact of school closures for COVID-19

An early report from Di Domenico et al (34), used data from three French towns with COVID-19 outbreaks and assumed children had a susceptibility to COVID-19 of 20% relative to adults and relative infectiousness of 50%. With these assumptions they suggested that school closure alone would have limited benefit in reducing the peak incidence (less than 10% reduction with 8-week school closure for regions in the early phase of the epidemic). However, when coupled with 25% adults teleworking, 8-week school closure would be enough to delay the peak by almost 2 months with an approximately 40% reduction of the case incidence at the peak.

3. Evidence on physical distancing measures for pandemic influenza

There are important differences between the COVID-19 pandemic and previous influenza pandemics. Three important differences are:

- It is well established that school children play a major role in spreading influenza virus because of higher person-to-person contact rates, higher susceptibility to infection, and greater infectiousness than adults. In contrast, children have accounted for fewer cases in the COVID-19 pandemic and their role in transmission is unclear.
- Pandemic influenza is thought to have a shorter incubation period (approximately 2 days) compared to COVID-19 (approximately 5 days).
- There is likely a greater proportion of severe and critical cases of COVID-19, than in pandemic influenza. (35)
- However, the evidence regarding physical distancing measures on influenza pandemics may still provide some insight into the role they may play in the response to COVID-19.

A recent review (prior to the COVID-19 outbreak) by Fong et al (36) surveyed the evidence for NPIs in pandemic influenza, in particular the effects of school closures, workplace measures and avoiding crowding.

3.1 School closures

They found compelling evidence that school closure can reduce influenza transmission, especially among school aged children. However, the duration and optimal timing of closure were not clear because of heterogeneity of data, and transmission tended to increase when schools reopened.

A correlation analysis between weekly mortality rates and interventions (which included school closure) during the 1918–19 pandemic in cities in the United States estimated that early and sustained interventions reduced mortality rates by ≤25%. (37)

Two studies conducted in Hong Kong as a public health response to the 2009 influenza A(H1N1) pandemic estimated that school closures, followed by planned school holidays, reduced influenza transmission. (38,39)

Two studies conducted in Japan estimated that due to reactive school closures the peak number of cases and the cumulative number of cases in the 2009 pandemic were reduced by ≈24% (40) and 20% (41). However, two studies (one evaluating the response to the 2009 pandemic and the other seasonal influenza) estimated that reactive school closures had no effect in reducing the total attack rate and duration of school outbreaks, and the spread of influenza. (42,43)

It is important to note that school closures can have a disproportionate impact on vulnerable groups (eg low-income families), particularly when meals are provided by schools. This could be ameliorated by dismissing classes but allowing some children to attend schools for meals or enable parents to work. It has also been noted that school closures may have an impact on health workforce availability, as health care workers may have to care for children.

3.2 Workplace interventions

A systematic review of workplace measures by Ahmed et al (44) concluded that there was evidence, albeit weak, to indicate that such measures could slow transmission, reduce overall attack rates or peak attack rates, and delay the epidemic peak. In this review, epidemiological studies reviewed the effects of segregating persons into small subgroups and working from home. Modelling studies most frequently simulated the effects of workplace measures as reducing contacts by 50%.

In this review, for studies modelling R0 ≤ 1.9, workplace social distancing measures alone (single intervention) showed a median reduction of 23% in the cumulative influenza attack rate in the general population. Workplace social distancing measures combined with other nonpharmaceutical interventions showed a median reduction of 75% in the general population. However, the effectiveness was estimated to decline with higher R0 values, delayed triggering of workplace social distancing, or lower compliance.

Paid sick leave could improve compliance with a recommendation to stay away from work while ill. (45,46)

3.3 Avoiding crowding

The review by Fong et al (36) identified three studies that assessed the effects of measures to avoid crowding (such as bans on public gatherings, closure of theatres) in pandemic influenza. These suggested that such measures helped to reduce excess mortality in the 1918 pandemic and a natural study comparing the effect of accommodating pilgrims for World Youth Day in smaller groups rather than a large hall reduced transmission in 2008.

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Appendix 3 – Physical distancing international comparison

This will be updated by REDACTED / REDACTED in due course.

Appendix 4 – Hotel Isolation Medical Screening Form

DHHS Hotel Isolation Medical Screening Form	
Registration Number:	
Full Name:	Male ☐ Female ☐ Other ☐
Address:	Indigenous ☐ Torres Strait Islander ☐
Phone Number:	Nationality:
Date of Birth:	Place of Birth:
Phone #:	Primary language:
Please provide the information requested below, as it may be needed in case of an emergency. This information does not modify the information on the emergency card.	
Allergies:	
Past Medical History: Alerts: Alcohol & Other Drugs Y/N Disability Y/N Significant Mental Health Diagnosis Y/N	
Medications:	
Regular Medical Clinic/Pharmacy:	
General Practitioner:	
Next of Kin	Contact Number:

Covid-19 Assessment Form

Name	DOB	Room	Date of Admission	mobile	

Ask patient and tick below if symptom present

Day	Date	Fever	Cough	SOB	Sore Throat	Fatigue	Needs further review (nurse assessment)	Reason (if needs further assessment)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								

Appendix 5 – Welfare Survey

Survey questions – daily check-in

Date:	
Time:	
Call taker name:	
Passenger location:	Hotel: Room number:
location (room number):	
Confirm passenger name:	
Passenger DOB:	
Contact number:	Mobile: Room:
Interpreter required:	Yes/no Language:

Script

Good morning / afternoon, I'm XXX. Can I confirm who I'm speaking with?

I am working with the Department of Health and Human Services to support people in quarantine following their arrival in Australia, and I'm giving you a call to check on your welfare. We know that this may be a stressful time for you, and our aim is to make sure that you are as comfortable as you can be during this quarantine period.

I am a Victorian Public Servant and any information that you provide to me is subject to privacy legislation.

We will be checking in with you and the people you have been travelling with every 24 hours to make sure that you are ok and to find out if you have any health, safety or wellbeing concerns that we can address.

