COVID-19

Pandemic plan for the Victorian Health Sector

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VICTORIA State Government | Health and Human Services

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Executive Summary

Introduction

Coronavirus (COVID-19) is a respiratory illness caused by a new virus. Symptoms range from a mild cough to pneumonia. Some people recover easily, others may get very sick very quickly. There is evidence that it spreads rapidly from person to person.

Travel restrictions and rapid public health responses have contained the spread of the virus in Australia so far. However, its rapid spread in other countries outside of China means COVID-19 is now an emerging pandemic.

The World Health Organisation (WHO) has declared a Public Health Emergency of International Concern due to an emerging pandemic of coronavirus disease 2019 caused by a newly identified virus, SARS-CoV-2.

Information about clinical assessment and public health characteristics of COVID-19 is at:

https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

Implications for Victoria

The growing risk of an outbreak in Australia requires an acceleration in planning our health response.

Victoria is well prepared for dealing with COVID-19. Victorian health services, hospitals, primary care and emergency services have existing pandemic influenza preparedness arrangements.

The health system undertakes pandemic response exercises and is prepared for the COVID-19 public health emergency. However, all health systems will be challenged in the event of a pandemic, so it is important we plan for all possible scenarios.

This is a guide for preparing and responding to the virus for Victoria's health sector and will be regularly updated as we learn more about the transmission of the virus, control measures and treatments.

The Victorian Government Department of Health and Human Services (DHHS) is the control agency for this Class 2 public health emergency[1] and will take urgent action under legislation including the *Public Health and Wellbeing Act 2008*, *Emergency Management Act 2013* and Commonwealth *Biosecurity Act 2015* to safeguard the health and wellbeing of all Victorians[1].

A staged response

Victoria's response to COVID-19 is a four-stage process, working together with all states, territories and the Commonwealth. The four stages may overlap through the course of pandemic response.

Responses within each stage of this plan should be considered a menu of initiatives to be deployed as appropriate at any time, informed by growing knowledge of the virus and local experience of its spread and impact. Victoria is passing through Stage 1 at this time but is preparing for, and may soon be at, Stage 2.[1]

The table overleaf outlines each of the four stage and these will be expanded on in the remainder of this document.

[1]A Class 2 emergency is a major emergency that is not a Class 1 emergency or a warlike act or act of terrorism. (Class 1 emergencies are either major fires or emergencies with MFB, CFA or SES as control agency). The response in a Class 2 emergency is a collaboration across the health sector, government agencies and the community.

Stages of response:	
Stage 1	**Initial containment stage**
Stage 2	**Targeted action stage**
Stage 3	**Peak action stage**
Stage 4	**Stand-down and recovery stage**

Overall objectives

The overall objectives of this plan are to:

1. Reduce the morbidity and mortality associated with COVID-19.
2. Slow the spread of COVID-19 in Victoria through rapid identification, isolation and cohorting of risk groups.
3. Empower the Victorian community, health professionals and the community to ensure a proportionate and equitable response.
4. Support containment strategies through accurate, timely and coordinated communication and community support.
5. Mitigate and minimise impacts of the pandemic on the health system and broader community.

Important principles

Our response is guided by the *Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)* and the pandemic response plans of other jurisdictions.

These principles guide us to ensure our response is:

- Flexible and proportionate, and can be scaled up or down as required
- Reliant on existing health systems and health system governance where possible
- Inclusive of all Victorians and acts to reduce any form of xenophobia in the response
- Focused on protecting vulnerable Victorians, including with underlying health conditions, compromised immune systems, the elderly, Aboriginal and Torres Strait Islanders, and those from culturally and linguistically diverse communities
- Integrated with the efforts of the Commonwealth, other states and territories and relevant public agencies and sectors to make best use of common systems, plans and processes.

Outlook

An emerging global pandemic

The evidence is incomplete, but strongly suggests that SARS-CoV-2, the virus that causes COVID-19, meets the criteria for being capable of causing a pandemic, which are:

1. Humans have little or no pre-existing immunity
2. The virus causes disease in humans, and
3. The virus has the capacity to spread readily or efficiently from person to person.

Likely impact on Victoria's population

The population health impact of COVID-19 will be determined by:

1. How readily it can be transmitted (transmissibility)
2. The seriousness of the illness it causes (clinical severity).

Response measures for a pandemic of a respiratory virus depend on factors such as:

1. How spread occurs
2. Whether a person is infectious prior to onset of symptoms, and
3. Severity of illness in those infected.

Modelling pandemic impact

An initial model has been developed by DHHS to estimate the impact of COVID-19 on the Victorian population to help Victorian health services plan and prepare.

The model estimates infections, healthcare-seeking episodes, hospitalisations, critical care admissions and potential for deaths at three different levels of clinical severity: mild, moderate and severe. The model relies on data about transmissibility, severity and how the outbreak of COVID-19 spreads, using the best current evidence for COVID-19.

There is a wide span of possibilities for the impact of a Victorian outbreak of COVID-19, but there is a high probability that any emerging pandemic and its impacts will be prolonged. Our aim is to ensure public health interventions are effective and well targeted, and can minimise the pandemic period and the consequent impacts on the health system and broader society.

The modelling makes an emphatic case for doing detailed planning now, regardless of the severity of any emerging pandemic: planning for the worst case should be a part of that work.

Healthcare services and health professionals must prepare for the possibility of a significant and prolonged increase in demand for healthcare services, and work to ensure the effectiveness and integrity of the health system through the period ahead.

Modelling will continue as further data is available to help the health sector estimate the potential impact on health services, general practice and the health sector. This will include estimates for consumption of personal protective equipment (PPE) based on different levels of usage and models of care.

Implications of the model

The trajectory of the COVID-19 pandemic is highly uncertain, but it is likely to coincide with the Australian influenza season, so the effects of both diseases may be felt simultaneously.

Although measures to reduce exposure such as social distancing, infection control and hygiene practices may be more effective for COVID-19 than influenza, we can expect human-to-human transmission via droplets, direct contact with nasal secretions or contact with objects or materials that carry the virus.

There will be increased, and potentially high, levels of workforce absenteeism. Older Victorians and people with chronic diseases are known to be at greater risk of COVID-19 infection. Early information suggests milder illness in children, particularly those nine years and under. Pregnant women are also reported to have no higher risk of severe disease than the general population.

However, the global situation is still evolving. As more data comes to hand, it is reasonable to expect that other groups (such Aboriginal and Torres Strait Islander communities or those with immunosuppression) may be reported as having a higher relative risk.

How is Victoria responding?

COVID-19 is assessed as being of moderate clinical severity, however, we are preparing so that we are ready to respond if a larger, or more severe outbreak occurs. This plan outlines these preparations, and critical actions our health system would take. These stages apply regardless of clinical severity, and primarily relate to the nature of transmission within Victoria. The stages are:

Stage 1 **Initial containment**	• Monitor and investigate outbreaks as they occur, identify and share accurate information about the virus on a timely basis • Contribute to local and international research efforts • Communicate with the community about the nature of COVID-19, risk reduction measures and ensure community cohesion • Communicate with at-risk groups about preventive actions • Prepare hospital surge management activities to be ready for potential increased demand • Engage closely with the primary care sector to ensure appropriate clinical knowledge, response and capacity
Stage 2 **Targeted action**	**In addition to the measures above**: • Slow the disease transmission with social distancing, and coordination with the plans of other government agencies, including police, ambulance, fire services, SES, transport and education agencies • Ramp up risk reduction communication activity across the community and especially at-risk groups • Begin to implement hospital resource and demand management strategies to maximise resources available for containment • Prioritise diagnostic testing to critical risk groups
Stage 3 **Peak action stage**	**In addition to the measures above:** • Coordinate and prioritise hospital activities to maintain essential services and support quality care • Divert resources from less urgent care, implement alternate models of care, staff surge strategies and appropriate management of supplies • Focus laboratory testing on areas of critical need

Scope and purpose of this plan

This plan is intended as an overarching guidance document to inform more detailed planning at individual practice and institutional level.

All healthcare providers should use this plan, and further materials provided by DHHS to determine how a pandemic may impact their service, their patients or clients and themselves as individual practitioners, and use those insights to determine further planning and preparedness activities required.

Detailed operational plans will be required across all healthcare services in order to be fully prepared for the potential impact of COVID-19 on our healthcare services and community more broadly.

This plan has a greater level of detail for General Practice and inpatient hospital services, because the bulk of acutely unwell patients will present there, however there are elements which are relevant across all healthcare providers.

This plan is not intended as education for the general public. Information for the general public can be found at the DHHS COVID-19 website:

https://www.dhhs.vic.gov.au/coronavirus

This plan is not intended as a guide for the broader, non-health sector. The Victorian Action Plan for COVID-19 Pandemic is under development and will be available from the Emergency Management Victoria website once complete.

Stage 1: Initial containment

The most effective way to reduce the impact of COVID-19 is to reduce exposure.

There is no antiviral therapy for COVID-19, nor is there a vaccine available. Our understanding of COVID-19 evolves every day. Its rapid global spread shows that COVID-19 is highly contagious.

Key priorities in the initial containment stage

Action by the Victorian health system in this stage focuses on:

- **Preparation and planning**
- **Maximising case detection**
- **Minimising transmission**
- **Engaging the community**
- **Characterising the virus, the disease and the epidemic.**

Preparation and planning

It is important the whole Victorian health system takes the opportunity to prepare for COVID-19 in the event the pandemic increases in scale or severity.

All health services should now develop or review local plans for pandemic preparedness, response and recovery. DHHS will develop checklists and templates for these relevant to specific sectors, however every organisation will have specific needs and differences. The below are a minimum set of considerations for all healthcare providers

For the **initial containment** stage these plans should include:

- Clear incident management governance protocols for your organisation
- Protocols to identify and test suspected cases in your organisation – including triage in emergency departments and general practice
- Protocols for case management specific to your organisation and setting
- Protocols for contact management specific to your organisation and setting, including contact tracing mechanisms
- Protocols for outbreak management in your setting, (if appropriate).
- Protocols for infection prevention and control procedures in your organisation, including updates and staff education and audits
- Staff absenteeism protocols
- Regular communications to staff, patients and/or clients.

For the **targeted action** stage plans should include (in addition to the above):

- Consideration of streamed or cohorted care in acute care settings
- Consideration of cancellation, or delay of non-urgent care or procedures
- Consideration of how your service might implement or articulate with alternate models of care relative to the service including (but not limited to)
  - Acute Respiratory Centres

  - Telehealth or Remote healthcare. This would apply for both local and remote consultations in order to minimise contact and exposure of suspected cases to the community.
  - Increased Hospital in the Home services
- Consideration of requirements to scale key clinical services, including critical care and palliative care
- Capacity and capability to manage outbreaks in all health settings, including residential and aged care, disability services and rehabilitation/step-down settings.
- Careful management of workforce capacity and wellbeing
- Supporting and maintaining quality care for those most in need
- Consideration of management through Residential In Reach (RIR) programs now in place statewide, providing multidisciplinary health services directly into public and private aged care facilities.

For the **peak action** stage these plans should include (in addition to the above):

- Implementing plans developed in the first two stages in a proportionate manner
- Significant triaging and prioritising of care needs
- Consideration of designated hospitals for COVID-19 patients, in addition to Acute Respiratory Centres
- Planning for the full range of scenarios relating to the size and duration of an outbreak.

Links to specific preparedness tools for different healthcare agencies to assist with preparedness and planning activities will be added to the DHHS COVID-19 website in coming days, at:

https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

Annual influenza planning should be integrated with your planning for dealing with COVID-19, to ensure a simultaneous surge in demand can be managed. Staff influenza immunisations, the promotion of influenza immunisation to all at-risk patients, and other annual measures will be even more important than usual.

Maximising case detection

The primary objective of the containment stage is to actively identify all cases of infection and contain them to prevent broader outbreaks.

Testing during this stage is focused on individuals with compatible illness from the highest risk countries and regions globally, with consideration given to all international travellers presenting with illness within 14 days of travel.

Work is currently underway to increase capacity in Victoria's reference laboratory, followed by quality assurance of commercial assays for use in metropolitan hospitals, before expansion to all primary laboratories, contingent on TGA approval (or exemption) and NATA accreditation of testing at national level.

All healthcare providers should regularly check the DHHS website at:

https://www.dhhs.vic.gov.au/coronavirus

This provides case definitions and geographic areas of risk, both internationally and within Australia.

All healthcare providers should have clear protocols and mechanisms in place for early identification potential cases of COVID-19 in patients, clients and staff. Rapid testing is critical to early identification and isolation of cases and their close and casual contacts.

Acute health care providers should also have procedures in place for:

- Early triage of presenting patients across the service
- Identifying patients who are presenting for unrelated clinical problems who may be from high risk regions or close contacts of confirmed cases
- Isolation and assessment of potential cases
- Identified testing pathways
- Clear follow up and procedures for test results
- Notification requirements to DHHS.

Other healthcare organisations should develop clear procedures for:

- Isolation of potential cases from other clients once identified
- Referral procedures and pathways for possible cases to the most appropriate clinical setting in order to facilitate testing.

Minimising transmission

There is growing evidence COVID-19 is transmitted directly through infectious droplets or indirectly through contact with surfaces contaminated by respiratory droplets.

Quarantine

Quarantine refers to home isolation of well people who are deemed at risk of COVID-19 due to travel location or contact with a case. As the COVID-19 emergency response has progressed there has been varying requirements for returned travellers to quarantine after being in a high-risk location.

Current quarantine requirements are available at:

https://www.dhhs.vic.gov.au/victorian-public-coronavirus-disease-covid-19

All healthcare services should remain abreast of the current quarantine requirements for staff in general, and staff working in higher risk occupations, such as acute health care and aged care. All healthcare services should have procedures in place for managing staff who are quarantined and facilitating return to work.

All healthcare services should ensure their staff are familiar with the most up to date quarantine advice for returned travellers in order to advise patients and clients appropriately.

Case management

Case management guidance can be found at: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19. This advice will change as more information becomes known about COVID-19 and the causative agent, SARS CoV-2. As case numbers increase, requirements may change for practical reasons.

All healthcare services must ensure the relevant staff are familiar with, and have ready access to, the most up to date case management guidelines.

All healthcare services with inpatients or residents should have procedures in place to manage small and large numbers of cases in their facilities in accordance with the guidelines at: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19. These procedures should consider location of patient/s or clients, staffing, infection prevention and control requirements, visitor policies and other care needs of the patient or client.

As a rule, cases should be managed in home or hospital isolation until they are no longer infectious. It is preferable for cases to be managed in the setting most appropriate to their clinical condition, however in the early stages of the response, many cases will be managed in hospitals to minimise any unnecessary exposure to other household members. As the pandemic progresses, appropriate triage arrangements must be targeted to support those requiring inpatient care.

All healthcare services should ensure staff are aware of clearance criteria for confirmed cases, in order to determine when patients can leave isolation, clients can return into regular healthcare access and staff with confirmed COVID-19 can return to work.

Contact identification and management

All healthcare providers should have procedures for identifying and managing contacts of confirmed cases in their organisations. Definitions for contacts and guidance on management of contacts can be found at:
https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19 .

All healthcare providers should consider how patients, clients, staff and visitors to their organisation could be identified and contacted rapidly if there are exposures in their organisation. Healthcare providers should also consider the impacts of exposures to vulnerable patients or clients, and on business continuity in the event of increased staff absences due to illness, quarantine or the need to care for family.

Infection control precautions

All healthcare providers should actively promote hand hygiene, respiratory hygiene and cough etiquette to staff, patients and visitors. Health services should review signage, update staff briefings and make hand sanitising stations, tissues and safe disposal facilities widely available.

Acute healthcare providers should have up to date guidance for their setting, in line with the Australian standards at:

https://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/national-infection-control-guidelines

and the Victorian guide:

https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19 .

Staff must be regularly trained and assessed in the use of appropriate PPE. Hand hygiene PPE usage, and cleaning and disinfection procedures should be audited for compliance and quality improvement during the initial action and containment stage of the COVID-19 response.

Other healthcare providers should ensure infection control practices in their facility or workplace are appropriate to their setting and in line with national guidance where available.

Engaging the community

It is critical to communicate to the public what is known about COVID-19, what is unknown, and what is being done. Communication of actions critical to mitigate impact and protect the population must be continually reinforced.

All healthcare providers should familiarise themselves with key messages on risks and characteristics of COVID-19, the focus of testing and approaches to contact tracing and case management. Community confidence in the health response will be affected by the accuracy, consistency and currency of information they receive from their health professionals.

Key messaging, social media tiles, posters, translated material and other communications materials can be found at:

https://www.dhhs.vic.gov.au/coronavirus.

DHHS has developed a communications plan to help encourage Victorians to take proactive measures to minimise disease transmission. It will:

- Provide timely, accurate and accessible information about risks at each disease stage and about changes in preparedness and response activities
- Provide transparent, consistent, responsive, and empathetic messaging in local languages through trusted channels of communication
- Provide information on the most appropriate channel for obtaining further information to minimise needless workload on high cost frontline services
- Inform the community about services available to support those diagnosed with COVID-19
- Ensure community cohesion and overcome any potential for racist responses that victimise identifiable groups in the community.

A regular review of messaging and communications approaches will ensure:

- messages are up-to-date, accurate and responsive to current public awareness and attitudes
- messages are consistent across Victoria and the rest of Australia
- messages are consistent across the health sector
- the frequency and content of communication is appropriate for the audience and response stage
- key spokespeople deliver clear, actionable, confident and authoritative messages
- communications are delivered to relevant audiences via the optimal channels and are culturally appropriate
- community networks are engaged to help disseminate important or urgent messages
- there is a balance between providing general information about the disease trajectory while ensuring accuracy, privacy to individual patients and the minimisation of public alarm.

Within DHHS, a dedicated media team is currently responding to media enquiries and helps to coordinate information relating to COVID-19 across government and the health sector. Healthcare services can contact the media team, 24 hours per day via +61 3 9096 8840.

Additional DHHS staff will be available for on-call help and support with localised or targeted communication activities.

Characterising the virus, the disease and the epidemic

Additional data will be required to improve understanding of COVID-19 to inform Victoria's response

strategies and minimise the spread and overall impact of the pandemic, especially in relation to:

- Infectious periods (pre and post symptom onset)
- Transmissibility parameters, including R0 (R nought)
- Mortality and morbidity
- Higher risk patients

DHHS is working with health services, laboratories and research organisations to collect, analyse and rapidly disseminate accurate epidemiological data regarding COVID-19.

All health services should ensure they are able to provide basic and enhanced data regarding cases and contacts upon request to ensure the broader response to COVID-19 is effective.

Victoria is well placed to support the global research effort into COVID-19 and SARS-CoV-2. Victoria has one of the world's best regarded medical research networks, and deep experience in tackling infectious disease.

Research work is being undertaken in five key areas:

- Diagnostics
- Epidemiological modelling and support
- Clinical research
- Treatment – assessment of antivirals
- Vaccine development,

Stage 2: Targeted action

If the pandemic escalates

The scale and severity of COVID-19 may worsen, and while it isn't inevitable, it's a possibility we must prepare for. If COVID-19 escalates in scale and severity, the priorities of DHHS and the Victorian health system must move to a different stage of response where the imperatives are:

- **Slowing the spread of the disease**
- **Adopting sustainable strategies and models of care**
- **Appropriate management of workforce and essential supplies**
- **Supporting and maintaining quality care for those most in need**

Slowing the spread of COVID-19

Minimising transmission of COVID-19 must continue to be a priority as the number of cases grows. This can be tackled both at the community level as well as across the health care system.

Community based actions

Social distancing measures

Slowing the peak of the outbreak with further social distancing measures may also help avoid a surge in demand for health services. These measures will be considered by government as new information comes to hand, and may include:

- Proactive and reactive school, vocational education and university closures
- Workplace measures, such as workplace closures and increased working from home
- Cancellation of mass gatherings, sporting and cultural events
- Voluntary isolation of people who may have been exposed to COVID-19

More direct community education

A community information campaign may be necessary to target key risk groups and the general community with information about infection prevention and control strategies, including hand and surface hygiene, cough and sneeze etiquette, staying home from work or school if sick, when to seek medical attention and how to find out more.

Key messages will continue to be developed with public health advice and in conjunction with Australia's key health officials. These messages will aim to protect, empower and build confidence amongst the general community about how to safeguard their health given their personal circumstances.

Healthcare system actions

Expanded testing

Testing during this stage is initially focused on individuals with compatible illness who are in a geographic cluster, population group or network known to have cases of illness or transmission, but extending to all individuals with compatible illness.

A Victorian Laboratory Plan for COVID-19 is in development, and COVID-19 testing capability will be extended from Public Health Laboratories into hospital and primary laboratories. DHHS is working with Commonwealth agencies to assist with this expansion.

Acute healthcare providers should plan for mechanisms to implement increased testing capacity in their laboratory services and to ensure results are rapidly transmitted to improve patient flow and ensure patients being managed in the community continue to home isolate.

The rapid testing and notification of results will also enable more timely identification and notification of close contacts, which will decrease further spread of illness.

Strict case and contact management

All healthcare providers should support workers to comply with public health recommendations for isolation if they become a case or close contact of a case. These requirements may change as the outbreak continues. Healthcare services must remain informed of the most current requirements for case and contact management which can be found here https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19.

Rapid identification and management of outbreaks in healthcare and other residential facilities

Respiratory illnesses spread rapidly in closed settings, particularly those with vulnerable patient or client groups. This has already been demonstrated to be the case with COVID-19 in international outbreaks.

All healthcare services who have patients, clients, or residents who reside permanently or temporarily in their facility should start preparing now for how to identify and manage an outbreak in their facility. DHHS and the Commonwealth will provide guidance with relevant protocols. Existing influenza outbreak guidelines provide appropriate principles and actions and should be used until specific protocols and guidance in developed.