There are 23 questions in total, and it should take only a few minutes to go through these with you. When you answer, we would like to know about you as well as any other occupants in your room.

If you have needs that require additional support, we will connect you with another team who can provide this support.

Introductory questions

1. Are you still in Room XXX at the hotel? Circle YES / NO

2. Are you a lone occupant in your hotel room? Yes/No if No:
   a. Who are your fellow occupants, including your partner or spouse, children or fellow travellers?

Name	Relationship	Age (children/dependents)

3. Have you or your fellow occupants had to leave your room for any reason? If so, what was the reason? YES /N0

Health questions

4. Have you had contact with a medical staff nurse whilst in quarantine? If yes, can you please provide details and is it being monitored?

5. Have you or your fellow occupants had any signs or symptoms of COVID-19, including fever, cough, shortness of breath, chills, body aches, sore throat, headache, runny nose, muscle pain or diarrhoea)?

6. Do you or anyone you are with have any medical conditions that require immediate support? (ie smokers requiring nicotine patches)

7. Do you, or anyone in your group (including children) have any immediate health or safety concerns?

8. Do you have any chronic health issues that require management?

9. Do you or anyone you are with have enough prescribed medication to last until the end of the quarantine period?

10. Are you keeping up regular handwashing?

11. What sort of things help you to live well every day? For example, do you exercise every day, do you eat at the same time every day?

Safety questions

12. How is everything going with your family or the people you are sharing a room with?

13. Is there anything that is making you feel unsafe?

14. Are there any concerns that you anticipate in relation to your own or other occupant's safety that might become an issue in the coming days?

If the person answers yes to either question 10 or the one above, you could say:

- You have identified safety concerns -would you like me to establish a safe word if you require additional support regarding your safety?

If yes…

- The word I am providing is <xxx> (different word for each individual). You can use that word in a conversation with me and I will know that you need immediate support/distance from other occupants in the room or may be feeling a high level of distress.

Where family violence, abuse or acute mental health is identified as an issue refer to specific guidance / escalate for specialist support.

Wellbeing questions

15. How are you and any children or other people that you are with coping at the moment?

16. Do you have any immediate concerns for any children / dependents who are with you?

17. Do you have any additional support needs that are not currently being met, including any access or mobility support requirements?

18. Have you been able to make and maintain contact with your family and friends?

19. What kind of things have you been doing to occupy yourself while you're in isolation, e.g. yoga, reading books, playing games, playing with toys?

20. Have you been able to plan for any care responsibilities that you have in Australia? Can these arrangements be maintained until the end of the quarantine period?

Final

21. What has the hotel's responsiveness been like? Have you had any trouble getting food, having laundry done, room servicing etc.?

22. Do you have any other needs that we may be able to help you with?

23. Do you have any other concerns?

End of survey

Thank you for your time today. We will contact you again tomorrow.

Office use only

1. Referral details

Nurse	
Authorised officer	
Complex Client Specialist	
Other	

2. NOTES:

3. Enter on spreadsheet

- Any referrals or issues
- Short or long survey for the next call contact (short may be by text message so they will need a mobile phone number)
- Safe word documented
- Make note of mobile number or if they don't have one.

Appendix 6 – Scripts for physical distancing call centre

Detail to be added about certain scenarios, including for funeral-related questions.

Appendix 7 – Direction and detention notice – Solo Children

DIRECTION AND DETENTION NOTICE

SOLO CHILDREN

Public Health and Wellbeing Act 2008 (Vic)

Section 200

1. Reason for this Notice

(2) You have arrived in Victoria from overseas, on or after midnight on 28 March 2020.

(3) 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.

(4) 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.

(5) 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.

(6) 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.

(7) 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.

(8) 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.

2. Place and time of detention

(9) You will be detained at:

Hotel: _____ *(to be completed at place of arrival)*

Room No: _____ *(to be completed on arrival at hotel)*

(10) You will be detained until: _____ on ____of _____2020.

3. Directions — transport to hotel

(11) 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.

(12) 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.

4. Conditions of your detention

(13) **You must not leave the room in any circumstances**, unless:

(c) you have been granted permission to do so:

(i) for the purposes of attending a medical facility to receive medical care; or

(ii) where it is reasonably necessary for your physical or mental health; or

(iii) on compassionate grounds; or

(d) there is an emergency situation.

(14) **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).

(15) Except for authorised people, the only other people allowed in your room are people who are being detained in the same room as you.

(16) 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.

(17) 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.

5. 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.

6. 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:

(a) We will check on your welfare throughout the day and overnight.

(b) We will ensure you get adequate food, either from your parents or elsewhere.

(c) We will make sure you can communicate with your parents regularly.

(d) We will try to facilitate remote education where it is being provided by your school.

(e) We will communicate with your parents once a day.

7. Offence and penalty

(19) 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.

(20) 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 8 – Guidelines for Authorised Officers (Unaccompanied Minors)

Guidelines for Authorised Officers - 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:

- **first**, understand in general terms which human rights will be affected by your decisions (these rights are set out below under 'relevant human rights');
- **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;
- **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 (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 9 – Authorised Officer Occupational Health and Safety

Purpose

The purpose of this document is to provide an occupational health and safety procedure for authorised officers when attending off site locations during the current State of Emergency.

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 cause death.

Compliance Activity

On 16 March 2020 a State of Emergency was declared in Victoria to combat COVID-19 and to provide the Chief Health Officer with the powers he needs to eliminate or reduce a serious risk to the public.

Under a State of Emergency, Authorised Officers, at the direction of the Chief Health Officer, can act to eliminate or reduce a serious risk to public health by detaining people, restricting movement, preventing entry to premises, or providing any other direction an officer considers reasonable to protect public health.

Using a roster-based system, you will be placed on call to exercise your authorised powers pursuant to section 199 of the *Public Health and Wellbeing Act 2008* ***(Act)***. **Your compliance role is only to exercise the powers under section 199 of the Act, any arrests, including moving people into detainment or physical contact with an offender suspect must be manage by Victoria Police**.

OHS

Occupational Health and Safety is a shared responsibility of both the employer and the employee. Officers must raise hazards, concerns, incidents with: REDACTED REDACTED

One of the foremost issues associated with site attendance is the 'uncontrolled environment' that exists. Officers 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.

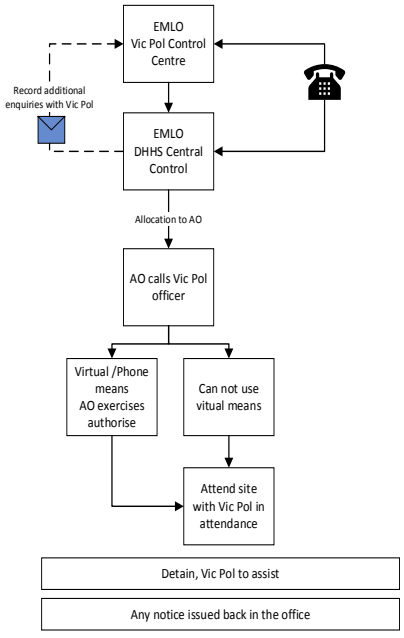
Officers and managers both have a shared responsibility for occupational health and safety. All employees have a responsibility to report and discuss hazards or perceived hazards, by bringing this to the managers attention.

Fatigue

Officers 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 manager.

To mitigate the risk of fatigue, officers 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

Officers are required to hold a valid motor vehicle license and are required to adhere to the requirements of the departments driving policy. Information about the departments policy can be found on the DHHS intranet site.



Risk assessment before attendance | Personal Protection

Officers must only take a direction to attend a site with the approval of the Central DHHS emergency Management Liaison Officer or DHHS duty manager. An officer must only attend a location where there is the confirmed attendance of the Victoria Police.

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, 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 measure 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.

Personal measures to reduce risk the risk of exposure to COVID-19 include:

- Stay healthy with good nutrition, regular exercise, sensible drinking, sleeping well, and if you are a smoker, quitting.
- 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 a site, 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 offender(s) a positive case of COVID-19?
- Has the offender(s) been recently in close contact with a positive case of COVID-19?
- Has the offender(s) recently returned from overseas within the last 14 days?

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:

- Face mask (N95 or equivalent)
- Gloves
- Hand Sanitizer

The following is only a guide for officers to consider.

PPE	Guide
Face mask	When there is known case of COVID-19, or an offender has been recently been exposed to COVID-19
Gloves	Always
Hand Sanitizer / Soap	Always
Social 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
Other infectious agen		Follow personal protective measures

Outbreak Management Plan – Rydges Swanston

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

Epi update 13 July 15:00

Purpose

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

Governance

Outbreak Management team

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

Outbreak Management Team meeting dates

First meeting – 1830 on Tuesday 26 May 2020.

Second meeting – 1130 on Wednesday 27 May 2020

Third meeting – 1000 on Thursday 28 May 2020

Fourth meeting – 1000 on Friday 29 May 2020

Fifth meeting – 1000 on Saturday 30 May 2020

Sixth meeting – 1000 on Sunday 31 May 2020

Seventh meeting – 1230 on Monday 1 June 2020

Eighth meeting – 1300 on Tuesday 2 June

Ninth meeting – 1300 on Wednesday 3 June

Tenth meeting – 1300 on Thursday 4 June

Eleventh meeting – 1300 on Friday 5 June

Twelfth meeting – 1300 on Saturday 6 June

Thirteenth meeting – 1300 on Monday 8 June

Fourteenth meeting – 1200 on Thursday 11 June

Fifteenth meeting – 1300 on Friday 12 June

Outbreak summary (Epi)

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

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

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

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

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

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

*QLD case not included in the above summary table

Situation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Epidemiological and clinical investigation