Adopting sustainable strategies and models of care

Growing home-based care across all health services, including hospital in the home

DHHS will work with the Commonwealth on models of telephone triage and support to suspected and confirmed cases of COVID-19. These services will help determine the clinical severity of illness prior to presentation for diagnosis and care. Individuals with mild illness can then be appropriately triaged to home care and away from Primary or Emergency Care settings. Advice will be widely distributed for individuals and carers on how to manage and sustain home isolation and the supports available.

All healthcare services should direct concerted focus towards supporting people at home using telehealth and phone consultations to avoid unnecessary presentations by patients with mild illness, or unnecessary attendance for consultations.

Hospital in the home (HITH) services allow a range of clinical conditions to be safely managed without the need for a stay in hospital. HITH services are already provided by many Victorian public health services and hospitals should consider expanding the nursing and other resources available to HITH.

Acute healthcare services should commence or continue planning on how these services can be expanded to ensure satisfactory standards of care during a COVID-19 pandemic response.

Non-acute/non-inpatient healthcare services should commence planning on how they might expand home based, telehealth or other remotely accessed services to maintain continuity of care for their clients whilst avoiding high risk settings.

Managing acute presentations to General Practice and emergency departments

Presentations to emergency departments and General Practice will increase as the response moves into the targeted action stage and case numbers increase.

All health services should have comprehensive triage and risk assessment protocols in place as per the initial containment stage (planning and preparation section).

Acute care providers should plan for mechanisms to segregate patients presenting with acute respiratory tract infections from the remainder of the patient population in both settings. Many services have already done this during previous outbreaks and pandemics and are already in planning to reinstate these processes.

Cohorting of these patients in a separate waiting room may become necessary as numbers of presenting patients increase, in both emergency departments and General Practice**.**

General practices may also consider having dedicated clinic times each day for patients with acute respiratory infections. These arrangements will depend on the establishment of other stand-alone clinics or other models for testing suspected patients.

Managing patient flows through acute respiratory clinics

Streamed and cohorted care should be implemented as cases increase.

DHHS is working with health services to identify appropriate locations and develop service models for acute respiratory clinics (ARCs).

ARCs provide one option for healthcare facilities to respond to increased patient demand during a pandemic. ARCs may be activated by health services at any time to meet local demand. DHHS, in consultation with health services, may also direct the opening of ARCs.

The purpose of ARCs is to ensure:

- Emergency departments and General Practices are not overwhelmed with suspected COVID-19 cases
- Hospital-associated transmission of COVID-19 is minimised by keeping potentially infectious patients separate from other patients
- A standardised method for assessing and managing patients is adopted.

Proximity to existing EDs or GPs will be considered in selecting sites for these clinics. This will reduce inconvenience for patients and staff moving to and from the clinics.

Potential ARC sites should offer layout enabling dedicated entrances and exits, separate waiting areas, receptions, triage and clinical areas.

Acute healthcare services should be prepared to set up their own acute respiratory clinic in the event of a surge in patients with respiratory illness. Services should draft rosters for multidisciplinary teams,

including administrative staff to schedule visits, answer calls and follow up results. As far as possible, staff for ARCs should not be drawn from existing EDs, intensive care or specialist units.

Some health services have large campuses without an ED. Each of these have a range of non-urgent services that could be deferred or relocated to create capacity for an ARC or cohorting of inpatients undergoing treatment.

DHHS will identify other potential community sites for ARCs. Some community health services have multiple sites with a significant footprint. Many or most of their services are non-urgent and some could be transferred to alternative locations to free up space for an ARC.

Victoria will work with the Commonwealth to plan enabling support for clinics. This may include changes to GP and acute care reimbursement models including, for example, phone triage and longer consultations as required. Commitment to existing patients may be a barrier to GP participation. The Commonwealth and Primary Health Networks will be asked to help support rescheduling and referring of existing patients.

DHHS will develop a standardised approach to rapid collection of patient data from these clinics, to inform the response at the health service and state level.

Health services should consider how to inform local healthcare providers of clinic locations and operating hours should the need arise. Private hospitals with EDs may also consider having plans for establishing clinics.

Managing demand on acute wards

All healthcare services who manage acute admissions for respiratory illnesses should commence internal planning to determine how to manage increasing numbers of patients who require inpatient support. Health services should plan for rapid test turnarounds to enable cohorting of confirmed cases.

Acute healthcare services should plan for alternative pathways to admission for patients being referred from ARCs in order to prevent bed block at emergency departments.

All healthcare services should plan for the possibility of a COVID-19 outbreak on a ward where non-COVID-19 patients are being cared for. Outbreak management plans should be in place and well understood by all staff.

Managing demand in critical care services

Critical care services could experience a significant increase in demand for personnel, specialised equipment and beds in the event of a significant increase in presentations. **All providers of critical care** should review existing stock and equipment to be able to cope with a potential increase in demand.

DHHS will continue to work with EDs of public and private health services on critical care service continuity planning to manage demand in intensive care units (ICUs), high-dependency units, paediatric intensive care units (PICUs), neonatal intensive care units (NICUs) and medical retrieval services, as these services operate at or near full capacity on a regular basis.

This planning will address critical care capacity and capability for severe COVID-19 infection against modelled scenarios and provide an ethical prioritisation framework for provision of critical care. All options to increase critical care capacity will be explored including equipment and staffing uplifts, reduction in non-emergency critical care admissions, prioritisation and triage of admission.

Managing palliative care services

COVID-19 impacts older people and those with pre-existing comorbid conditions more than younger and otherwise healthy people. Just as we see in influenza season, an escalation in coronavirus cases will result in **palliative care services** experiencing demand. Many of these services will need to be delivered

in the home. Likewise, **acute healthcare services and general practitioners** should ensure the advanced care plans of very elderly and unwell patients are up to date and well understood by the patient's regular care team, family or next of kin.

Appropriate management of workforce and essential supplies

A people challenge for health service leaders

An escalation in COVID-19 cases may have some management challenges for Victoria's health services leadership. There may be a simultaneous increase in demand for clinical staff, public health staff, aged care outreach staff, administrative, support and human resources staff, while at the same time, we see an decrease in staff availability due to illness, quarantine or carer duties.

DHHS will work with health services and industrial partners/unions to develop workforce surge guidelines to manage the identification, recruitment and use of surge staff across Victoria's health networks. Further work will be undertaken with industrial partners on employment conditions that would apply during a pandemic, including attendance, salary payments and the ability to require staff to provide additional support outside their usual job description.

Health services should refresh pandemic human resource plans developed during the initial containment stage as required to:

- Ensure staff are aware that requests for flexibility on their part will be appropriate to their skills and Enterprise Bargaining Agreement.
- Determine minimum staffing levels sufficient to safely maintain services
- Identify part time staff who can work additional hours
- Identify staff who are prepared to defer annual or long service leave
- Identify casual staff who can work additional hours
- Confirm timely approval for overtime and appropriate rest to minimise the risk of fatigue
- Identify employees whose 'return to work' plans may allow them to be deployed
- Identify staff who have recently left the organisation and who might be temporarily re-engaged
- Identify staff who can provide non-clinical support and could be redeployed
- Identify available agency resources
- Identify staff who can perform planning, communication and resource management, as well as the training and orientation of surge staff
- Ensure occupational health and safety risks are assessed and documented and infection control guidelines are well understood
- Ensure a list of health professional volunteers is developed and able to be drawn from, consistent with previous practice in other public emergencies.

Managing people at a challenging time

Staff must be rostered appropriately, with manageable shift lengths, down-time between shifts, regular breaks and access to refreshments.

Support with preparing for and recovering from management of an outbreak escalation should include:

- Appropriate and open communication about the status of the pandemic and plans in place

- Education and training tailored to every role, whether front-line, public health, laboratory, primary healthcare, emergency services or other clinical work. This may be in the form of webinars to ensure timely and maximal access for participation
- A properly briefed Employee Assistance Program to support staff mental health needs.

Staff exposure to COVID-19

Healthcare workers can be exposed to infections including COVID-19 as part of their duties, placing themselves and other staff and patients at risk. As well as undertaking full infection prevention and control measures, health care facilities should specify a framework for the assessment, screening and vaccination of healthcare workers, including the influenza vaccine.

If a healthcare worker is exposed to COVID-19 or becomes a case, **all healthcare services** should ensure the recommended procedures for healthcare worker management are well known and in place as per the guidelines for health services and general practice found here:

https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19 .

Broader workforce support

Managing staff fatigue will be essential for a surge period of potentially many weeks. Staffing in the middle of a COVID-19 related surge would need to consider team-based assessment approaches to determining appropriate admissions and discharges from the ICU, including prompt resumption of care on a non-critical care ward by a usual care team and step-down care. This may require increasing the staffing and clinical oversight of step-down wards, and potentially increasing the acuity of patients leaving ICU.

Where staff are identified as potential surge staff they should be familiarised with the current ICU environment prior to any COVID-19 related surge and undergo appropriate training in the use of PPE.

DHHS will continue to work with the Commonwealth to support all health practitioners to have the appropriate capability and capacity to respond to an escalation of COVID-19. Key partners will be the Royal Australian College of General Practitioners (RACGP), the Australian College of Rural and Remote Medicine (ACRRM), the Australian Nursing and Midwifery Federation (Victorian Branch) (ANMF) and the Australian Medical Association, who all provide important channels for assisting and educating GPs and infection control nurses.

DHHS will also work with the Commonwealth and Aged Care sector to build capacity for:

- Outbreak detection and management
- Infection prevention and control
- End of life planning and care.
- Personal protective equipment and consumables.

DHHS has existing comprehensive guidance for the management of outbreaks in Residential and Aged Care settings available here:

https://www2.health.vic.gov.au/public-health/infectious-diseases/infection-control-guidelines/respiratory-illness-management-in-aged-care-facilities.

These guidelines will be republished for COVID-19 outbreak management. There are also existing national guidelines for influenza management in aged care. The Commonwealth is leading in the development of a national COVID-19 plan for residential and aged care. The national guidelines for influenza management are available here:

https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-flu-guidelines.htm.

Personal Protective Equipment (PPE) and consumables

Adequate access to supplies of PPE will be critical to protect health professionals as they manage the spread of COVID-19. DHHS has worked with primary health networks to support general practitioners through the distribution and monitoring of P2 respirators.

An initial round of distribution of P2 respirators (N95 masks) has been undertaken by Primary Health Networks. At the request of DHHS, PHNs provided limited P2 respirators to each general practice in their distribution where there was knowledge that the general practice was low on P2 respirators, and at the time when P2 respirators were required for testing of all samples due to limited information about mode of transmission.

DHHS is assessing stocks of critical devices such as oxygen machines, ventilators and ECMO machines.

Health services should review their own fleets of critical equipment and work with Health Purchasing Victoria and DHHS to ensure that enough treatment capacity exists to meet a possible surge in demand.

The Australian Government is responsible for maintaining the National Medical Stockpile (NMS), which provides strategic reserves of medicine and equipment to enable rapid access to standardised items that may not be available in a timely routine supply channels during periods of increased national or international demand. The Chief Health Officer can request deployments from the NMS.

DHHS will work continue to with the Australian Government to coordinate provision of PPE to healthcare settings. DHHS will work with health services, Primary Health Networks, Health Purchasing Victoria and clinical networks to:

- Develop a **COVID-19 Personal Protection Equipment and Consumables Plan** to centralise procurement and distribution to primary care, acute respiratory illness clinics and hospitals. The plan will consider strategies to promote prudent use of PPE consumables and ensure PPE is prioritised for acute healthcare settings. A PPE supply team will be identified in DHHS and HPV to manage all logistics of PPE management and supply.
- Identify any potential pharmaceutical or equipment shortages that could arise from increased local and overseas demand or supply chain issues. Work is underway to identify critical consumables, especially by a critical care working group, in relation to intensive care provision.
- Model by scenario possible PPE consumption in different models of care will be undertaken, and over different scenarios. This modelling will show assumptions including use rates for different types of healthcare workers, and
- Review supply chains for critical PPE and consumables to understanding options and probability of acquisition of critical consumables and options for local manufacturing and supply.

Supporting and maintaining quality care for those most in need

It is reasonable to expect that population groups already known to be at increased risk of severe influenza infections will also be at increased risk during COVID-19, including elderly Victorians, Aboriginal and Torres Strait Islanders or those from culturally and linguistically diverse (CALD) communities.

Information materials have been developed in a range of languages for the COVID-19 response, including Chinese.

Primary healthcare and public health services may wish to adapt information or develop their own material based on their known specific client needs. It is important, however, to be consistent with infection prevention and control and other public health principles set out in this plan.

Victoria's public health services include significant aged care services and will include responses for

those services in their local pandemic response plans.

Aboriginal communities are a focus for pandemic planning as they are characterised by having higher numbers of at-risk individuals (i.e. people at higher risk of severe complications from respiratory infections) than the general community. DHHS also recognises the importance of self-determination in development of health initiatives for Aboriginal communities.

Planning activities are being undertaken at Commonwealth level to develop appropriate guidance and materials to support Aboriginal people, communities and health services throughout the stages of the COVID-19 response.

There are a number of barriers for Aboriginal people to access mainstream health services, such as availability, location, cost and continuity of care. For a range of reasons there may be potential for wide-spread reluctance of Aboriginal people to present to EDs, dedicated clinics and other mainstream health services during a pandemic.

Health services must ensure that appropriate services are available to mitigate the impact of COVID-19 in Aboriginal communities. Aboriginal Community Controlled Health Organisations (ACCHO) should be engaged through established partnerships at a health service level. DHHS will work with VACCHO at a statewide level to seek advice on pandemic planning and its cultural appropriateness for Aboriginal people and communities.

Other closed settings

Risks of outbreak are greater in residential and secure services. DHHS will work with the non-government sector to provide guidance to disability and private aged care services, and with government agencies to support the readiness of secure services. This will include work with Justice Health to develop a specific **COVID-19 Response Plan for Custodial Health.**

Stage 3: Peak action

In the event of a severe and sustained outbreak

Action by the Victorian health system in this stage focuses on:

- **Managing impacts and protecting capacity**
- **Managing triage and models of care to minimise morbidity and mortality;**
- **Managing business and community continuity**

Managing impacts, protecting capacity

A severe and sustained outbreak of COVID-19 would have significant impacts on Victoria's health system, resulting in:

- significantly increased numbers of presentations to general practitioners, emergency departments, hospital admissions, intensive care unit admissions and excessive levels of healthcare use
- potential exposure to health workers, police, in-home community services and others encountering potentially affected people
- increased numbers of patient transfers for Ambulance Victoria, combined with the challenge of ensuring rapid turnaround of ambulance disinfection protocols.

Testing during this stage is for all individuals with compatible illness but may be limited by capacity; management of cases may therefore also occur based on clinically compatible illness alone.

If the clinical severity is high, widespread severe illness will cause high levels of morbidity and mortality and challenge the capacity of the health sector. The community focus of governments, agencies and sectors will be on maintaining essential services.

Regular communication with Victoria's health sector and the community will be focused on providing accurate information about the status of the outbreak and implications for access to health services.

Managing triage and models of care to minimise morbidity and mortality

Triaging COVID-19 presentation

The general principles on presentation of cases to EDs are likely to include:

- providing appropriate signage in multiple languages on entry doors and in waiting area and triage assessment points
- ensuring appropriate infection prevention and control measures are taken by all staff and by parents of presenting children and any others who are likely to be in the same room as a suspected case
- if required, immediately isolating the patient in a NPIR (or single room if NPIR not available) and minimise unnecessary staff and family contact
- reconfiguring waiting areas in EDs to increase social distancing to minimise the potential for transmission of COVID-19
- discouraging the patient from leaving prior to further assessment

- obtaining clinical and exposure information to allow for an initial risk assessment to be made
- screening and triage according to case definitions provided by DHHS, ensuring suspected patients wear a mask while being moved to a ward, and keeping the patient separated as much as possible from other patients and staff.

Emergency departments may also be required to compile lists of patients and staff who were in contact with the patient, including their mobile phone numbers and other contact information, for contact follow up if required.

Further useful information is available from the Australasian College of Emergency Medicine (ACEM) who have developed guidelines on the management of severe influenza, pandemic influenza and emerging respiratory illnesses in Australasian emergency departments.

Safe and effective medical, nursing and midwifery care for all patients

It will be vital to ensure the right care is delivered to the right patient in the right location.

People presenting with symptoms of COVID-19 together with other health issues such as trauma, or cardiovascular acute presentations must be managed appropriately in the most appropriate location, using appropriate infection control.

Not all patients with COVID-19 symptoms should be diverted to a separate clinic if they require specialist emergency department care for another reason. Emergency departments and health facilities will need to have plans to manage such patients.

Patients presenting with other symptoms may also have COVID-19. Hence it is important to have an enhanced focus on infection prevention and control in the ED.

Assessment of patients being triaged for intensive care should ideally be undertaken prior to the patient being transported to the ICU. Triage should occur in the ED or referring unit, or other hospital where clinicians need to have effective collaboration between ED, specialty and ICU clinicians to achieve the best outcome for the patient. This may be face-to-face or via telephone or telehealth to connect clinicians to discuss appropriateness for intensive care admission.

Triage will be enacted at the same level across the state, to promote equity of access of patients to intensive care. It is important that these tools are used for all potential admissions, not just infection-related admissions. Tools are being refined to promote national consistency.

Other strategies for preserving clinical resources

During the peak action stage of the pandemic, health services should implement plans already developed during earlier stages. This may include the activation or expansion of additional clinics to manage increasing volumes of patients.

Health services should adopt a systematic and transparent prioritisation of services as demand for treatment grows. DHHS will work with health services through the governance mechanisms outlined in this plan to develop consistent thresholds and responses.

These may include:

- Deferring non urgent elective surgeries
- Transfer of elective surgery to other public or private hospitals
- Early discharge or transfer of patients when safe to do so
- dealing with emergencies only.

As demand for critical care grows, health services will need to strengthen team-based decisions about appropriate admissions and discharges from the ICU (including prompt resumption of care on a non-

critical care ward by a usual care team) and ensure that adequate step-down care is available. This may require increasing the staffing and clinical oversight of step-down wards, in light of potentially increased acuity of patients leaving ICU.

Health services may need to open additional beds in existing non-commissioned physical intensive care bed spaces and consider progressively converting appropriately monitored beds to intensive care. These may include Coronary Care Units (CCU), High Dependency Units (HDU) and any other available space.

Health services will be expected to work with private hospitals to utilise private ICU capacity, especially for patients requiring more routine post-operative care.

As demand for critical care capacity increases DHHS and Safer Care Victoria will facilitate guidance from clinical experts on how to manage priorities appropriately.

Managing business and community continuity

A pandemic is likely to cause significant disruptions to society and challenge social cohesion. Social distancing measures may have wide-ranging effects on business, the economy and public sentiment. The main economic and social impacts are likely to be on events, travel, tourism, the logistics and supply chain industry, higher education, tertiary and vocational education institutions.

With the potential for large numbers of people in self-isolation at home, digital connectivity will be an essential tool to ensure community cohesion and disseminate accurate and timely COVID-19 updates.

The Victorian Action Plan is a plan for all sectors and outlines key roles and responsibilities for managing business continuity and effects across the Victorian heath and wider community. It is currently in development and applies similar principles to the existing Victorian Action Plan for Pandemic Influenza:

https://files-em.em.vic.gov.au/public/EMV-web/Victorian-action-plan-for-pandemic-influenza.pdf.

Victorian Government responsibilities

All Victorian government departments, their sectors and agencies are responsible for preparing for and supporting the response to a COVID-19 pandemic.

Each Victorian government department is required to have preparedness arrangements in place, including business continuity plans, and must develop a COVID-19 incident response plan that outlines the operational actions DHHS will consider undertaking in response to a COVID-19 pandemic.

Preparedness activities for a COVID-19 pandemic should also include:

- ensuring business continuity plans are current and well understood
- identifying incident management plans and systems
- communicating COVID-19 plans and arrangements with staff
- promoting good hygiene, which includes hand hygiene and respiratory/cough etiquette.

Local councils

Local councils and should now implement existing pandemic plans including adapting plans for COVID-19, including business continuity plans. Councils should use information about the timing and magnitude of likely illness as a guide to the general magnitude and timing of potential illness peaks.

DHHS will also provide advice about the potential benefits of social distancing interventions, such as school or university closures, mass gathering cancellations or quarantine and isolation measures.

Businesses and non-government organisations

Government cannot manage the impact of pandemic or maintain essential services on its own.

Businesses and non-government organisations will also play a vital role to help contain the disease and assist communities to continue functioning.

The Victorian Government encourages all organisations to be prepared. Organisations that provide key services or operate critical infrastructure must be able to continue operations.

Business continuity planning that includes pandemic-specific considerations will help minimise the impact of a pandemic on the organisation, protect staff and contribute to community functioning.

Stand-down and recovery

A careful transition back to normal

Action by the Victorian health system in this stage will focus on:

- **Ceasing activities that are no longer needed;**
- **Undertaking monitoring and surveillance for a possible further outbreak;**
- **Transitioning the Victorian health system to normal business;**
- **Working with the Victorian community on the ongoing work of recovery;**
- **Undertaking an evaluation and revision of plans for the pandemic.**

A co-ordinated response to minimise risks

Depending on the scale of the outbreak, recovery following a pandemic could be significant and require a whole of government and community response.

Stand down and recovery activities will start with the onset of a decline in presentations and recorded cases and may take many weeks to decline significantly. The scale and duration of recovery is dependent upon the scale and duration of the outbreak.

Ceasing activities no longer required

Commercial arrangements for supply or expanded services put in place during the pandemic will be terminated in accordance with contract provisions.

Whole of government and sector specific channels will be used to advise workplaces, schools and other sections of the community about how a safe and healthy return to normal business can occur.

Monitoring for further outbreak

Ongoing laboratory testing will be required to identify any emerging resistance to antiviral medication which would pose risks of further outbreaks.

Transition to normal business

In the health sector, elective and other non-urgent services will resume. Careful review and prioritisation of patients whose care was delayed, and whose condition may have deteriorated, will need to occur to ensure that adverse outcomes are minimised.