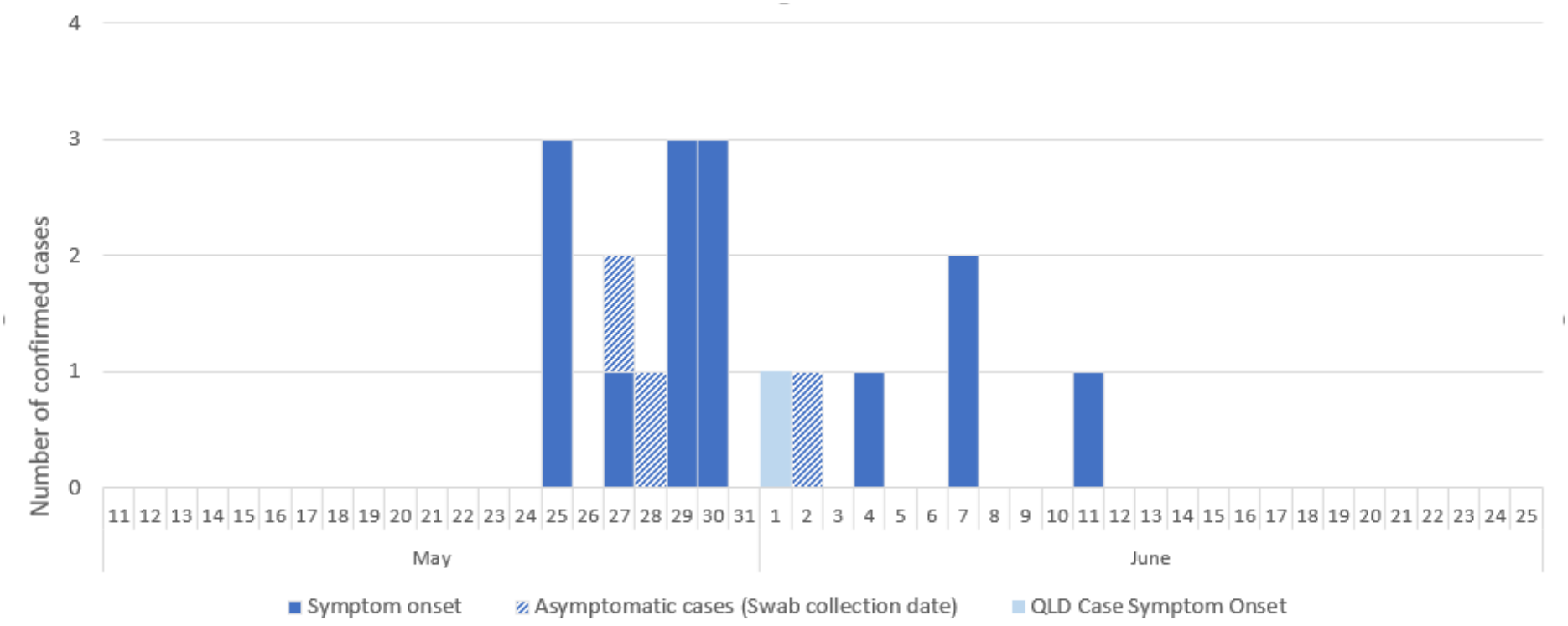


Figure 1: Epidemic curve for Rydges on Swanston Outbreak, by date of calculated symptom onset, including QLD case

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

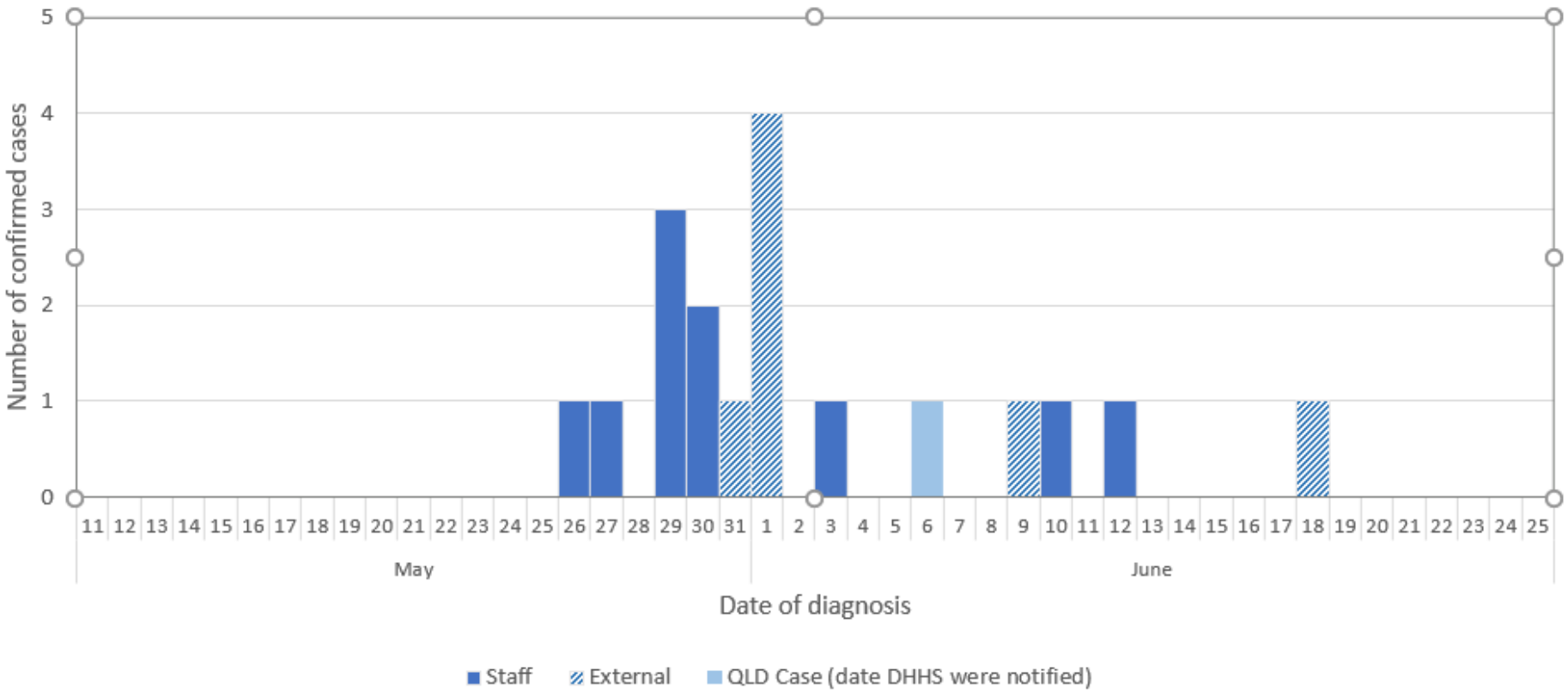


Figure 2: Epidemic curve for Rydges on Swanston Outbreak, by date of diagnosis, including QLD case

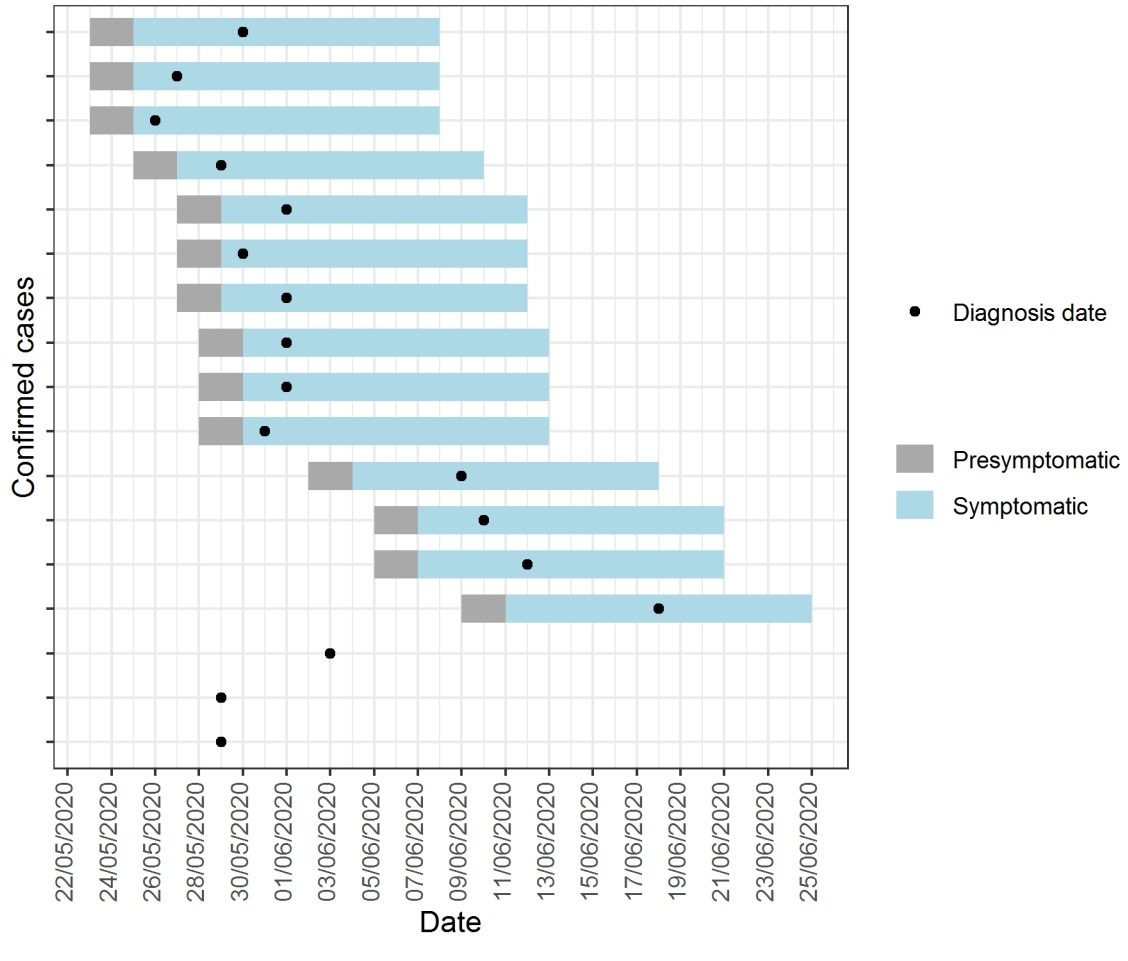


Figure 3: Onset date and incubation period for confirmed cases, Rydges on Swanston

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

Case definitions

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

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

Outbreak case definitions

Confirmed case:

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

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

Close Contact:

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

Casual Contact:

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

Acquisition period:

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

Case follow-up

All cases are well having completed isolation.

Close Contact Follow up

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

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

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

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

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

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

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

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

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

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

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

Environmental investigation

The hotel is located at 701 Swanston Street, Carlton.

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

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

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

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

Discussion with nurses who cleaned room REDACTED and changed linen:

-

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

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

Genomic Investigation

Request:

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

Details of these genomic findings are at REDACTED

Results

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

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

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

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

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

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

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

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

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

Hypothesis

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

Control measures

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

Identified close contacts have been quarantined.

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

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

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

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

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

Stakeholder mapping

Rydges Hotel Management:

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

Your Nursing Agency (YNA)

SwingShift (mental health nurses):

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

Alfred Hospital (nursing staff)

- REDACTED

Unified Security

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

Medi7 GPs:

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

DJPR:

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

Operation Soteria (Pam Williams, Merrin Bamert)

Issues/risks:

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

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

Risk communication

Key events

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

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

Communication with exposed settings

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

Key messages – general public

Approved media holding lines as of 26 May 2020

Statement

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

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

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

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

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

Background

The hotel is not currently open to the public.

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

The cause of the infection is under investigation.

Timeline of outbreak

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

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

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

OMT meeting actions list

Outbreak Meeting 1 – 26th May

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

Outbreak Meeting 2 – 27th May

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

Outbreak Meeting 3 – 28th May

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

Outbreak Meeting 4 – 29th May

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

Outbreak Meeting 5 – 30th May

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

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

Outbreak Meeting 11 – 8 June

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

Outbreak Meeting 14 – 11 June

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

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

Line list

List does not include the QLD notified case.

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

Outbreak demographic summary

Includes Victorian notified cases only.