Stockpiles of critical consumables and equipment will need to be reviewed and replenished as required, including to prepare for any further outbreaks.

Just as clear communication and community engagement is required for pandemic responses, the community will need to understand and support a lowering of safeguards and scaling back of response efforts.

The community will need reassurance that ongoing vigilance will be maintained. Specific information for groups at risk or with special will be provided about the transition of services. This includes Aboriginal and Torres Strait Islanders, elderly Victorians and people from culturally and linguistically diverse backgrounds.

Ongoing recovery

Some sections of the health system, economy and community may be more adversely affected than others.

Relief and recovery will need to be well-informed by local community and targeted for best effect.

Pandemics, like other emergency events can cause or exacerbate a range of psychological reactions and symptoms. Most people recover from such traumatic events, but for some the effects are long lasting.

Bereaved people and workforces on the frontline are at higher risk.

Racist responses to an outbreak threaten the wellbeing and mental health of groups targeted.

Mental health impacts can be reduced by recognising and supporting community resilience through all stages of emergencies from prevention, preparedness, response and recovery. Targeted support to groups more at-risk will be critical to promote a sense of safety, collective community support and recovery.

Psychological first aid, community engagement and psycho-social support, along with formal mental health interventions will form part of the health response to COVID-19.

Resources for coping with the impact of natural disasters are available on the Australian Centre for Post-traumatic Mental Health at www.acpmh.unimelb.edu.au

Evaluation and revision of plans

It will be critical to evaluate and review planning and implementation of the COVID-19 response across the health and other sectors, and at a whole of government level. The Victorian government will ensure that learnings from the COVID-19 experience inform future planning for pandemics and other large scale health system activations.

Governance

National plans and responsibilities

This plan is informed by the *Australian Health Sector Emergency Response Plan for Novel Coronavirus* (COVID-19).

The Australian Health Protection Principal Committee (AHPPC), comprising Chief Health Officers from states and territories and chaired by the Australian Government Chief Medical Officer, is the main coordinating body for public health policy matters for the COVID-19 response.

The Chief Human Biosecurity Officers group, which includes Victoria's Chief Health Officer, reports to the Australian Government Chief Medical Officer in their capacity as Director, Human Biosecurity under the *Commonwealth Biosecurity Act 2015*.

Chief Human Biosecurity Officers and Human Biosecurity Officers have powers in relation to listed human diseases. This includes powers to quarantine and manage risk related to suspected or confirmed COVID-19 cases.

The Communicable Diseases Network Australia (CDNA), reporting to the AHPPC, provides public health guidance and coordinates specialist assessment and management of cases, contacts and surveillance.

Victorian Legislative powers and authorising environment

Chief Health Officer and public health legislation

The *Public Health and Wellbeing Act 2008* aims to protect the health and wellbeing of the population and establishes provisions for managing infectious disease. The Act gives the Victorian Chief Health Officer powers and responsibilities for managing risks to public health arising from outbreaks of infectious disease.

The Act empowers the Victorian Minister for Health, on the advice of the Chief Health Officer - and after consultation with the Minister for Police and Emergency Services and the Emergency Management Commissioner - to activate emergency powers when there is a serious risk to public health.

Public health emergency powers

The Chief Health Officer and authorised delegates may exercise certain powers under a state of emergency in order to investigate, eliminate or reduce a serious risk to public health. The emergency powers include the power to:

- Detain persons or groups within the emergency area for a period reasonably necessary to eliminate or reduce a serious risk to public health
- Restrict movement of a person or group within the emergency area
- Prevent any person or group from entering the emergency area
- Give any other direction that is considered reasonably necessary to protect public health.

The Secretary of DHHS may order a municipal council, officer or authorised officer to perform any functions or duties or exercise any powers that the Secretary directs.

The Secretary may also perform any functions or duties, or exercise any powers, of a municipal council.

A Class 2 emergency

A Class 2 emergency exists when there is a statewide emergency of likely major impact. A Class 2 public emergency has been declared in the case of COVID-19 and a Class 2 controller has been appointed to coordinate inter-agency responses at the state level. DHHS is the lead agency.

Public and denominational hospitals

The *Health Services Act 1988* empowers the Secretary to DHHS to give written directions to public hospitals (metropolitan and rural) and denominational hospitals in relation to matters including:

- actions that the hospital should take to ensure the health services provided by the hospital are safe, patient-centred and appropriate
- the purposes which the hospital should serve and those to which the hospitals should give priority
- the number and types of patients that should be treated
- the manner and extent of co-ordination of admission, care and treatment of patients with hospitals and health care agencies.

The Minister for Health may also give directions to public hospitals (metropolitan and rural) on any matter the Minister thinks is in the public interest provided it relates to the operation of hospitals and other health care agencies.

Private Hospitals, Day procedures centres and other health service establishments

Private hospitals, day procedure centres and other health service establishments are registered by the Secretary of DHHS under the *Health Services Act 1988*. The Secretary has limited powers to give directions to private hospitals, day procedure centres and other health service establishments. These are:

- to require the proprietor to comply with standards in regulations relating to the health care provided by that agency.
- to provide specified information to the Secretary by a specified date in a specified manner.

Victorian plans and governance

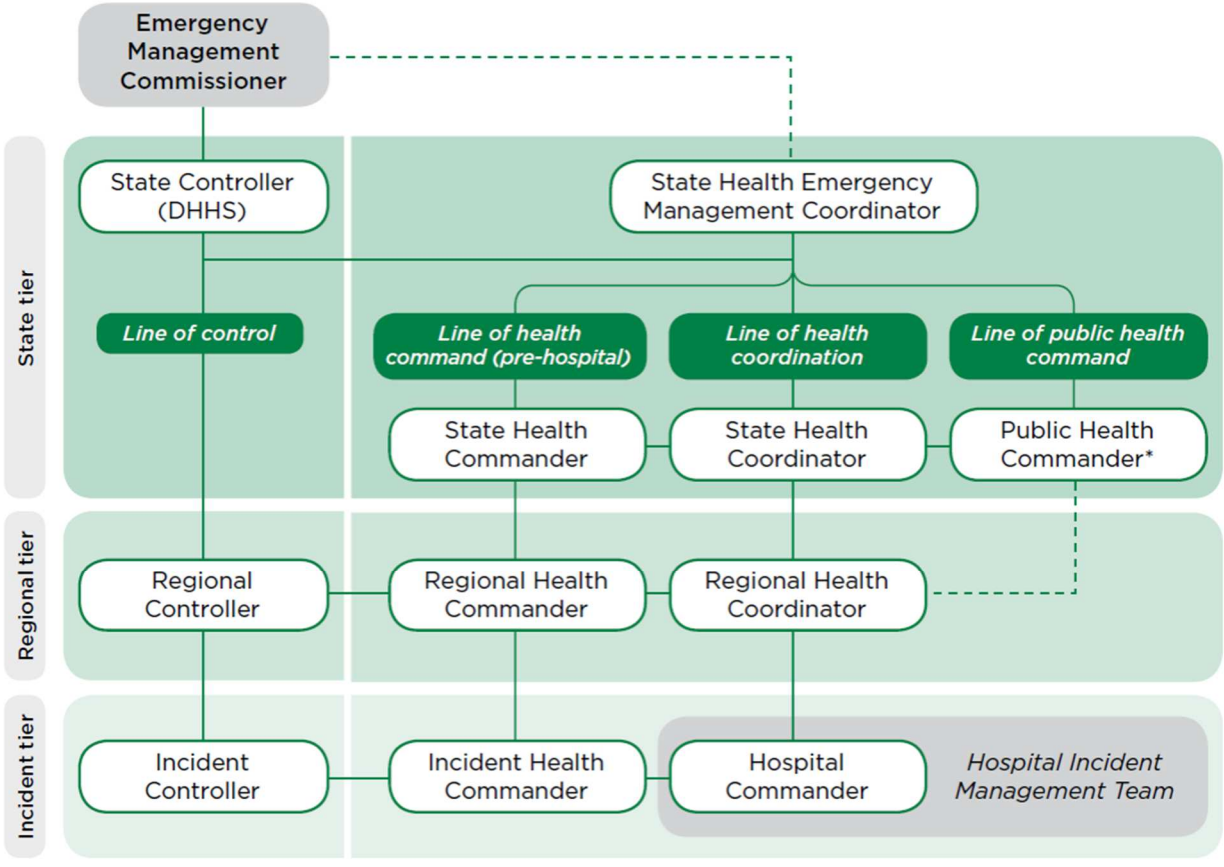
This plan is based on principles and proposed actions outlined in the Victorian Health Management Plan for Pandemic Influenza (VHMPPI).

Department Incident Management Team

The Secretary of DHHS chairs a Health Services Pandemic Leadership Team to mobilise advice and leadership across the Victorian health system.

The DHHS response is coordinated through a single Departmental Incident Management Team (DIMT) chaired by the Public Health Commander for this public health emergency.

The DIMT reports to the Chief Health Officer and Class 2 Controller and is operating under the principles of the State Health Emergency Response Plan, State Health Emergency Response Arrangements and Concept of Operations for Health Emergencies.



Advisory groups and bodies

The clinical networks of Safer Care Victoria provide expert advice to the DIMT and DHHS' response. DHHS will engage with chief executive officers and chief medical officers of Victorian public health services and Victorian private hospitals, the Royal Australian College of General Practitioners and other peak bodies and stakeholders to maximise clinical engagement in determining the best measures to combat this rapidly emerging pandemic.

Short-life working groups may be convened, and lead officers on the DIMT working to the principles of the Australasian Inter-Service Incident Management System (AIIMS) will lead work to coordinate DHHS' response.

Concept of Operations

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

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1. Contents

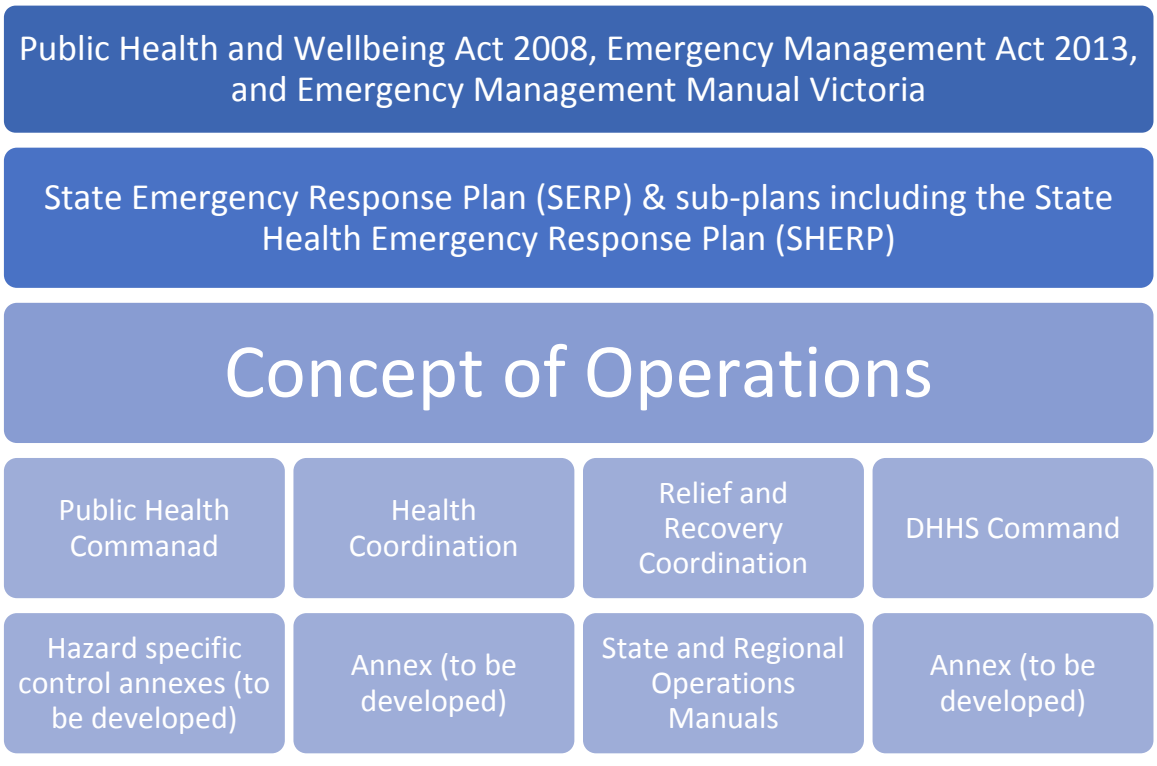
2. Purpose

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.

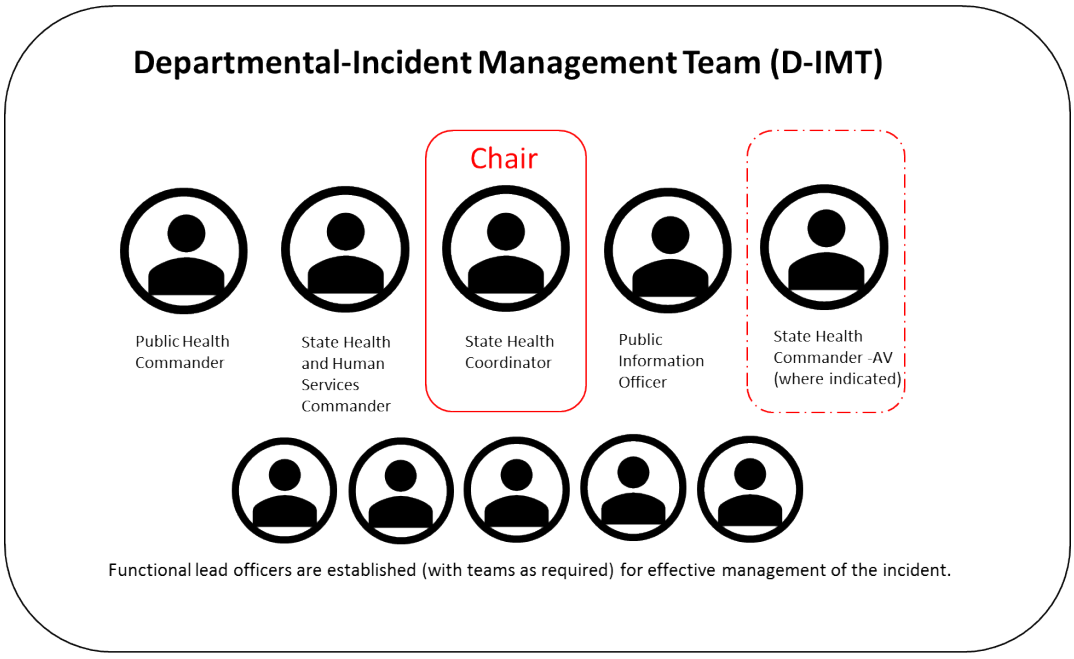
Initial actions for the D-IMT

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

Operation Soteria

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

Operations Plan

Approved for distribution by:

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

Operation Soteria

Distribution

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

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1.0	Final Version released			Andrew Crisp	28 March 2020 2000 hours

Operation Soteria

1. SITUATION

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

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

1.1 Background

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

1.2 Authorising Environment - TBC

Public Health and Wellbeing Act 2008 (Vic)

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

1.3 Definitions

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

2. MISSION

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

Operation Soteria

3. EXECUTION

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

3.1 Phases to achieve identified objectives

3.1.1 Preliminary Actions

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

3.1.2 Phase 1 – Reception

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

3.1.3 Phase 2 – Transport

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

3.1.4 Phase 3 – Accommodation

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

3.1.5 Phase 4 – Return to the Community

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

Operation Soteria

3.2 Preliminary Phase

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

3.3 Phase 1 – Reception

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

3.3.1 Communications

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

3.3.2 Airside Operations

3.3.2.1 AFP/ABF

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

3.3.2.2 DHHS

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

3.3.2.3 AFP/ABF

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

3.3.2.4 Department of Transport (DoT)

- Manage bus transport State-side to accommodation

3.3.2.5 VicPol

REDACTED

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3.3.3 State-side Operations

3.3.3.1 DHHS and DJPR

- Reception parties established and coordinated at all identified accommodation

3.3.3.2 VicPol

REDACTED

3.4 Phase 2 – Transport

Note: DoT are lead

3.4.1 Communications

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

3.4.2 DoT

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

3.4.3 AFP

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

3.4.4 VicPol

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

3.4.5 DHHS and DJPR

- Prepare for incoming passenger accommodation registration

3.5 Phase 3 – Accommodation

3.5.1 Communications

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

3.5.2 DJPR

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

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- Management of services for all passengers including food and amenities

3.5.3 DHHS

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

3.5.4 VicPol

- Provision of support to private security as required

3.6 Phase 4 – Return to the Community

3.6.1 Communications

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

3.6.2 DHHS

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

3.6.3 DoT

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

3.7 Strategies and tactics proposed to achieve tasks and objectives

3.7.1 Coordinating Instructions

3.7.1.1 Timings

Preliminary Phase

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

Phase 1

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

Phase 2

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

Phase 3

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

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Phase 4

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

3.7.1.2 Locations

Airports

- Tullamarine

Maritime Ports

- TBC

Quarantine Accommodation

- TBC

3.8 Daily arrivals schedule – *see Appendix 2*

3.9 Synchronisation matrix - *See Appendix 4*

4. COORDINATION

State Control Centre is the central coordination point for all phases

4.1 Communications Plan (Lead DHHS - Marita Tabain)

4.1.1 Authorisation of communications plan by DPC

4.1.2 Communications plan to incorporate:

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

4.2 Planning Points of Contact – *See Appendix 3*

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Appendix 1

Detention Order pending

Operation Soteria

Appendix 2

DAILY TIMINGS (AS AT 28 1609 MAR 20)

Arrivals for 29 March 2020

Passenger arrivals MEL (Tullamarine)

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

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

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

Operation Soteria

Appendix 3

Contacts List

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

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Appendix 4

Outline of agency involvement across the stages of enforced quarantine

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

Operation Soteria

Mandatory Quarantine for all Victorian Arrivals

Approved for distribution

Emergency Management Commissioner	Signature	Date
Andrew Crisp		

Distribution

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

Document Details

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

Abbreviations/Acronyms

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

Contents

1 Introduction

1.1 Purpose

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

1.2 Scope

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

1.3 Audience

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

1.4 Background

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

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

The objectives for people returning from overseas to Victoria are:

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

1.5 Mission

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

1.6 Inter-agency cooperation

Agencies engaged to deliver Operation Soteria include:

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

1.7 Process Flow

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

These phases include the following:

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

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

2 Governance

2.1 Governance

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

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

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

2.2 Legislative powers

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

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

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

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

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

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

2.2 Organisational Structure

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

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

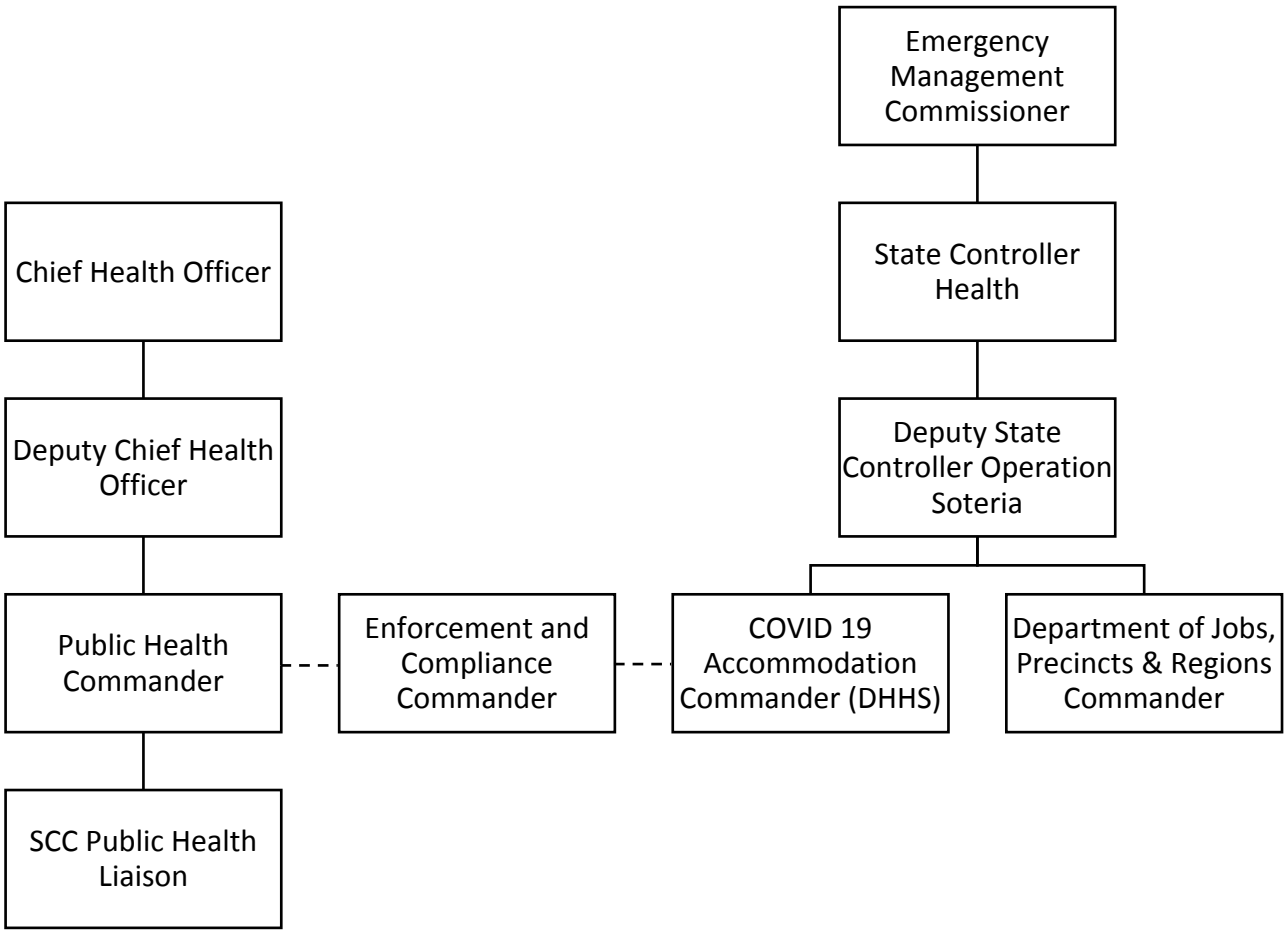


Figure 1: Operation Soteria governance structure

2.3 Roles and Responsibilities

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

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

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

The DHHS Commander COVID-19 Accommodation is responsible for:

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

2.4 Department of Health and Human Services (DHHS)

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

2.4.1 Airside operations - biosecurity

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

2.4.2 Airport Operations - reception

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

2.4.3 Public Health Directions

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

2.4.4 Health Coordination

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

2.4.5 Health and Wellbeing of passengers at accommodation

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

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

2.4.6 Communications including public communications

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

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

REDACTED

2.5.1 Airside operations

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

2.6 AFP

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

2.7 Department of Foreign Affairs and Trade

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

2.8 Department of Transport (DoT)

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

2.9 Ambulance Victoria

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

2.10 Victoria Police (VicPol)

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

REDACTED

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

2.11 Department of Jobs, Precincts & Regions (DJPR)

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

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

3 Detention Authorisation

Section approver: Enforcement and Compliance Commander.