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

Shifts worked by staff cases at Rydges

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

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

*text in red denotes shifts worked during infectious period

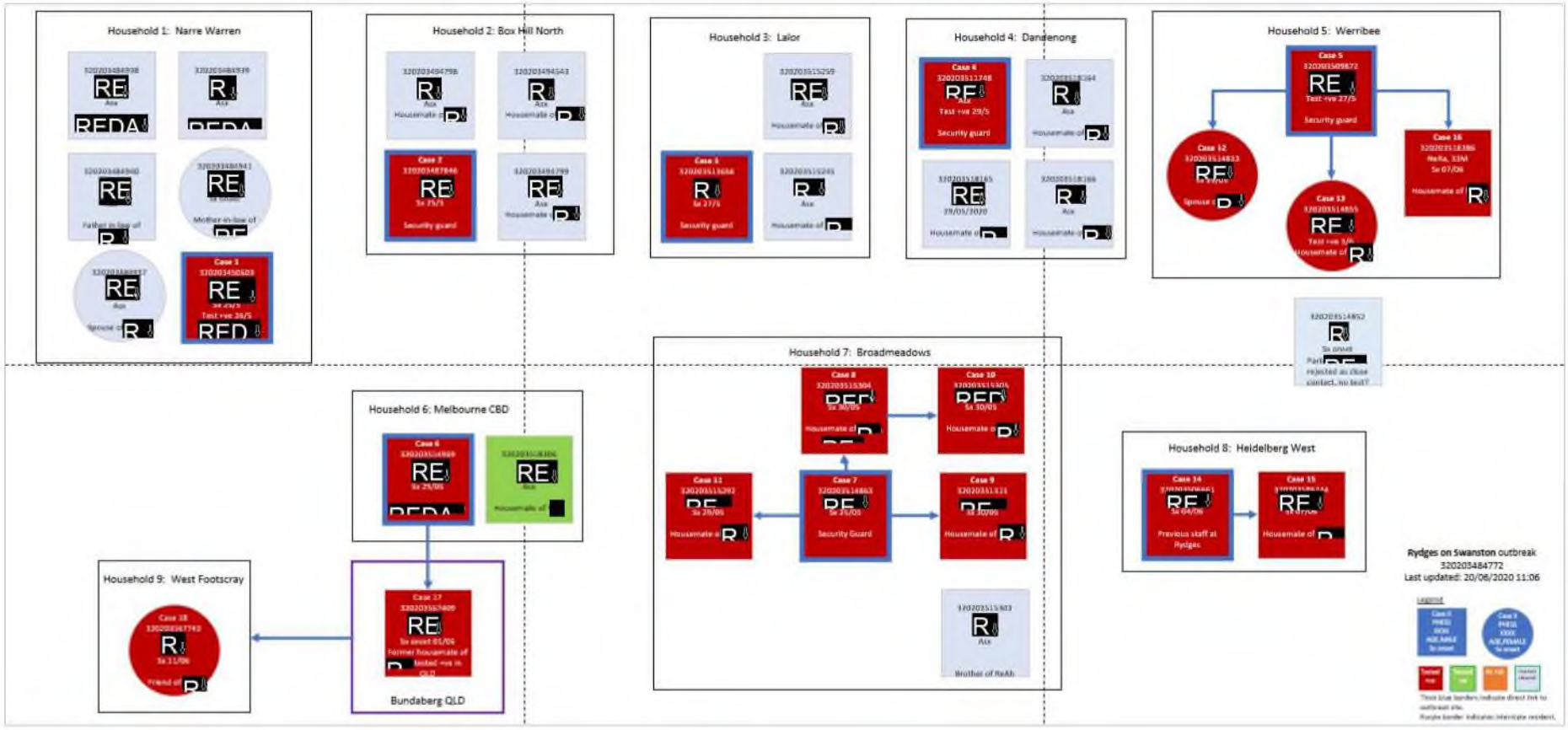


Figure 4: Visio transmission diagram, Rydges Swanston, Updated 21 June 2020, 15:00

Outbreak Management Plan – Stamford Plaza

PHESS ID: 320203632182

OMT Lead updated 25 June 23:20

Epi updated 19 July 10:30

Purpose

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

Governance

Outbreak Management team

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

Outbreak Management Team meeting dates

Tuesday 16 June (OMT Lead: Simon Crouch)

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

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

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

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

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

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

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

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

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

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

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

Outbreak summary (Epi)

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

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

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

Situation

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

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

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

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

Epidemiological and clinical investigation

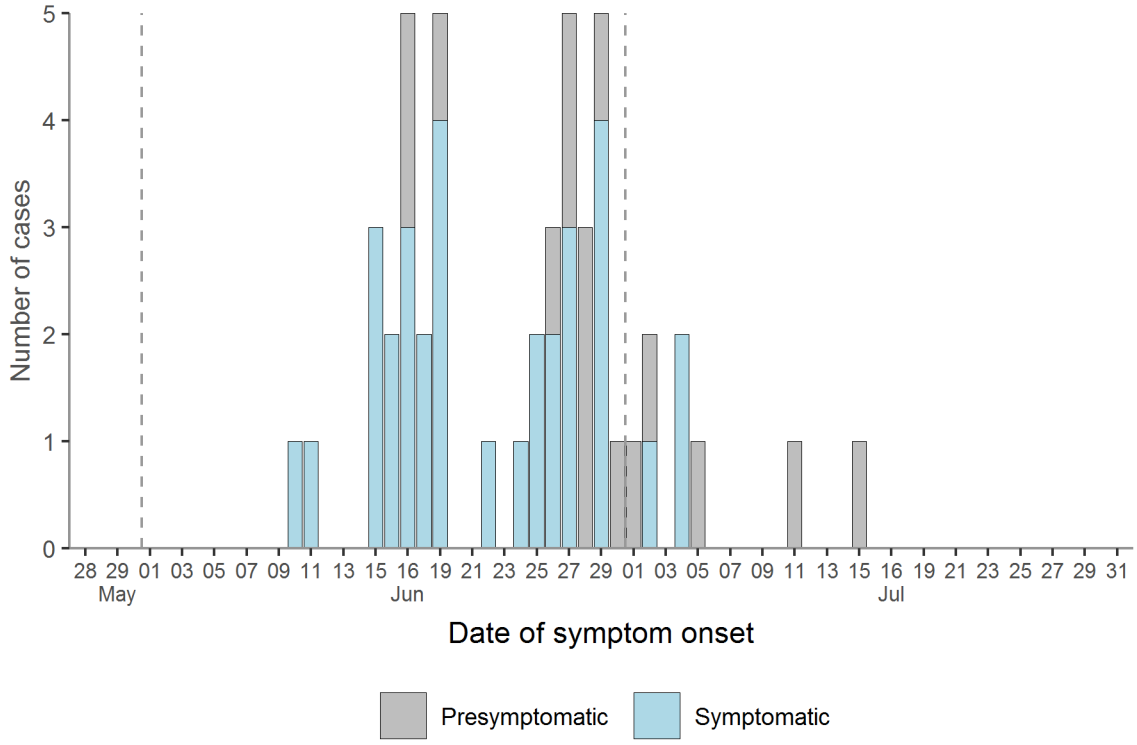


Figure 1: Epidemic curve for Stamford Plaza Outbreak by date of symptom onset* as of 17 July 2020

*for asymptomatic cases, calculated symptom onset date is used

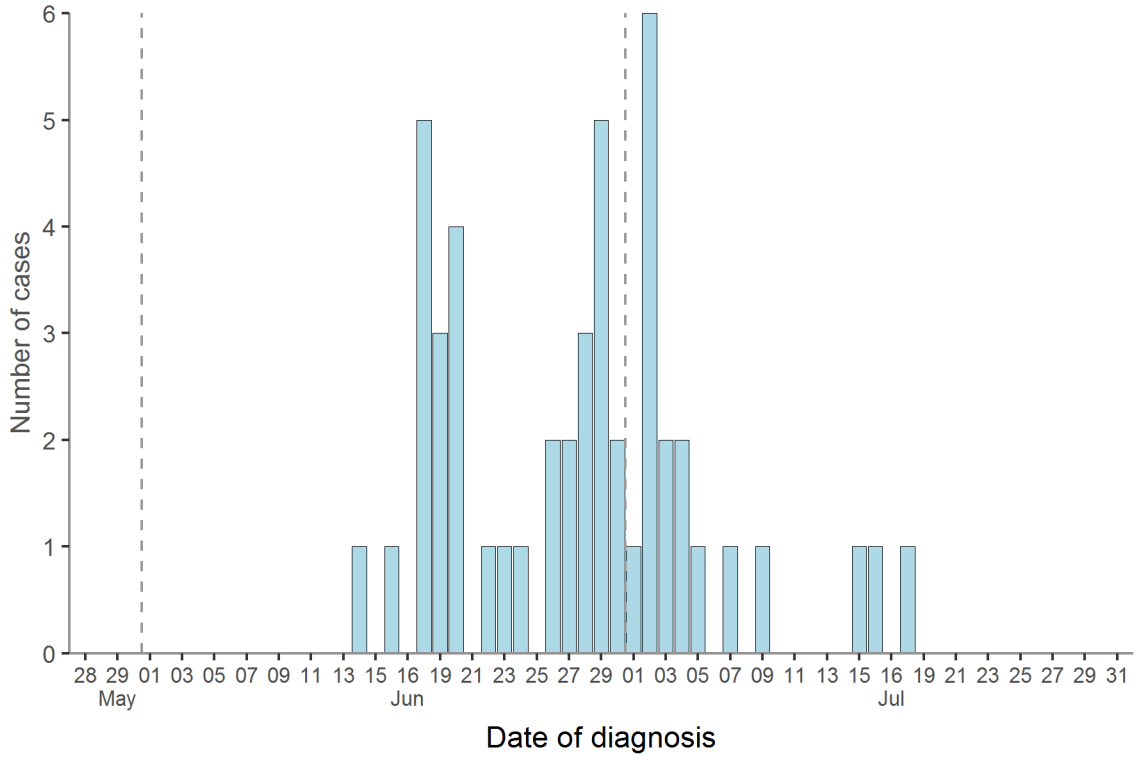
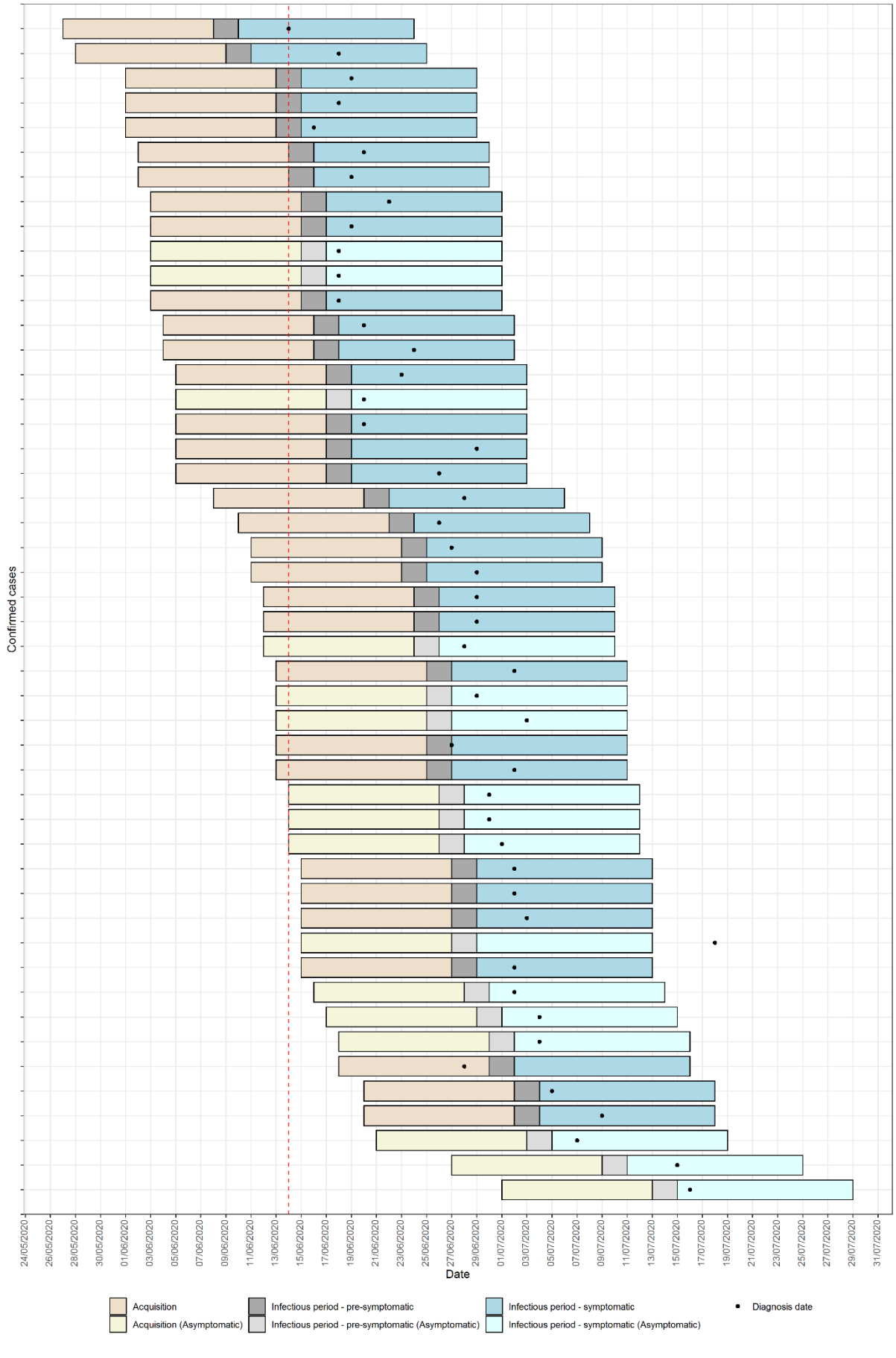


Figure 2: Epidemic curve for Stamford Plaza Outbreak by date of diagnosis as of 17 July


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

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

Case definitions

Current COVID-19 case definition

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

Outbreak case definitions

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

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

In this setting close contacts at risk of infection include

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

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

In this setting casual contacts include

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

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

Close contacts

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

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

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

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

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

Environmental investigation

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

Observations include:

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

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

Education of staff was conducted at the site.