Last review date: 24 April 2020

3.1 Purpose

The purpose of this Detention Authorisation section is to:

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

3.2 Processes may be subject to change

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

3.3 Enforcement and Compliance Command for Mandatory Quarantine

Deliverables of the enforcement and compliance function

Enforcement and Compliance Command is responsible for:

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

Authorised officer* and Chief Health Officer obligations

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

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

3.4 Direction and detention notices

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

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

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

More information can be obtained from:

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

3.5 Exemptions and exceptional circumstances

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

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

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

3.7 Processes and Procedures

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

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

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

3.7.1 Enforcement and compliance information

Further information is available at the links below

- At a glance: Roles and responsibilities
- Authorised officers: Operational contacts
- Authorised officers: Powers and obligations
- Authorised officers: Charter of Human Rights obligations
- Authorised officers: Responsibilities at the Airport
- Authorised officers: Responsibilities at the Hotel
- Authorised officers: Responsibilities for departure from mandatory detention
- End of Detention Notice
- End of Detention Notice (confirmed case or respiratory illness symptoms)
- Compliance and Infringements
- Authorised officers: Occupational Health and Safety
- Unaccompanied minors

- Direction and Detention Notice – Solo Children
- Ensuring physical and mental welfare of international arrivals in individual detention (unaccompanied minors)
- Management of an unwell person at the airport
- Transfer of an uncooperative person
- Request for exemption or temporary leave from quarantine
- Permission for temporary leave from detention
- Requests for to leave room/facility for exercise or smoking
- Hospital transfer plan
- Hospital and Pharmacy contacts for each hotel

4 Operations

Section approver: COVID-19 Accommodation Commander.

Last review date: 24 April 2020

4.1 Purpose

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

4.2 Method

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

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

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

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

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

4.3 Processes and Procedures

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

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

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

5 Health and Welfare

Section approver: Public Health Commander.

Last review date: 24 April 2020

5.1 Purpose

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

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

Clinical governance framework

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

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

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

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

5.2 Standards

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

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

Standard 1. Rights of people in mandatory quarantine

Criterion 1.1 Charter of Human Rights and Responsibilities

Criterion 1.2 People with disabilities

Criterion 1.3 Use of translators

Criterion 1.4 Feedback and complaints process

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

Criterion 2.1 Health and welfare risk factors

Criterion 2.2 Schedule for screening

Criterion 2.3 Methods of screening

Criterion 2.4 Staff undertaking screening

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

Standard 3. Provision of health and welfare services

Criterion 3.1 Meeting the needs of people in mandatory quarantine

Criterion 3.2 Provision of on-site clinical services

Criterion 3.3 Provision of welfare services

Criterion 3.4 Provision of pharmacy and pathology services

Criterion 3.5 COVID-19 guidelines in mandatory quarantine

Standard 4. Health promotion and preventive care

Criterion 4.1 Smoking

Criterion 4.2 Fresh air

Criterion 4.3 Exercise

Criterion 4.4 Alcohol and drugs

Standard 5. Infection control

Criterion 5.1 Personal protective equipment (PPE)

Criterion 5.2 Cleaning and waste disposal

Criterion 5.3 Laundry

Criterion 5.4 Isolation protocols

Standard 6. Allergies and dietary requirements

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

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

Criterion 7.2 Information security

Criterion 7.3 Transfer of personal information (including medical records)

Criterion 7.4 Retention of personal information (including medical records)

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

5.3 Guidelines

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

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

At the airport

Airport health screening

Management of an unwell person at the airport

Refusal of testing

- At the airport
- At the hotel

At the hotel

Quarantine and isolation arrangements

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

Confirmed cases entering detention

- Current infectious cases
- Recovered cases

Throughout detention

Clinical assessment and testing for COVID-19

- Timing of testing
- Pathology arrangements
- Communication of results

Case management

- Management of suspected cases
- Management of confirmed cases

Hospital transfer plan

- Transfer from hospital to hotel

Exiting detention

Release from isolation

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

Exit arrangements

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

Operational guidance for mandatory quarantine

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

Infection control and hygiene

- Cleaning
- Laundry

- Personal protective equipment

Further information is available at the links below

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

Further information is available at the links below:

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

6 Information and Data Management

6.1 Information management systems

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

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

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

6.2 Data access, storage and security

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

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

6.2.1 Privacy

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

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

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

6.2.2 Sending information by email

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

6.2.3 Electronic security of passenger/detainee information

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

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

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

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

6.3 Medical records

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

6.3.1 Requirement for accessible medical records

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

6.3.2 Confidentiality and access to medical records

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

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

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

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

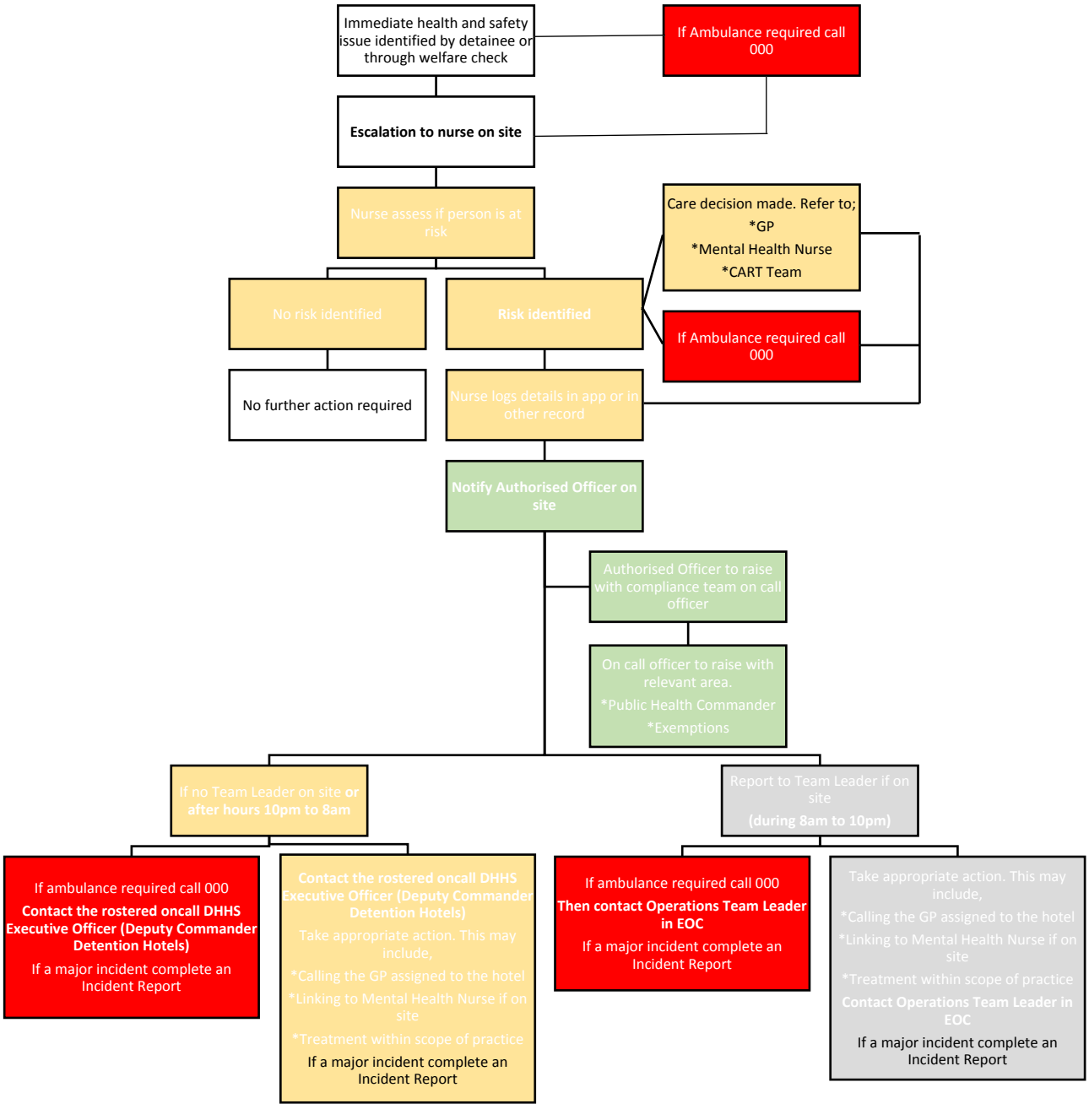
7 Issues escalation and incident reporting

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

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

7.1 Hotel escalation process

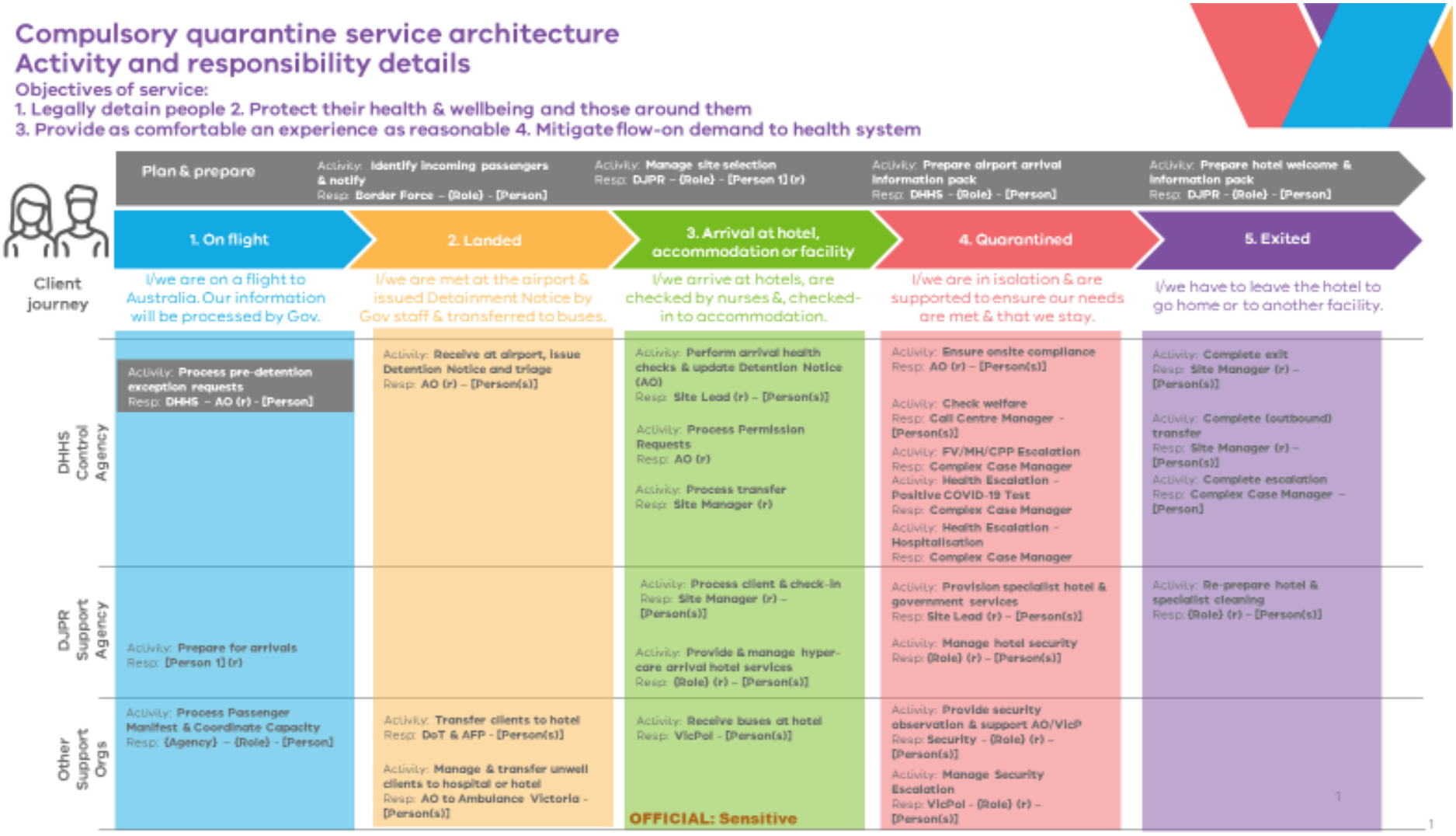
The escalation process in Figure 2 below must be followed for all health and medical risks arising in quarantine hotels.



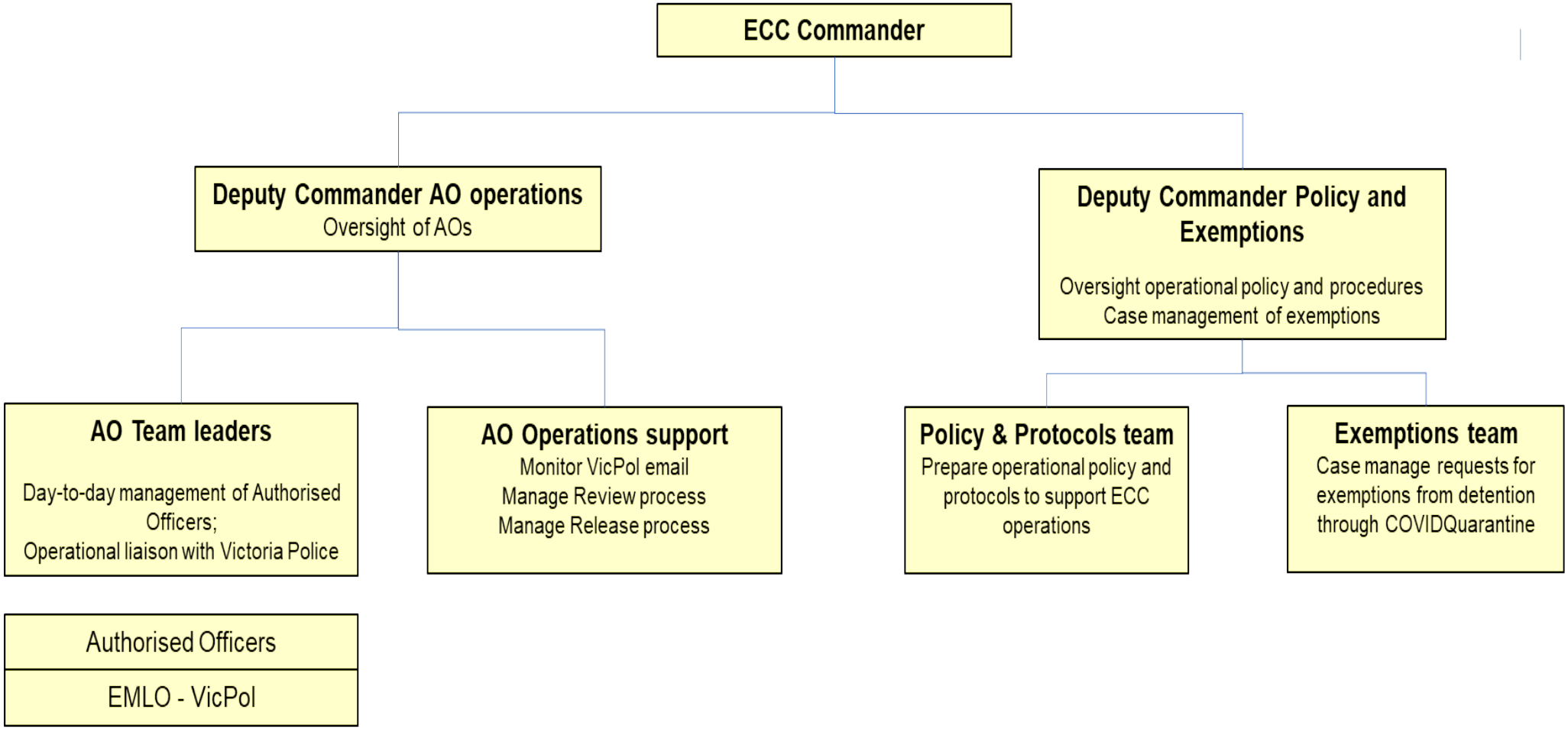
7.2 Incident reporting

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

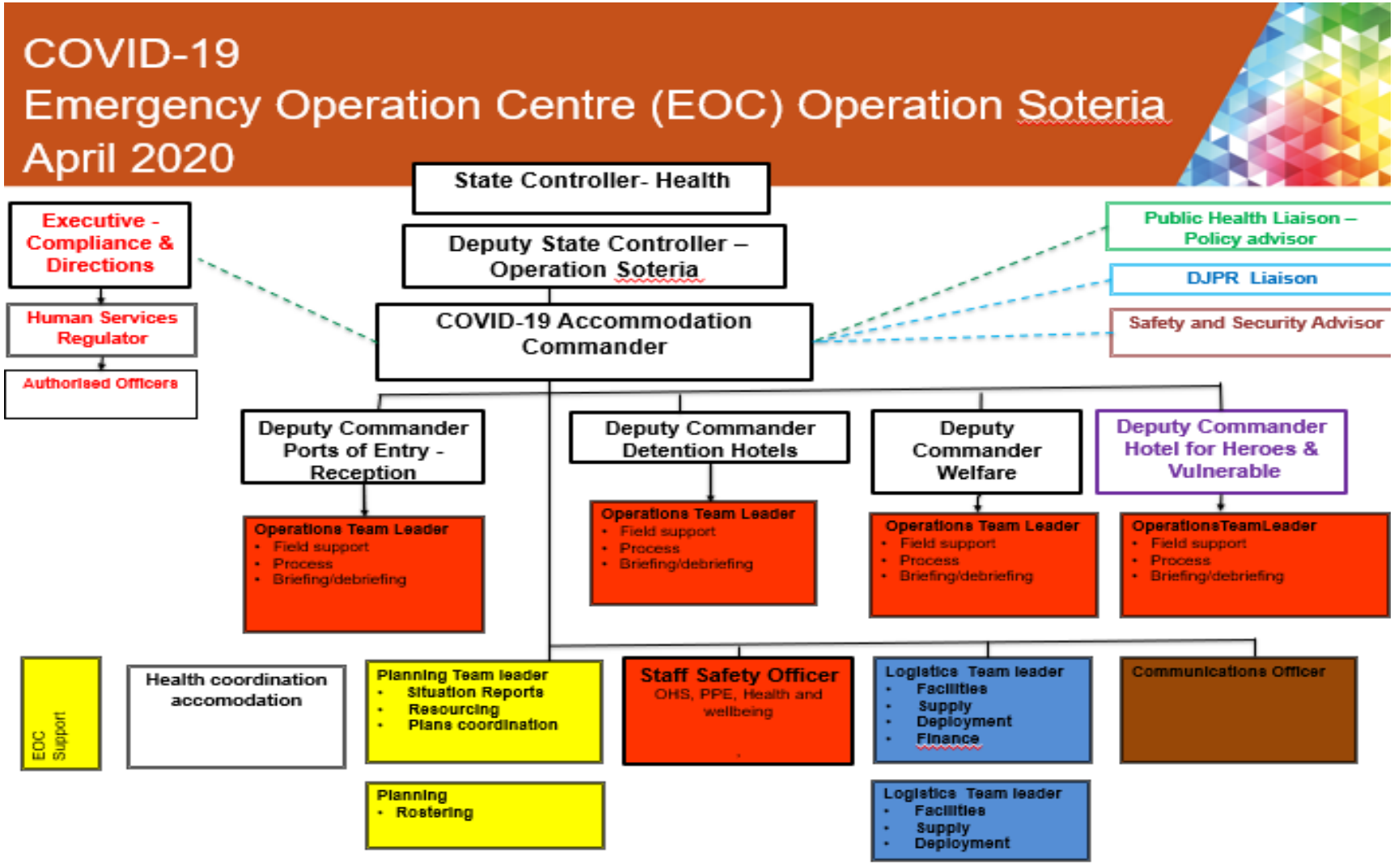
Appendix 1 - Operation Soteria process phases



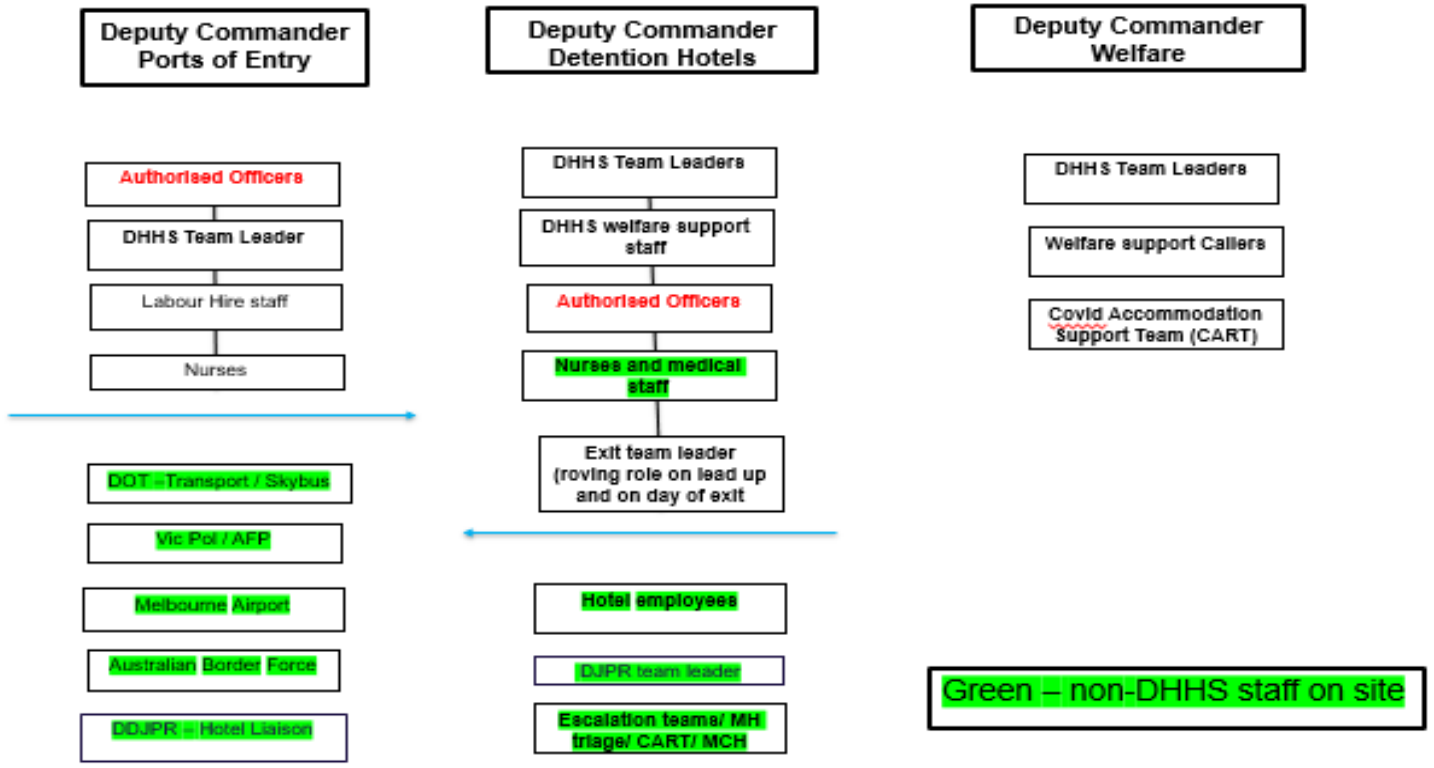
Appendix 2 - Enforcement and Compliance Command structure



Appendix 3. Emergency Operations Centre Structure



Operation Soteria – on site teams



Appendix 4 - DHHS COVID-19 Quarantine – incident reporting

1. Introduction

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

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

This document was last reviewed on 21 April 2020.