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

Genomic Investigation

Request:

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

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

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

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

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

Results:

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

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

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

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

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

Hypothesis

Control measures

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

Stakeholder mapping

Authorised officers (DHHS):

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

Security:

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

Stamford Plaza Hotel:

- [redacted]

Your Nursing Agency (YNA)

- [redacted]

SwingShift (mental health nurses)

- [redacted]

Alfred Hospital (nursing staff)

- [redacted]

Medi7 GPs:

- [redacted]

DJPR:

- [redacted]

Operation Soteria

- Key contact: Merrin Bamert, Pam Williams

Hairdressing facility:

- Key contact: REDACTED

Child Protection Services (Relevant for Case 1)

- REDACTED

Issues/risks:

Relating to populations and transmission

Relating to control measures and contact tracing

Relating to communication about the outbreak

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

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

Risk communication

Key messages – general public

Media lines for release on 19 June:

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

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

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

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

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

Timeline of outbreak

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

OMT meeting actions list

Line list

Exposure PHESS ID: 320203632182

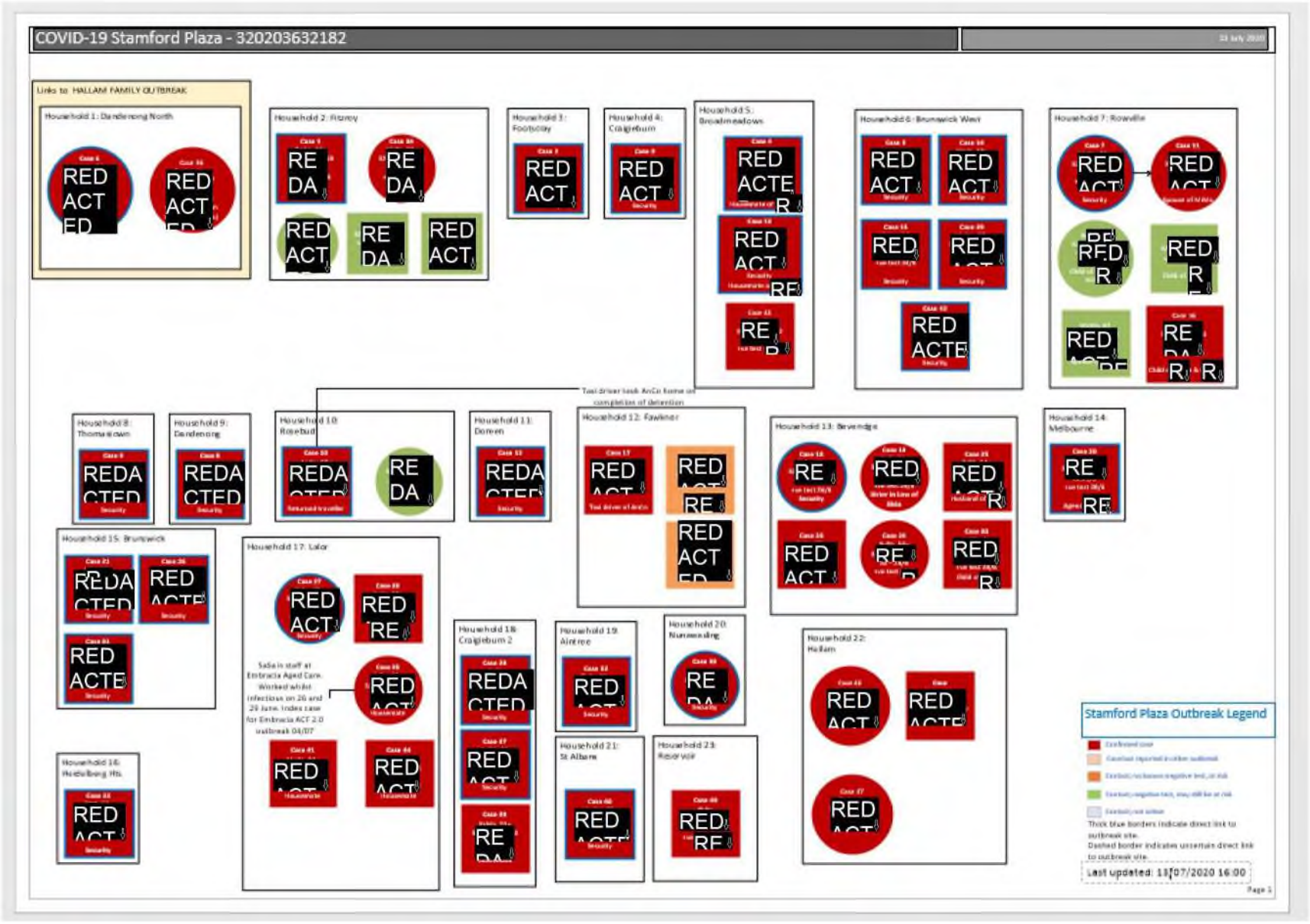
This outbreak is linked to the [redacted] family though the REDACTED case (320203619599). RE[redacted] is therefore included in both outbreak s RED[redacted] contacts are not included here but are in the [redacted] Family Outbreak (320203632182). Please check PHESS before entering new IDs as several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

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

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

Case demographics summary

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


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

Add additional information below

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

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

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

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