2. Reviewing and endorsing incident reports

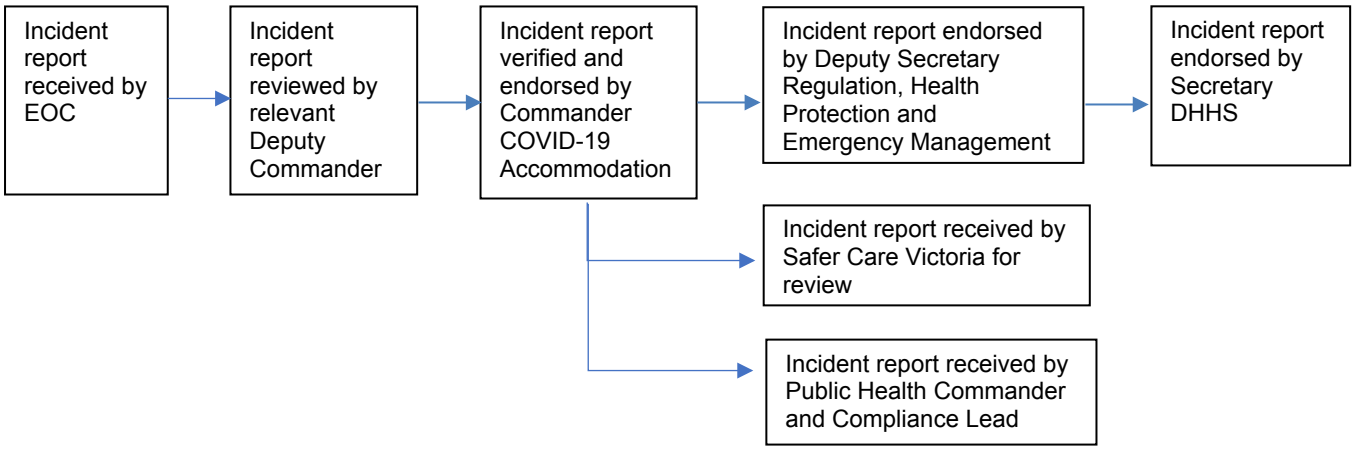
This section outlines the steps required for reviewing and endorsing incident reports, once provided to the DHHS Commander COVID-19 Accommodation via dhhsopsoteriaeoc@dhhs.vic.gov.au following verbal report via phone from the relevant Deputy Commander. Figure 1 below provides an overview of the process.

2.1. Overview

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

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

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



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

2.2. Deputy Commander receives an incident report

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

2.2.1. Reports about passengers/detainees who are also clients

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

2.3. Review of the incident report

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

They must review the incident report and:

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

2.4. Verify and endorse the incident category

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

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

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

2.5. File the completed incident report

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

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

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

2.6. Incident report records management and privacy

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

2.7. Local investigation and causal analysis

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

Incident investigations should:

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

3. Privacy

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

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

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

3.1. Sending information by email

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

3.2. Electronic security of passenger/detainee information

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

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

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

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

DHHS Quarantine – incident reporting template

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

1. Service provider details

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

2. Incident dates

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

3. Incident description

Location of incident	
Detailed incident description	

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

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

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

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

6. Service provider response details

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

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

7. Incident report authorisation – EOC Command

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

8. Incident report authorisation – Deputy Secretary

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

9. Incident report authorisation - Secretary

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

As at 30 March 2020

Private security support for hotel quarantine

Roles and responsibilities of security staff assisting with hotel quarantine

Security personnel have been engaged by the Department of Jobs Precincts and Regions (DJPR) to support authorised officers from the Victorian Department of Health and Human Services (DHHS) and Victoria Police to uphold mandatory quarantine directions from the Chief Health Officer.

The duties of these security staff at the hotels are as follows:

- Support the Chief Health Officer, authorised officers and Victoria Police in the enforcement of the *Isolation (International Arrivals) Directions* on the premises of the hotel.
- Support Victoria Police, hotel staff and Victorian Government staff to register people under quarantine at the hotel and escort them to their rooms.
- Ensure people under quarantine do not leave their rooms for the period of their quarantine without the permission of an authorised officer. This includes a security presence for: the front foyer, each floor on which guests are located, and at entry and exit points throughout the hotel.
- Refer enquiries and concerns from people under quarantine to authorised officers and other support services being provided at the hotel.
- Ensure that any disputes are de-escalated without physical contact. If unable to de-escalate, the security staff have been instructed to immediately escalate to Victoria Police.

Security companies that have been engaged: as at 30 March 2020

Hotel	Security company	Approximate number of security personnel engaged*
Crown Promenade 8 Whiteman St, Southbank VIC 3006	Unified Security	30 security personnel 24/7 across 6 floors
Crown Metropole 8 Whiteman St, Southbank VIC 3006	Unified Security	45 security personnel 24/7 across 15 floors
Crowne Plaza 1-5 Spencer St, Melbourne VIC 3008	Wilson Security	27 security personnel 24/7 across 6 floors

** The number of security personnel at these hotels will be increased as more people are accommodated at these sites. Further security will also be engaged as more hotels are activated for quarantine. Negotiations are currently underway with Wilson Security for it to undertake security for the next two hotels that are being prepared for activation: Pan Pacific Melbourne and ParkRoyal Melbourne Airport. DJPR is also in preliminary discussions with MSS Security should more sites be required, including in regional Victoria.*

Operation Soteria

Mandatory Quarantine for all Victorian Arrivals

Approved for distribution

Emergency Management Commissioner	Signature	Date
Andrew Crisp		

Distribution

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

Document Details

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

Abbreviations/Acronyms

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

Contents

1 Introduction

1.1 Purpose

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

1.2 Scope

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

1.3 Audience

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

1.4 Background

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

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

The objectives for people returning from overseas to Victoria are:

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

1.5 Mission

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

1.6 Inter-agency cooperation

Agencies engaged to deliver Operation Soteria include:

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

1.7 Process Flow

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

These phases include the following:

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

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

2 Governance

2.1 Governance

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

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

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

2.2 Legislative powers

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

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

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

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

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

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

2.2 Organisational Structure

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

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

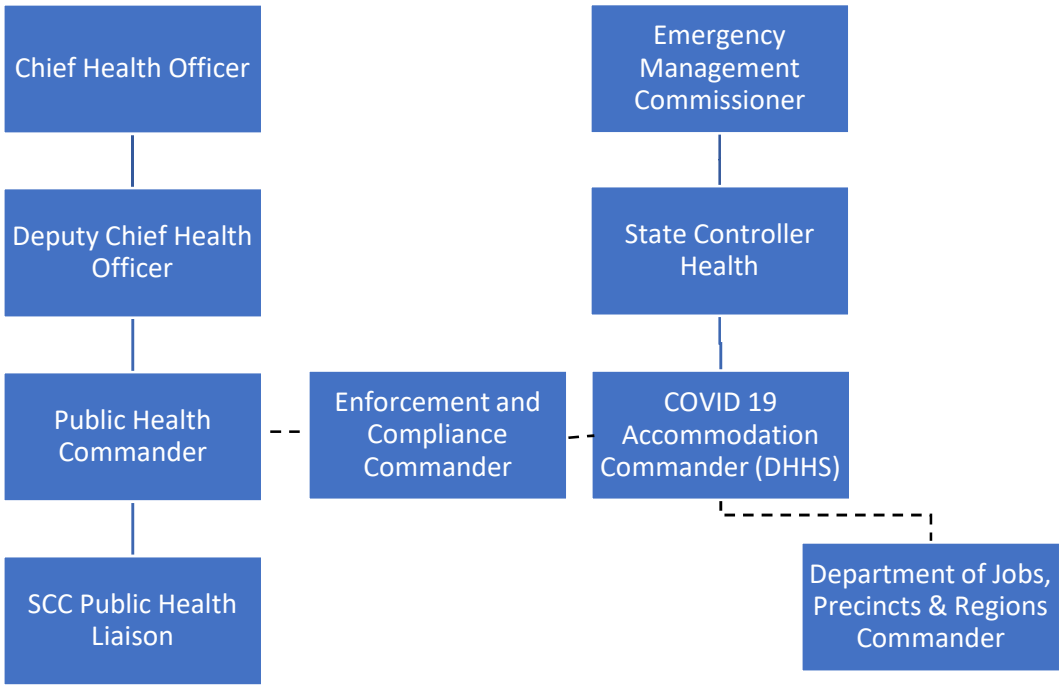


Figure 1: Operation Soteria governance structure

2.3 Roles and Responsibilities

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

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

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

The DHHS Commander COVID-19 Accommodation is responsible for:

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

2.4 Department of Health and Human Services (DHHS)

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

2.4.1 Airside operations - biosecurity

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

2.4.2 Airport Operations - reception

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

2.4.3 Public Health Directions

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

2.4.4 Health Coordination

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

2.4.5 Health and Wellbeing of passengers at accommodation

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

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

2.4.6 Communications including public communications

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

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

REDACTED

2.5.1 Airside operations

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

2.6 AFP

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

2.7 Department of Foreign Affairs and Trade

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

2.8 Department of Transport (DoT)

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

2.9 Ambulance Victoria

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

2.10 Victoria Police (VicPol)

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

REDACTED

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

2.11 Department of Jobs, Precincts & Regions (DJPR)

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

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

3 Detention Authorisation

Section approver: Enforcement and Compliance Commander

Last review date: 8 May 2020

3.1 Purpose

The purpose of this Detention Authorisation section is to:

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

3.2 Processes may be subject to change

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

3.3 Enforcement and Compliance Command for Mandatory Quarantine

Deliverables of the enforcement and compliance function

Enforcement and Compliance Command is responsible for:

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

Authorised officer* and Chief Health Officer obligations

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

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

3.4 Direction and detention notices

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

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

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

More information can be obtained from:

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

3.5 Exemptions and exceptional circumstances

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

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

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

3.7 Processes and Procedures

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

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

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

4 Operations

Section approver: DHHS Commander COVID-19 Accommodation

Last review date: 8 May 2020

4.1 Purpose

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

4.2 Method

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

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

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

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

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

4.3 Processes and Procedures

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

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

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

5 Health and Welfare

Section approver: Public Health Commander

Last review date: 8 May 2020

5.1 Purpose

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

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

Clinical governance framework

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

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

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

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

5.2 Standards

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

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

Standard 1. Rights of people in mandatory quarantine

Criterion 1.1 Charter of Human Rights and Responsibilities

Criterion 1.2 People with disabilities

Criterion 1.3 Use of interpreters

Criterion 1.4 Feedback and complaints process

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

Criterion 2.1 Health and welfare risk factors

Criterion 2.2 Schedule for screening

Criterion 2.3 Methods of screening

Criterion 2.4 Staff undertaking screening

5.3 Operational Guidelines

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

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

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

At the airport

Airport health screening

Management of an unwell person at the airport

Refusal of testing

- At the airport
- At the hotel

At the hotel

Quarantine and isolation arrangements

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

Confirmed cases entering detention

- Current infectious cases
- Recovered cases

Throughout detention

Clinical assessment and testing for COVID-19

- Timing of testing
- Pathology arrangements
- Communication of results

Case management

- Management of suspected cases
- Management of confirmed cases

Hospital transfer plan

- Transfer from hospital to hotel

Exiting detention

Release from isolation

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

Exit arrangements

- Suspected cases
- Confirmed cases
- Quarantine domestic travel checklist

- Care after release from mandatory quarantine

Operational guidance for mandatory quarantine

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

Infection control and hygiene

- Cleaning
- Laundry
- Personal protective equipment

6 Information and Data Management

6.1 Information management systems

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

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

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

6.2 Data access, storage and security

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

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

6.2.1 Privacy

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

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

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

6.2.2 Sending information by email

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

6.2.3 Electronic security of passenger/detainee information

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

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

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

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

6.3 Medical records

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

6.3.1 Requirement for accessible medical records

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

6.3.2 Confidentiality and access to medical records

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

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

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

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

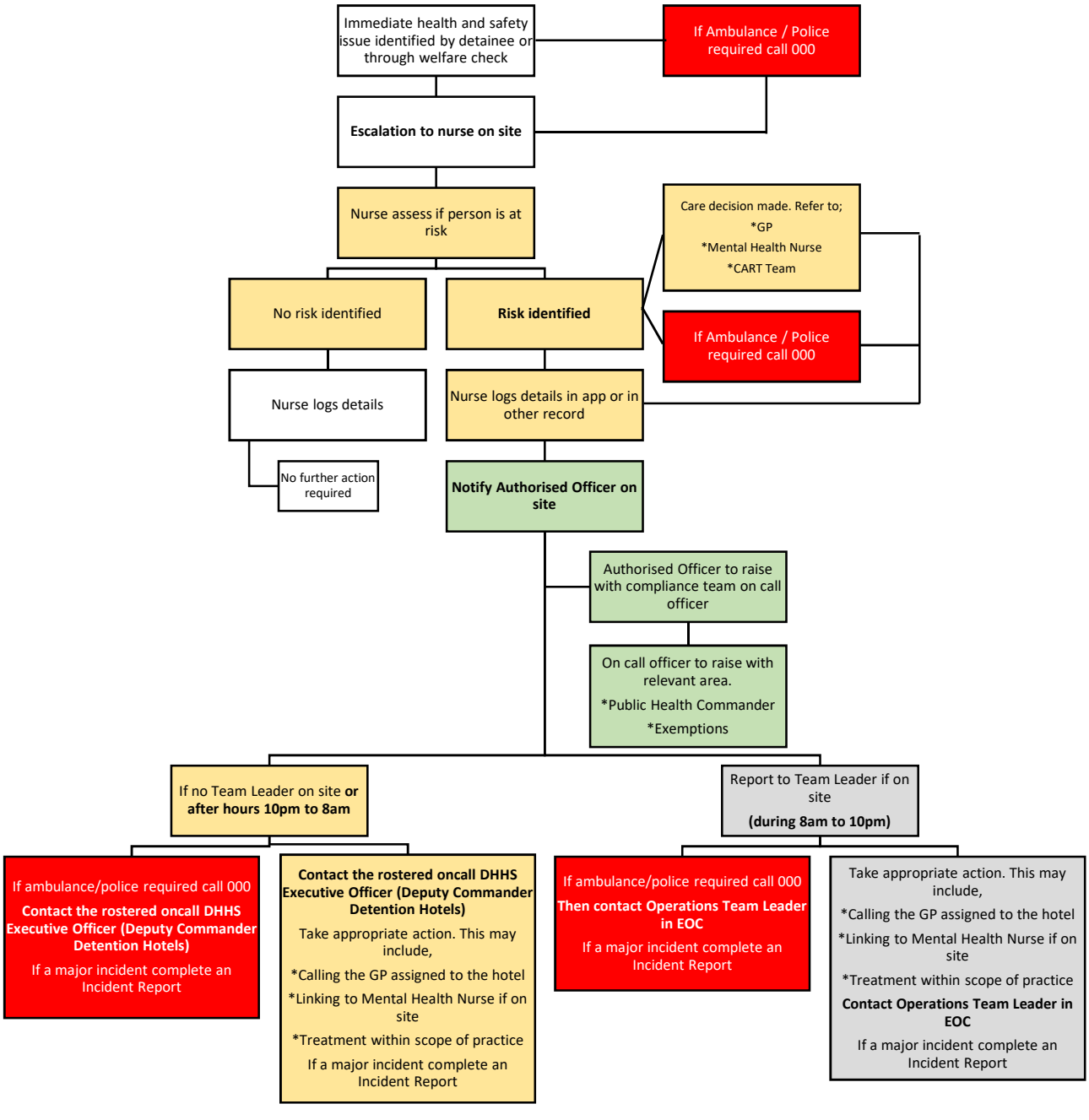
7 Issues escalation and incident reporting

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

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

7.1 Hotel escalation process

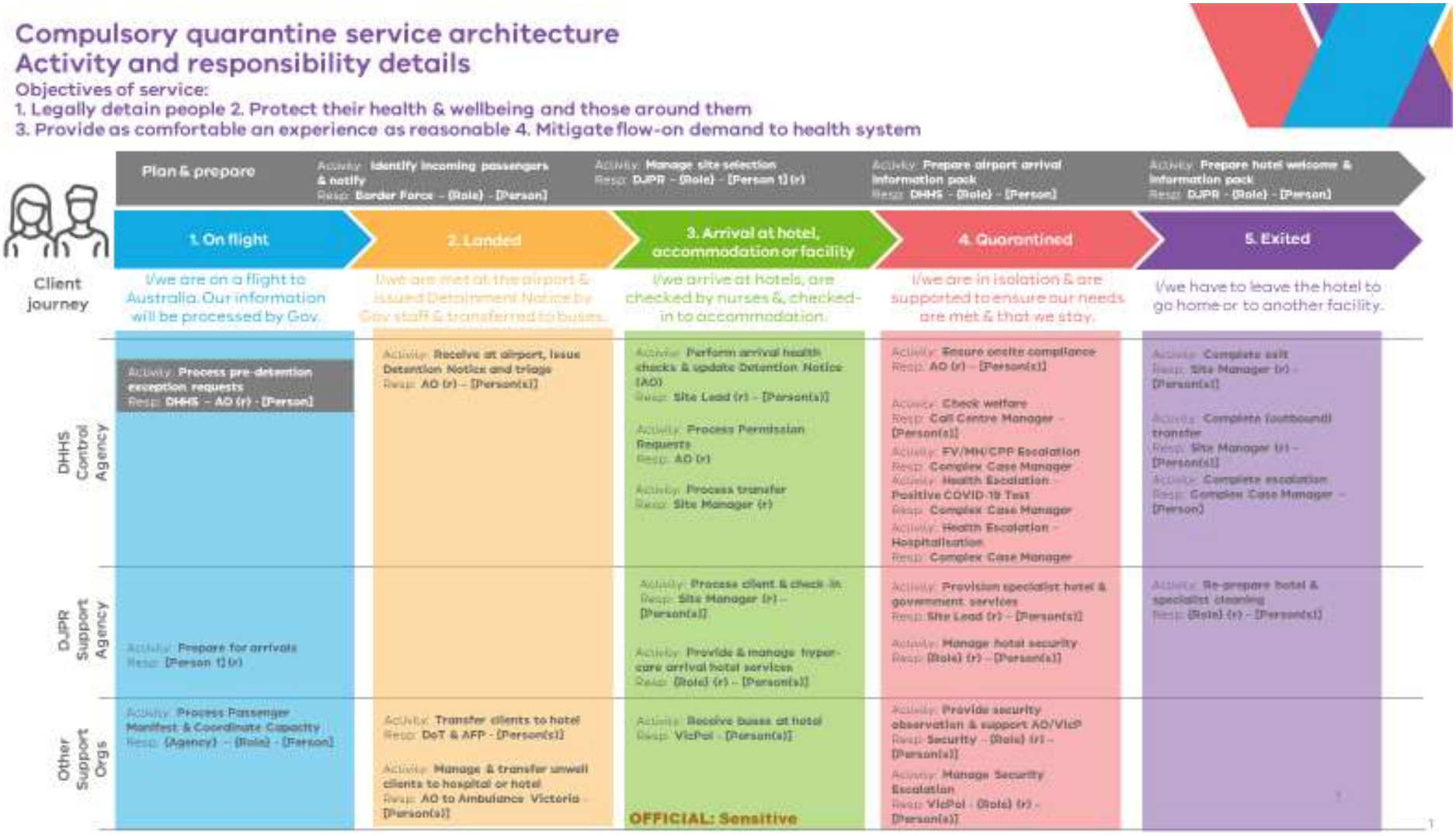
The escalation process in Figure 2 below must be followed for all health and medical risks arising in quarantine hotels.



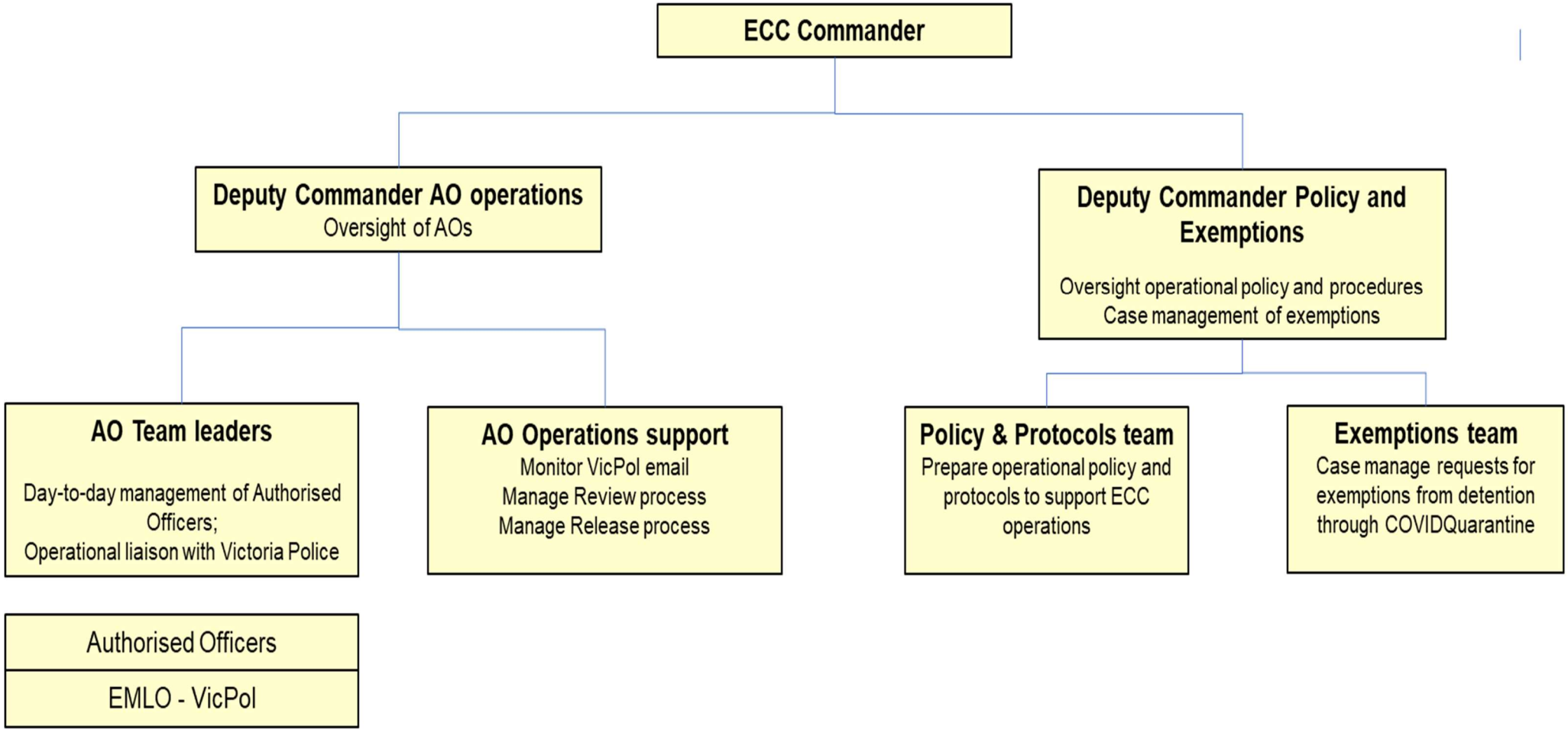
7.2 Incident reporting

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

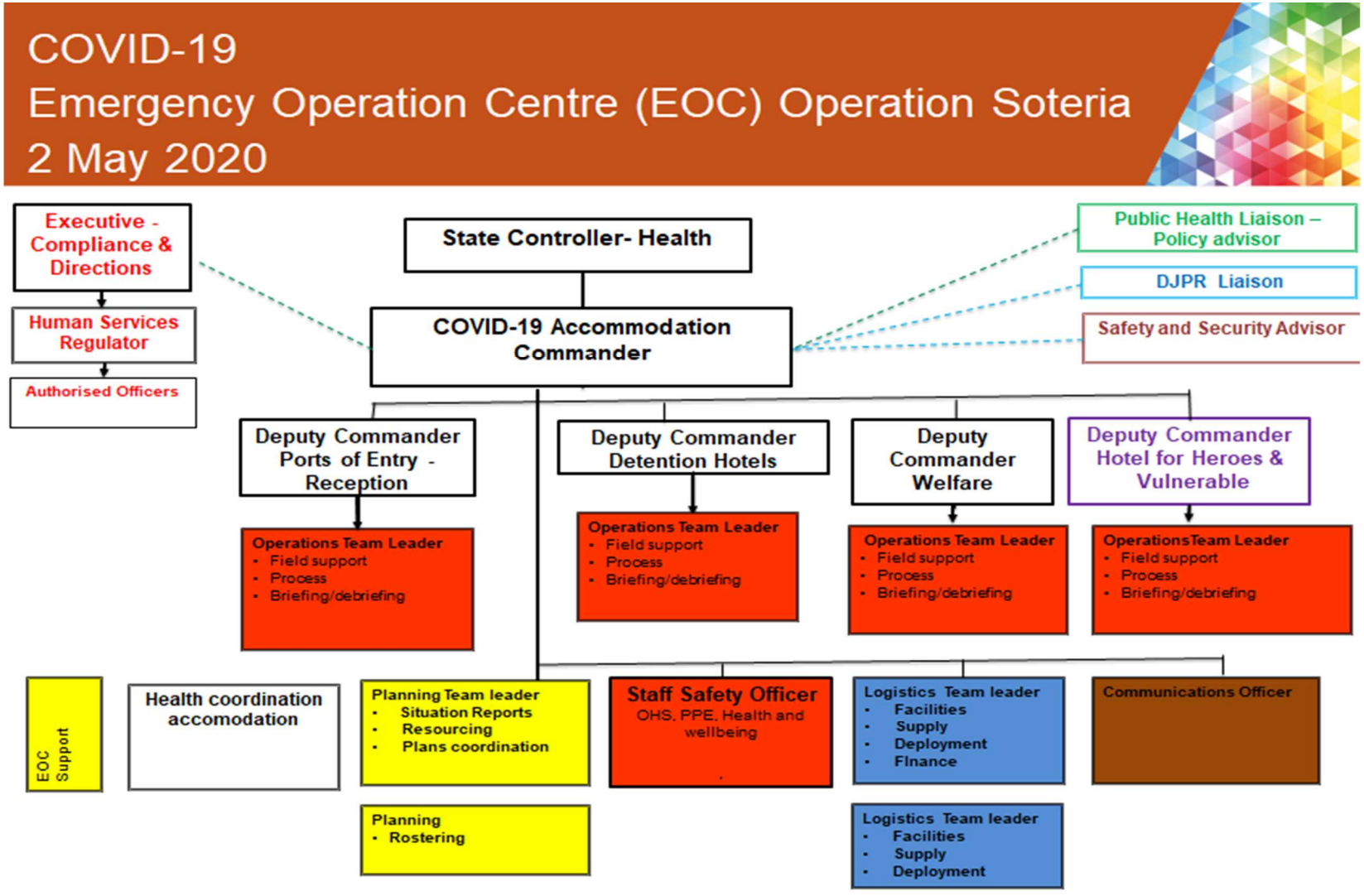
Appendix 1 - Operation Soteria process phases



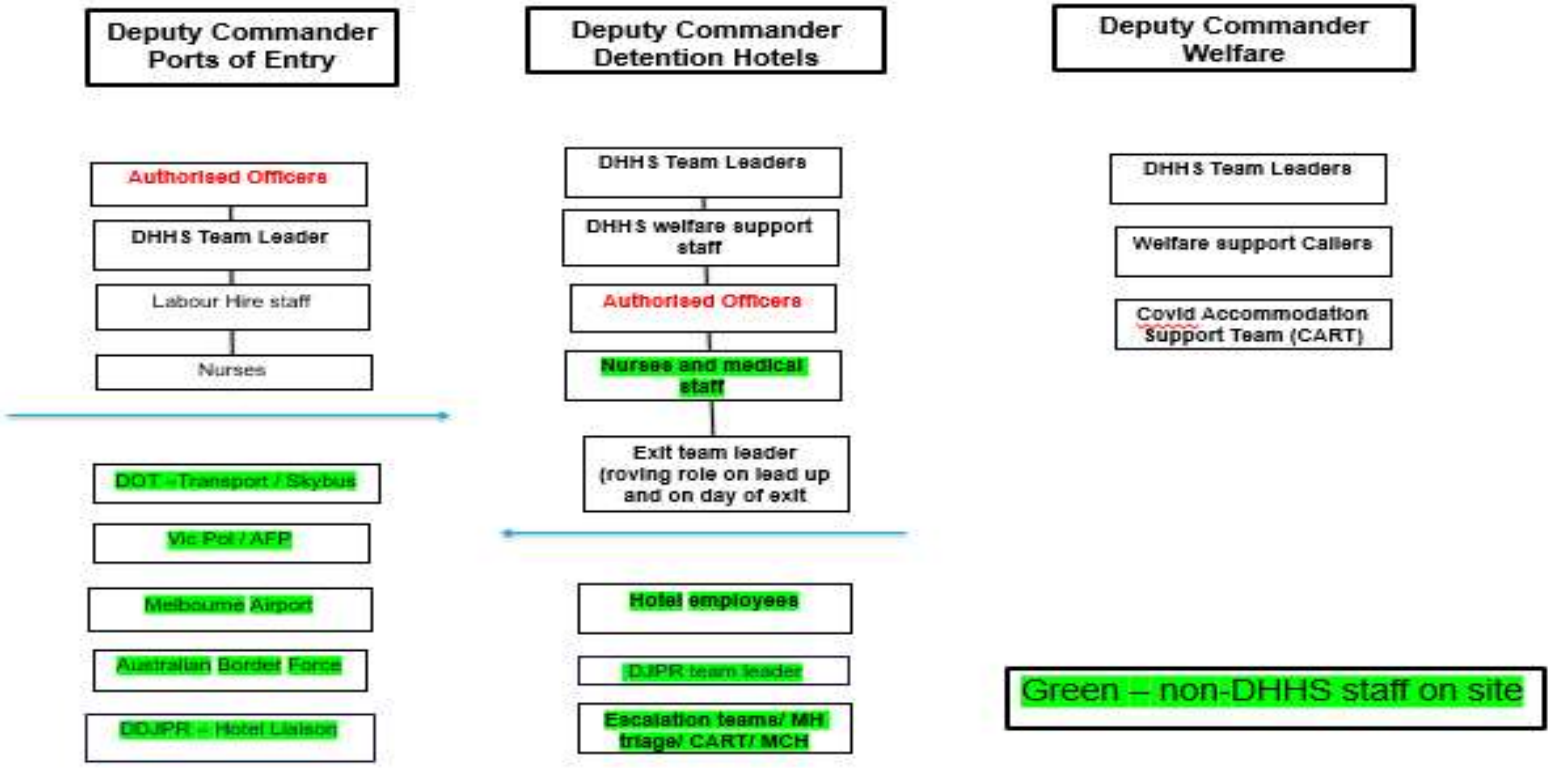
Appendix 2 - Enforcement and Compliance Command structure



Appendix 3 - Emergency Operations Centre Structure



Operation Soteria – on site teams



Appendix 4 - DHHS COVID-19 Quarantine – incident reporting

1. Introduction

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

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

This document was last reviewed on 29 April 2020.

2. Reviewing and endorsing incident reports

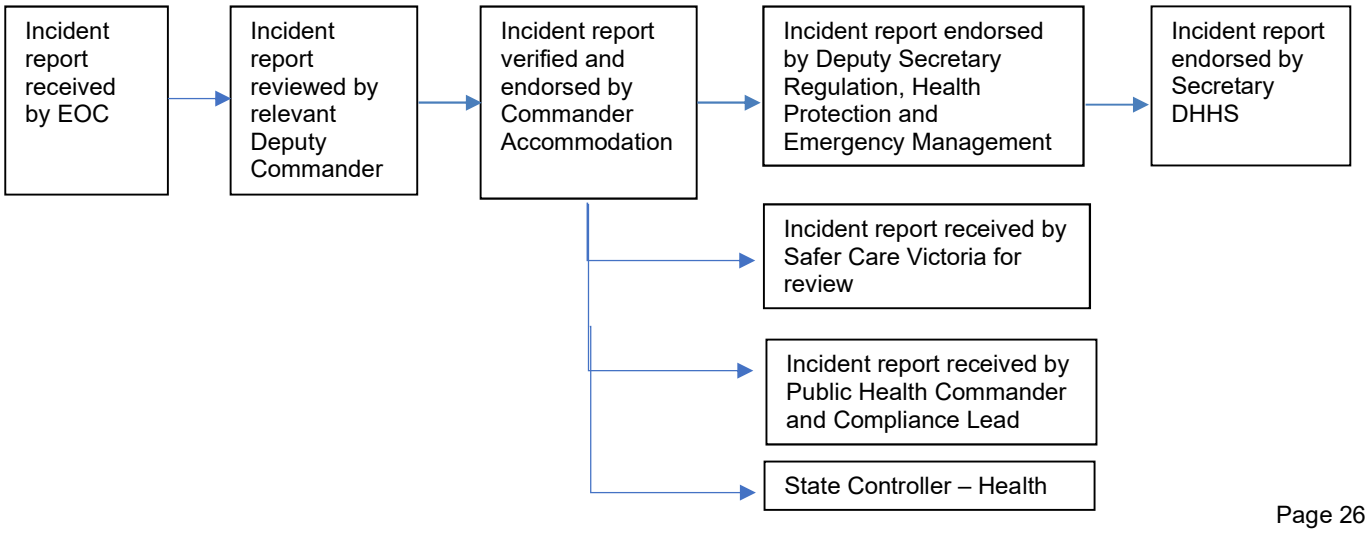
This section outlines the steps required for reviewing and endorsing incident reports, once provided to the DHHS Commander Accommodation via dhhsopsoteriaeoc@dhhs.vic.gov.au following verbal report from the relevant Deputy Commander. Figure 1 below provides an overview of the process.

2.1. Overview

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

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

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



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

2.2. Deputy Commander receives an incident report

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

2.2.1. Reports about passengers/detainees who are also clients

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

2.3. Review of the incident report

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

They must review the incident report and:

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

2.4. Verify and endorse the incident category

The Commander Accommodation verifies and endorses the incident report.

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

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

2.5. File the completed incident report

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

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

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

2.6. Incident report records management and privacy

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

2.7. Local investigation and causal analysis

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

Incident investigations should:

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

3. Privacy

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

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

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

3.1. Sending information by email

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

3.2. Electronic security of passenger/detainee information

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

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

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

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

DHHS Quarantine – incident reporting template

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

1. Service provider details

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

2. Incident dates

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

3. Incident description

Location of incident	
Detailed incident description	

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

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

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

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

6. Service provider response details

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

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

7. Incident report authorisation – EOC Command

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

8. Incident report authorisation – Deputy Secretary

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

9. Incident report authorisation - Secretary

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

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

NATIONAL GOVERNANCE

Chief Health Officer*
Brett Sutton

Emergency Management Commissioner
Andrew Crisp

State Controller (Class 2)
Andrea Spiteri

State Control Team (Key relationships only)

Public Health Commander
Annaliese Van Diemen

State Health Coordinator
Prof. Euan Wallace

State Strategic Communications Manager
Appointed in SCC

State Consequence Manager
Appointed in SCC

State Relief Coordinator
Appointed in SCC

Deputy State Controller – Operation Soteria
Appointed in SCC

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

Public Health Emergency Operations and Coordination | Jacinda de Witts*

Public Health Incident Management Team

PATHOLOGY AND IPC |

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

Pathology Operations |

Pathology Strategy & Policy |

IPC Operations |

IPC Strategy & Policy |

CASE, CONTACT & OUTBREAK | REDACT

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

Operations |

Strategy & Policy |

PHYSICAL DISTANCING |

Coordinate public health response planning, including compliance

Strategy & Policy |

PUBLIC INFORMATION |

Public Information Officer |

Strategic Communication |

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

INTELLIGENCE | Kira Loeb

Operations |

Strategy & Policy |

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

PUBLIC HEALTH OPERATION COORDINATION |

Logistics Advisor |

Provide corporate services to the Incident Management Team.

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

STATE HEALTH EMERGENCY RESPONSE PLANNING/PREPAREDNESS

Terry Symonds* | Helen Mason | Peter Breadon

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

HEALTH SECTOR LOGISTICS

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

Phuong Pham – Equipment and consumables

Deanne Leaver - Infrastructure

HEALTH AND WELLBEING PMO

Denise Ferrier | Jason Phillips

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

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

COMMUNICATIONS

Merita Tabain*

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

E: dhhscovidcomms@dhhs.vic.gov.au

PSYCHOSOCIAL SUPPORT

DHHS Senior Liaison Officer (EM-rostered)

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

ACCOMMODATION (OPERATION SOTERIA)

Commander COVID-19 Accommodation

Pam Williams| Colleen Clark

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

DHHSOpSoteriaEOC@dhhs.vic.gov.au

CROSS-CUTTING DEPARTMENTAL SUPPORT AND COORDINATION

RHPEM COORDINATION

Melissa Skilbeck*

John Spasevski

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

rhpem.coordination@dhhs.vic.gov.au

COMPLIANCE

Meena Naidu |

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

coviddirections@dhhs.vic.gov.au

LEGAL SERVICES

Sean Morrison | Ed Byrden

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

CORPORATE SUPPORT

Greg Stenton*

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

NATIONAL CABINET

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

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

intergovernmentalrelationsdirectorate@dhhs.vic.gov.au

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

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

NATIONAL GOVERNANCE

Chief Health Officer*
Brett Sutton

Public Health Commander
Annaliese Van Diemen

Emergency Management Commissioner
Andrew Crisp

State Controller (Class 2)
Andrea Spiteri

State Health Coordinator
Prof. Euan Wallace

State Control Team (Key relationships only)

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

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

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

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

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

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

Information Management and Governance
[redacted]

Digital Health/TeleHealth
[redacted] | Neville Board

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

Data and Reporting
[redacted], Rosangela Merlo

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

NATIONAL GOVERNANCE

Emergency Management Commissioner
Andrew Crisp

State Control Team (Key relationships only)

Chief Health Officer*
Brett Sutton

State Controller (Class 2)
Andrea Spiteri

Public Health Commander
Annaliese Van Diemen

State Health Coordinator
Prof. Euan Wallace

State Strategic Communications Manager
Appointed in SCC

State Consequence Manager
Deb Abbott

State Relief Coordinator
Sharon MacDonnell

Deputy State Health Controller - Accommodation
Chris Eagles

State Health Incident Management Team, including:

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

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

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

COVID Compliance
Executive Lead – Meena Naidu REDACTED

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

Compliance Operations

Compliance Policy Permissions and Exemptions

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

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

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

NATIONAL CABINET
Chair – Prime Minister

AUSTRALIAN HEALTH PROTECTION PRINCIPAL COMMITTEE
Chair – Chief Medical Officer

Victorian Premier

Department of Premier and Cabinet

DHHS Secretary
Kym Peake

Deputy Secretary
Amity Durham

A/General Counsel
Sean Morrison

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

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

Chief Health Officer
Dr Brett Sutton

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

National Cabinet Policy and Projects Team

AHPPC Secretariat
REDACTE

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

Executive -
COVID Compliance

Human Services Regulator

Authorised Officers

State Health Controller

Deputy State Controller
Operation Soteria

COVID-19 Accommodation Commander

Public Health Liaison -
Policy Advisor

DJPR Liaison

Safety and Security Advisor

Deputy Commander
Ports of Entry - Reception

Deputy Commander
Detention Hotels

Deputy Commander
Welfare

Deputy Commander
Hotel for Heroes & Vulnerable

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

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

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

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

EOC Support

Health coordination accomodation

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

Staff Safety Officer
- OHS
- PPE
- Health and wellbeing

Logistics Team leader
- Facilities
- Supply
- Deployment
- Finance

Communications Officer

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

Deputy Commander Ports of Entry

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

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

Deputy Commander Detention Hotels

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

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

Deputy Commander Welfare

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

Key — Non-DHHS staff on site

Operation Soteria

Mandatory Quarantine for all Victorian Arrivals

Approved for distribution

Emergency Management Commissioner	Signature	Date
Andrew Crisp		

Distribution

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

Document Details

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

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

Abbreviations/Acronyms

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

Contents

1 Introduction

1.1 Purpose

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

1.2 Scope

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

1.3 Audience

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

1.4 Background

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

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

The objectives for people returning from overseas to Victoria are:

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

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

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

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

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

1.5 Mission

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

1.6 Inter-agency cooperation

Agencies engaged to deliver Operation Soteria include:

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

1.7 Process Flow

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

These phases include the following:

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

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

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

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

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

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

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

2 Governance

2.1 Governance

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

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

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

2.2 Legislative powers

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

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

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

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

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

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

2.2 Organisational Structure

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

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

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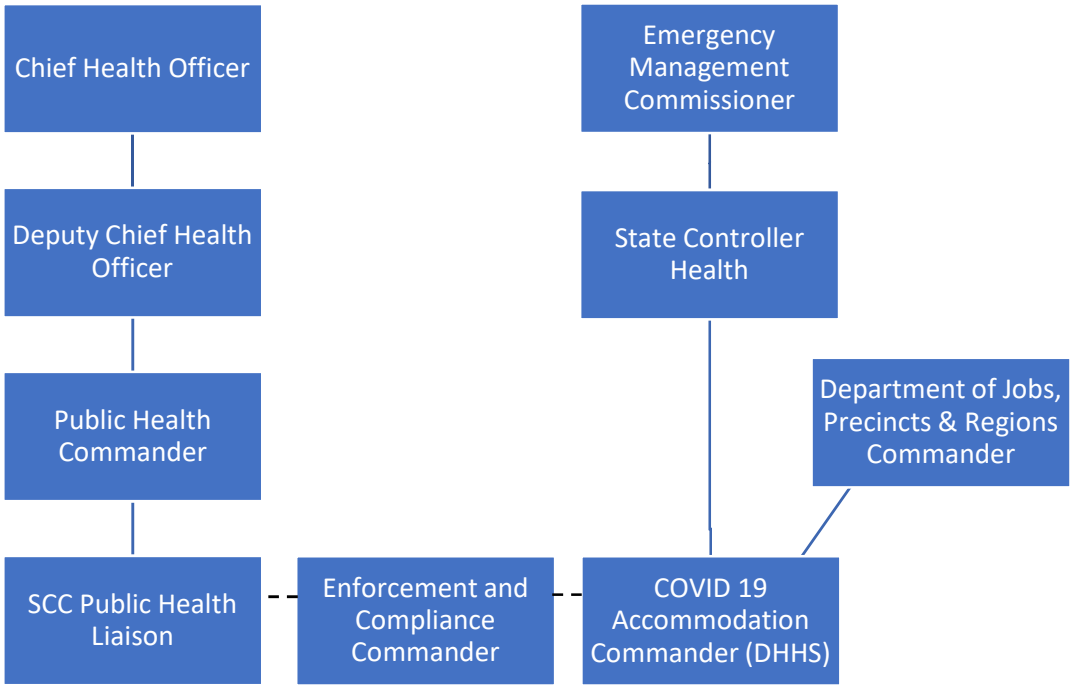


Figure 1: Operation Soteria governance structure

2.3 Roles and Responsibilities

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

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

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

The DHHS Commander COVID-19 Accommodation is responsible for:

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

2.4 Department of Health and Human Services (DHHS)

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

2.4.1 Airside operations - biosecurity

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

2.4.2 Airport Operations - reception

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

2.4.3 Public Health Directions

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

2.4.4 Health Coordination

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

2.4.5 Health and Wellbeing of passengers at accommodation

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

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

2.4.6 Communications including public communications

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

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

REDACTED

2.5.1 Airside operations

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

2.6 AFP

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

2.7 Department of Foreign Affairs and Trade

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

2.8 Department of Transport (DoT)

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

2.9 Ambulance Victoria

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

2.10 Victoria Police (VicPol)

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

- Provision of support to private security as required

REDACTED

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

2.11 Department of Jobs, Precincts & Regions (DJPR)

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

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

3 Detention Authorisation

Section approver: Enforcement and Compliance Commander.

Last review date: 8 May 2020

3.1 Purpose

The purpose of this Detention Authorisation section is to:

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

3.2 Processes may be subject to change

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

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

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

3.3 Enforcement and Compliance Command for Mandatory Quarantine

Deliverables of the enforcement and compliance function

Enforcement and Compliance Command is responsible for:

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

Authorised officer* and Chief Health Officer obligations

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

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

3.4 Direction and detention notices

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

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

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

More information can be obtained from:

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

3.5 Exemptions and exceptional circumstances

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

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

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

3.7 Processes and Procedures

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

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

Annex 1: Operation Soteria – Authorised Officer Standard Operating Procedures

4 Operations

Section approver: DHHS Commander COVID-19 Accommodation

Last review date: 1 June 2020

4.1 Purpose

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

4.2 Method

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

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

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

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

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

4.3 Processes and Procedures

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

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

Annex 3: Operation Soteria – Operational Guidelines for Mandatory Quarantine

5 Health and Welfare

Section approver: Public Health Commander.

Last review date: 1 June 2020

5.1 Purpose

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

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

Clinical governance framework

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

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

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

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

5.2 Standards

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

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

Standard 1. Rights of people in mandatory quarantine

Criterion 1.1 Charter of Human Rights and Responsibilities

Criterion 1.2 Diverse groups

Criterion 1.3 Use of interpreters

Criterion 1.4 Feedback and complaints process

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

Criterion 2.1 Health and welfare risk factors

Criterion 2.2 Schedule for screening

Criterion 2.3 Methods of screening

5.3 Public Health Policy for COVID-19 in Mandatory Quarantine

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

5.4 Operational Guidelines

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

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

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

6 Information and Data Management

6.1 Information management systems

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

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

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

6.2 Data access, storage and security

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

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

6.2.1 Privacy

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

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

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

6.2.2 Sending information by email

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

6.2.3 Electronic security of passenger/detainee information

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

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

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

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

6.3 Medical records

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

6.3.1 Requirement for accessible medical records

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

6.3.2 Confidentiality and access to medical records

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

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

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

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

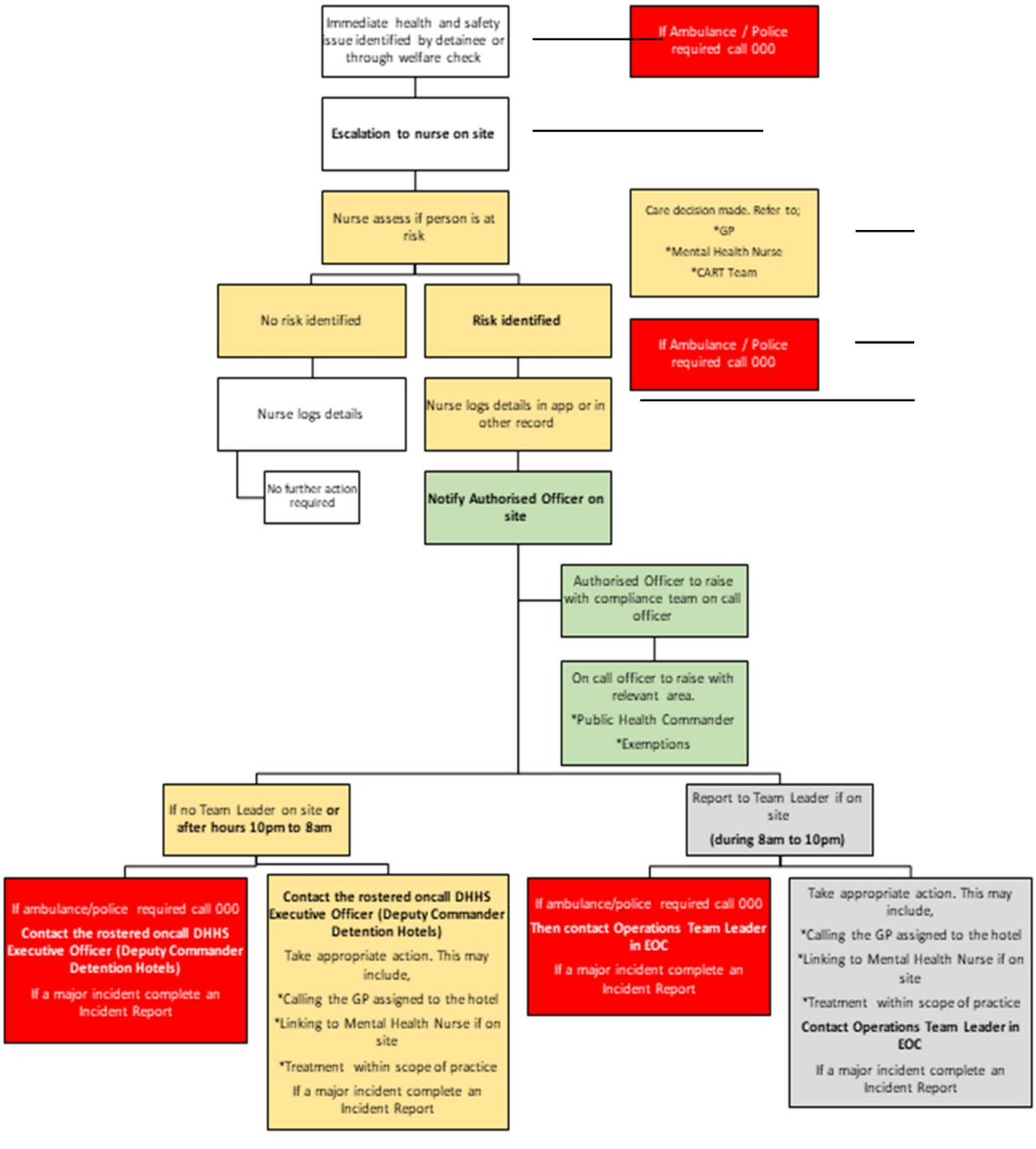
7 Issues escalation and incident reporting

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

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

7.1 Hotel escalation process

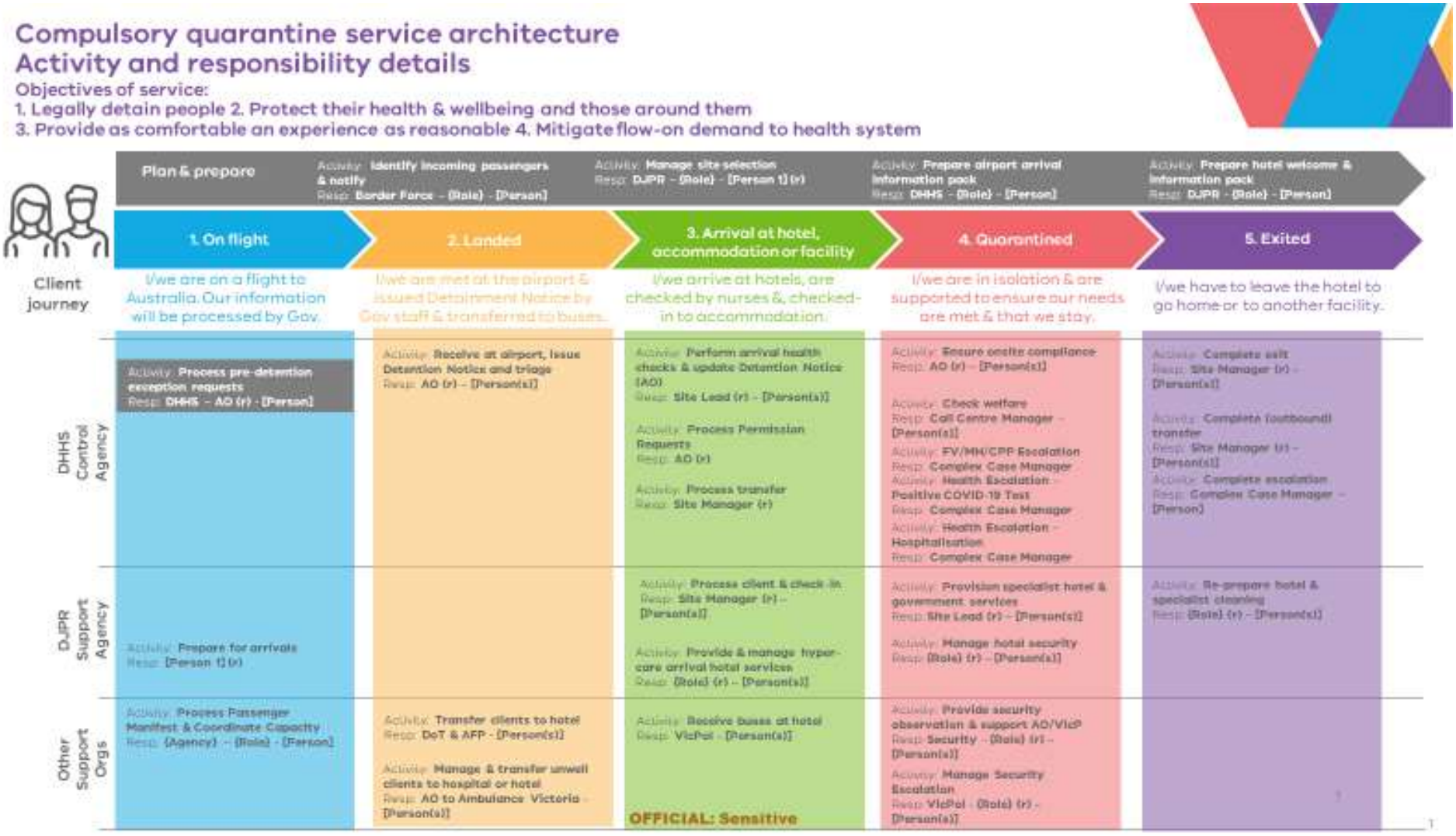
The escalation process in Figure 2 below must be followed for all health and medical risks arising in quarantine hotels.



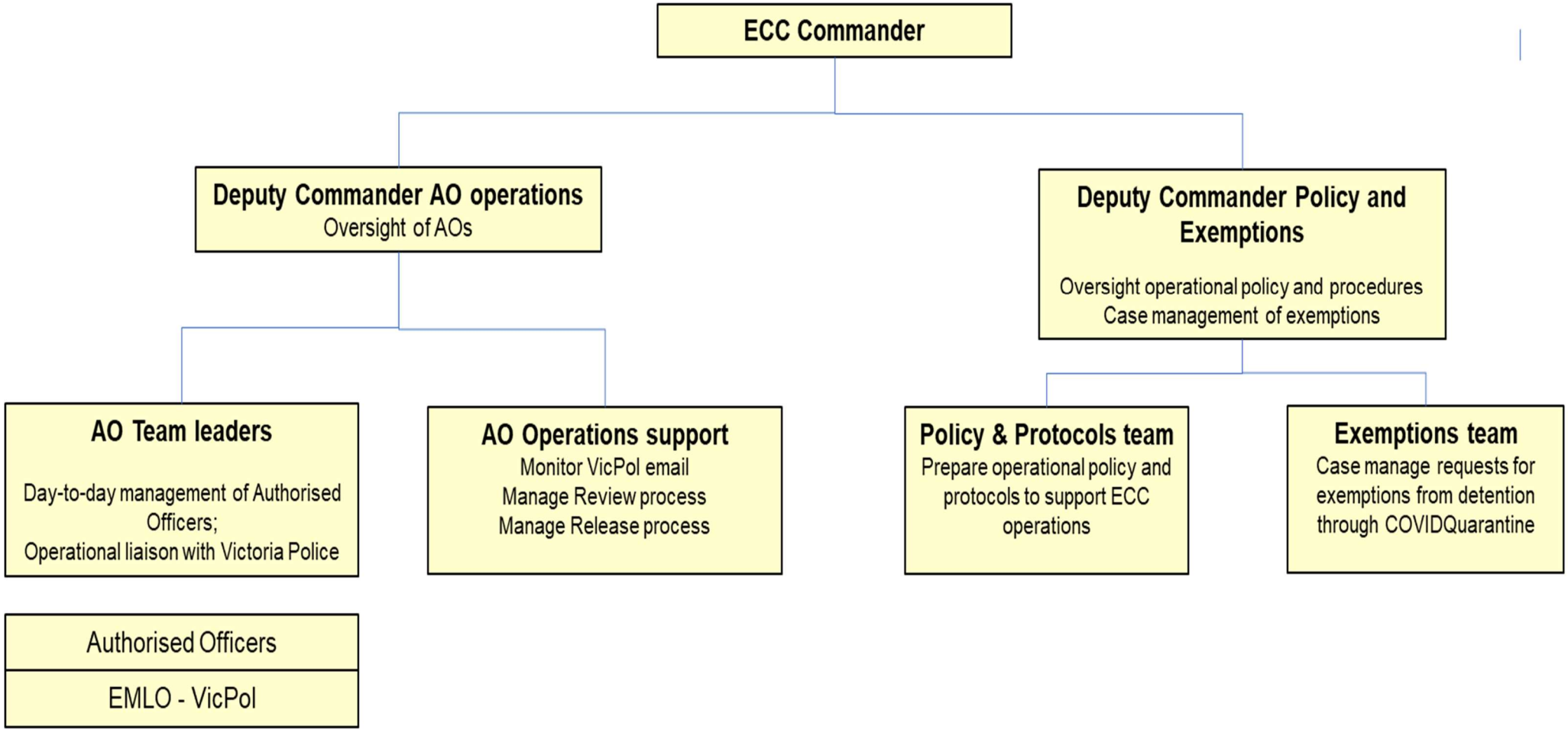
7.2 Incident reporting

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

Appendix 1 - Operation Soteria process phases

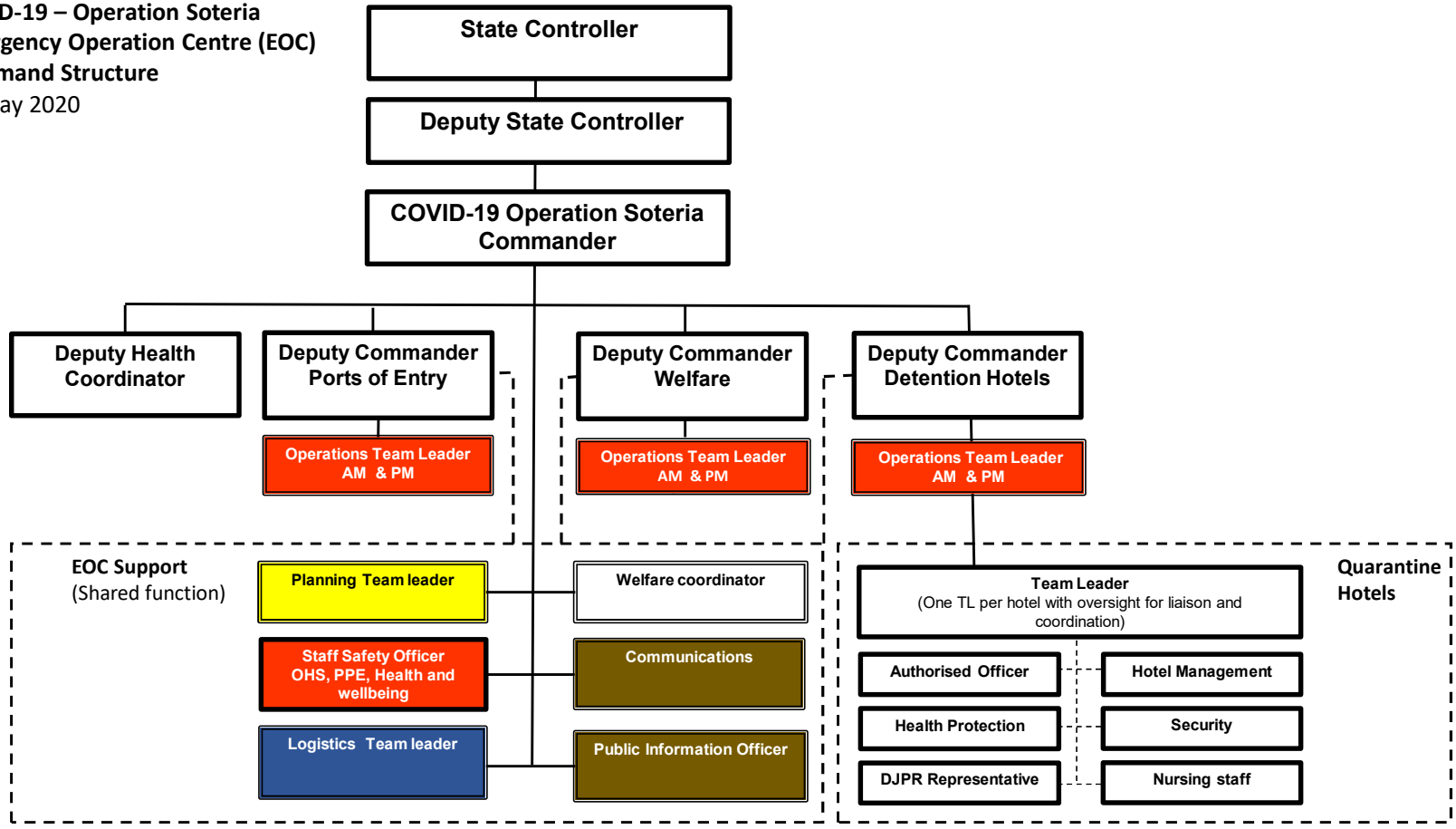


Appendix 2 - Enforcement and Compliance Command structure

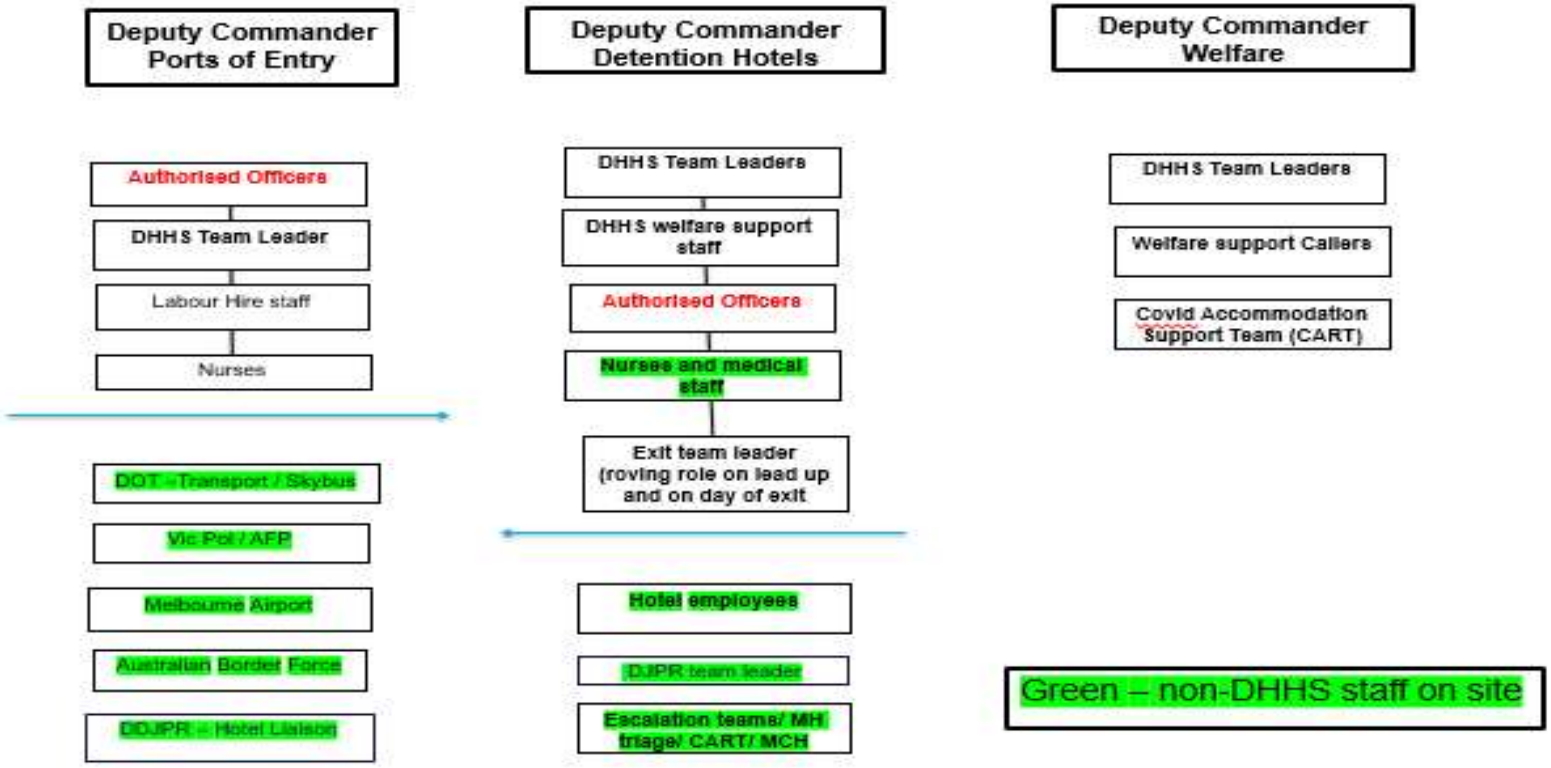


Appendix 3 Emergency Operations Centre Structure

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



Operation Soteria – on site teams



Appendix 4 - DHHS COVID-19 Quarantine – incident reporting

1. Introduction

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

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

This document was last reviewed on 29 April 2020.

2. Reviewing and endorsing incident reports

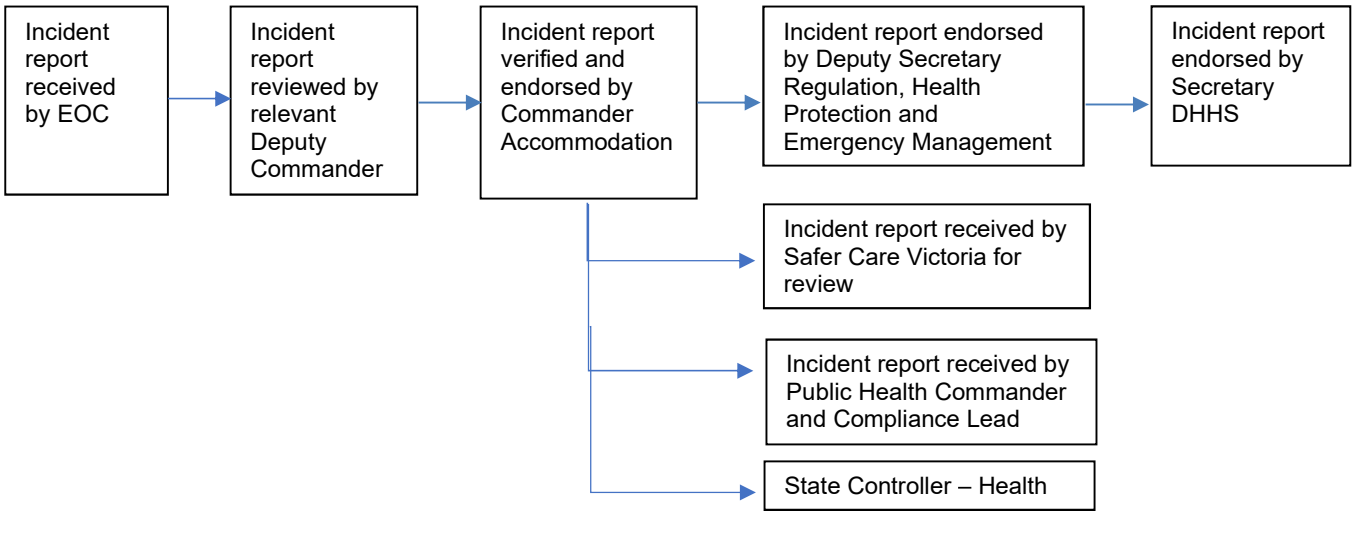
This section outlines the steps required for reviewing and endorsing incident reports, once provided to the DHHS Commander Accommodation via dhhsopsoteriaeoc@dhhs.vic.gov.au following verbal report from the relevant Deputy Commander. Figure 1 below provides an overview of the process.

2.1. Overview

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

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

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



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

2.2. Deputy Commander receives an incident report

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

2.2.1. Reports about passengers/detainees who are also clients

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

2.3. Review of the incident report

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

They must review the incident report and:

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

2.4. Verify and endorse the incident category

The Commander Accommodation verifies and endorses the incident report.

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

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

2.5. File the completed incident report

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

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

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

2.6. Incident report records management and privacy

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

2.7. Local investigation and causal analysis

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

Incident investigations should:

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

3. Privacy

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

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

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

3.1. Sending information by email

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

3.2. Electronic security of passenger/detainee information

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

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

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

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

DHHS Quarantine – incident reporting template

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

1. Service provider details

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

2. Incident dates

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

3. Incident description

Location of incident	
Detailed incident description	

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

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

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

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

6. Service provider response details

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

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

7. Incident report authorisation – EOC Command

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

8. Incident report authorisation – Deputy Secretary

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

9. Incident report authorisation - Secretary

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

Annex 1 – Detention Compliance and Enforcement

Annex approver: DHHS Commander Enforcement and Compliance

Last version date: v2.0 1 June 2020

1. Purpose and background

1.1 Purpose

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

1.2 Background

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

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

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

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

2. Authorised officers and powers

2.1 Key points

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

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

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

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

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

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

2.3 Authorised officer[1] and Chief Health Officer obligations

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

.1.1.1 Mandatory obligations for AOs

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

Table 1: Mandatory obligations of AOs

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

Note:

The notice to the Chief Health Officer must include:

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

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

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

General powers and obligations under the PHWA

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

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

Produce your identity card - s166

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

Inform people of their rights and obligations

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

3 AO responsibilities at airport

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

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

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

3.1 Key points

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

3.2 Key responsibilities

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

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

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

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

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

	interpreter and any associated issues.		

For noting - transfer of uncooperative person to be detained

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

4 AO responsibilities at hotels

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

4.1 Key points

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

4.2 Shift change over

This section outlines the process for changing shift.

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

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

4.3 Hotel check-in

The purpose of hotel check-in is to:

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

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

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

4.4 Monitoring compliance

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

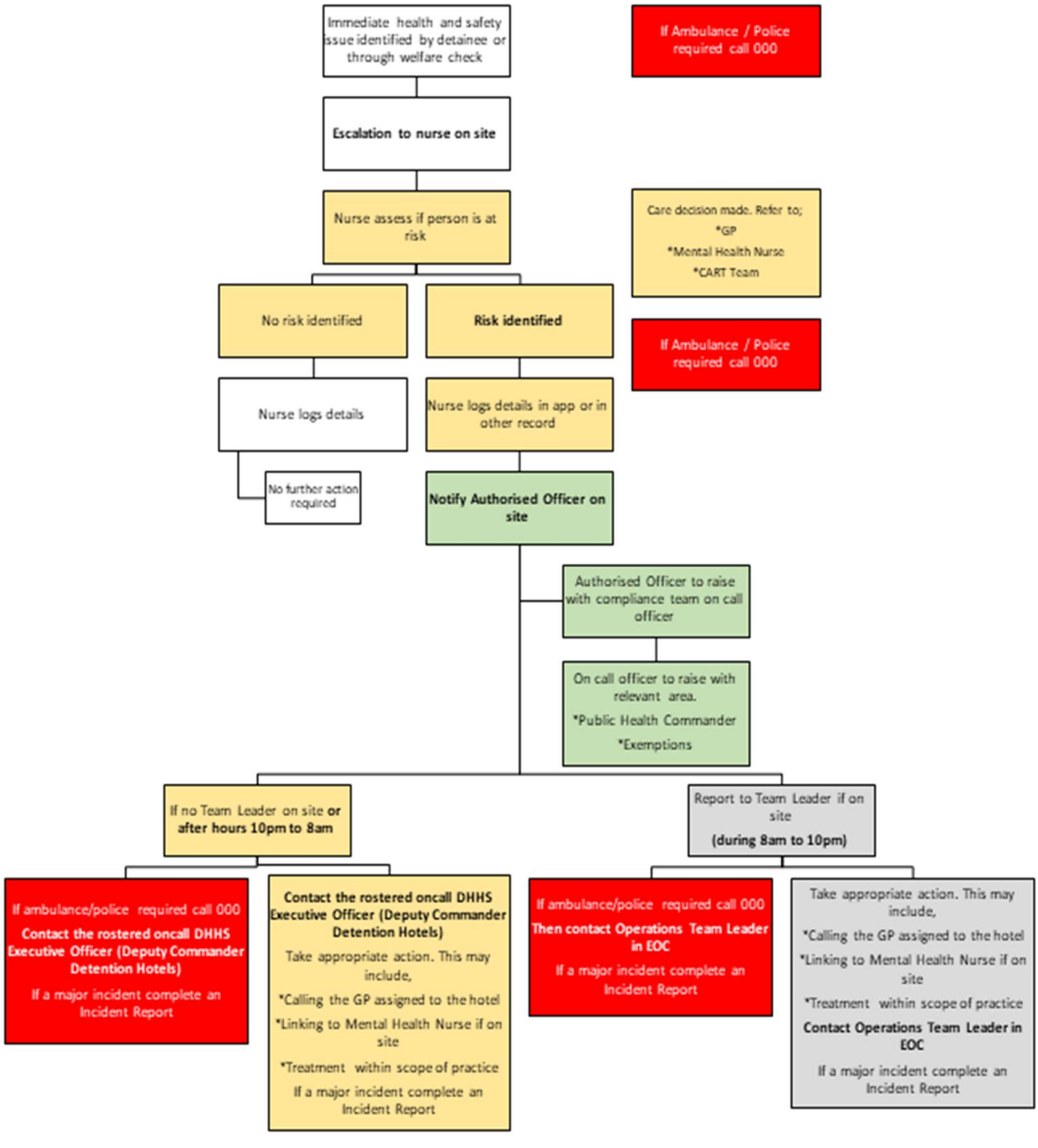
Table 5: Key steps and AO roles and responsibilities – monitoring compliance

Step	AO roles and responsibilities	Mandatory obligation	Section (PHWA)
Liaise with security	1. Check that security personnel are undertaking floor walks to encourage compliance and deter non-compliance.		
Oversee compliance	2. Oversee and provide advice on compliance-related issues such as: • a person refusing to comply and a person demanding to be removed from detention • reminding a person of the reason for the detention, their obligations under the detention and direction notice and the penalties if they do not comply • responding to requests from security to address compliance • answering questions from hotel staff, security and police as to what persons may be permitted or not permitted to do • seeking assistance from security or Victoria police to support compliance efforts • facilitating any reasonable requests for communication. For translation, call Victorian Interpretation and translation service on 9280 1955. PIN code is REDACT		203(1)
Permissions	3. See Section 6 (Permissions). 4. Raise requests for permission to leave with AO Team Leader if there is not an authorised area for the detainee to exercise the permission or there is complexity in applying the transition (e.g. requires leaving the hotel site). All requests by detainees to leave the hotel site must be escalated to Deputy Command AO operations if not already approved. 5. Administer permission to leave and monitor compliance.		203(1)
Exemptions	6. See Section 5 (Exemptions). 7. Raise any exemption requests with AO Team Leader in the first instance. The AO Team Leader may then refer exemption requests to covidquarantine@dhhs.vic.gov.au,[or may request the AO to do so] for decision. 8. Issue Direction and Detention Notices for detention in alternate locations if ECC Commander approves an exemption request. In this case, a case manager from the Exemptions Team will contact the AO with details.		200(2),200(4) and 202(1)
Records	9. Make notes of compliance related issues and actions. The means of recording notes are dependent of the availability and use of		

	technology and could include the COVID Compliance Application. 10. Record all permissions in the permissions register and COVID-19 Compliance App 11. Upload photos of all amended direction notices issued while at the hotel to the COVID-19 Compliance Application.		
Other issues	12. Inform nurse, medical practitioner, welfare staff or DHHS concierge staff of other matters you become aware of.		

4.5 Emergency health and welfare incidents

Where there is an immediate health and welfare issue identified at the hotel, the following process is to be followed.



4.6 Clarity about role of AO

AOs should be aware that their role and scope is related to administration of, and compliance with, the direction and detention notice under the PHWA. Activities outside the scope of the role of the AO include:

- transport - this is the responsibility of the DHHS Team Leader on-site. If a DHHS Team Leader is not on-site, please refer to the Emergency Operations Command at DHHSOpSoteriaEOC@dhhs.vic.gov.au and title the email “Referral to organise transport”
- physically moving COVID-19 patients. Please see procedure under ‘Occupational Health and safety”
- retrieving luggage
- food quality

- inspecting care packs, removing items from care packs such as perishables and alcohol and ordering food such as Uber eats
- monitoring or ordering PPE or other supplies.

If an AO becomes aware of these or other non-compliance related issues in a hotel, they should refer them to the DHHS Team Leader on-site for follow up. For medical and welfare issues, the AO should inform on-site medical and nursing staff in accordance with section 4.5 above.

4.7 Daily review and reporting by the AO Review Team

The daily review is a mandatory obligation to determine whether continued detention of a person is reasonably necessary to eliminate or reduce a serious risk to health. There are mandatory obligations for the AO to inform the Chief Health Officer (CHO) and the CHO to inform the Minister. This is the responsibility of the Deputy Commander AO Operations who will be aided by the AO operations support team in fulfilling this task.

Table 6: Key steps and AO Review Team roles and responsibilities – daily review

Step	AO Review Team roles and responsibilities	Mandatory obligation	Section (PHWA)
Daily review	1. AO operations support Team will – at least once every 24 hours – review whether the continued detention of the person is reasonably necessary to protect public health.	Yes	S 200(6)
Review checks	2. Undertake an electronic review of detainment arrangements by viewing the COVID-19 Compliance Application. This includes: ○ reviewing the date and time of the previous review (to ensure it occurs at least once every 24 hours) ○ reviewing the number of detainees present at the hotel ○ reviewing the duration each detainee has been in detention for, to ensure that the 14-day detention period is adhered to ○ noting individuals who have been tested and cleared of COVID-19 by Public Health Command while in detention 3. Determine whether continued detention of each detainee is reasonably necessary to eliminate or reduce a serious risk to health 4. Consider the human rights being impacted – refer to 'Charter of Human Rights' obligations in Appendix 11 5. Consider any other issues that have arisen.		
Review considerations	6. Consider that the person is a returned overseas traveller who is subject to a notice and that they are obliged to comply with detainment. 7. Consider that detainment is based on expert medical advice that overseas travellers are of an increased risk of COVID-19 and form most COVID-19 cases in Victoria. 8. Consider any other relevant compliance and welfare issues, such as:		

	○ The person's health and wellbeing ○ any breaches of self-isolation requirement ○ issues raised during welfare checks (risk of self-harm, mental health issues) ○ actions taken to address issues ○ a person having been tested and cleared of COVID-19 while in detention ○ any other material risks to the person.		
Possible release from detention	9. Review could identify that detention may no longer be required. These matters will be provided to the Deputy Commander Policy and Exemptions for further consideration.		
Record	10. Record the outcomes of their review (high level notes) (for each 24-hour period) in the **COVID-19 Compliance Application**. This allows ongoing assessment of each detainee and consideration of their entire detention history.		
Prepare brief (Minister)	11. Prepare brief from CHO to Minister to advise of notice received about detention and review. The brief will serve as a written notice that: ○ a person has been made subject to detention ○ following a review, whether continued detention is reasonably necessary to eliminate or reduce the serious risk to public health. 12. The notice to the CHO must include: ○ the name of the person being detained ○ statement as to the reason why the person is being, or continues to be, subject to detention. 13. Deputy Commander AO operations to review and approve the Review and Brief 14. Report to be sent to Public Health Commander, cc to ECC Commander and Deputy Commander Policy and Exemptions		Sections 200(7) and (8) Section 200(9)

4.8 Departure – release from mandatory detention

The purpose is to ensure and confirm the person being detained:

i. has completed their period of detention under the Direction and Detention notice
ii. is released in a timely and orderly manner.

Pre-check out

Prior to release of a person being detained, DHHS (with the help of hotel security) will provide each person being detained with either:

1. an End of Detention Notice, **Appendix 7;**
2. an End of Detention Notice (confirmed case or respiratory illness symptoms), **Appendix 8** or
3. an End of Detention Notice for close contacts (to be supplied).

The notice provides information about the discharge process and the obligations of the detainees until they are discharged.

Health check

Health checks will be undertaken by clinical staff on the second last day prior to the 14-day period ending to make an assessment of whether each person being detained is well, symptomatic or positive.

Everyone will be offered a voluntary temperature and symptom check by a nurse around 24 hours before release.

If people being detained have a temperature or other symptoms of coronavirus before leaving or at the health check, this will not affect the completion of their detention. They will not be detained for longer than the 14-day quarantine period, even if they have symptoms consistent with coronavirus. However, if they do have symptoms at the health check, when they are released, they will need to seek medical care and will be required to self-isolate (as is required as of all members of the community).

Day of release

Security will provide detainees approximately 1 hour notice of their exit time. Security will then bring detainees down at their scheduled exit time.

Check-out process overview (compliance check-out)

The release process will consist of an organised check-out procedure (the compliance check-out). This means people being detained will be released in stages throughout a set time period on the day of release.

Security will bring travelling parties down to reception in stages to complete the check-out process. People being detained will also need to settle any monies owing to the hotel for additional meals and drinks if they have not already done so. Physical distancing must be maintained throughout this process.

Table 7: Key steps, roles and responsibilities at check-out (AO role unless specified)

Step	Roles and responsibilities	Mandatory obligation	Section (PHWA)
Notification of COVID-19 cases of close contacts	1. ECC Operations Support Team, to inform AO of those who are confirmed cases of COVID-19 (cleared or not yet cleared, suspected cases ofCOVID-19 or close contacts. Public health will have contacted each detainee in these categories to discuss arrangements post detention. 2. AO to note and to inform security that COVID-19 cases will need separate check-out time and implement extra precautionary measures.		
Check-out	3. Request to see identification (passport) and the End of Detention notice from each person 4. Cross check the person's identification details and room number with information on exit sheet 5. Sign the End of Detention notice and provide back to the person 6. Confirm the period of detention and explain detention period has ceased 7. Confirm self-isolation requirements for all confirmed COVID cases. 8. Detainee to sign discharge exit sheet as evidence they have received a notice and have been discharged		
Record	9. Provide exit list to a translator team member on site for updating in the COVID-19 Compliance Application (note this may be a data entry update after the process has been completed). 10. All exit sheets are to be returned to the Operational Support team as soon as possible		

Where a person has been COVID-19 cleared, their detention release must be accompanied with a COIVD-19 Clearance letter provided by Public Health Command. This will be included in the release pack prepared by the AO Operations Support team.

5 Exemption requests

5.1 Key points

- AOs must be aware of how requests for exemption from detention are escalated.
- DHHS case manager from the Exemptions Team will liaise with AO Team Leader regarding approved exemption request.

5.2 Exemption requests – overview

In limited circumstances, approval may be sought to undertake detention in another location, transit to another state/country or for early release. **Generally, exemptions are not granted.**

Requests for exemption from mandatory hotel detention may be considered before a person commences detention or while in detention. The Public Health Commander is responsible for approving and granting approvals to alter the way in which mandatory quarantine applies. The Public Health Commander may delegate approvals to the ECC Commander in accordance with *Guidance Note — Exceptions to the General Quarantine Policy,* see **Appendix 9.**

While each exemption request must be considered on its own merits, the following circumstances have been identified as open for consideration of early release or change of detention location. These include:

- Unaccompanied minors in transit to another state
- Unaccompanied minors where a parent or guardian does not agree to come into the hotel
- Foreign diplomats coming into the country
- ADF staff travelling for essential work
- People with a terminal illness
- People whose health and welfare cannot be accommodated in a hotel environment (e.g. mental health or requirements for in-facility health treatment)
- People who are transiting directly to another country (and who do not need to travel domestically first)
- Air crew
- Maritime workers who have come off a boat and will be leaving by boat
- Maritime workers who have come off a plane and will be leaving by boat within the quarantine period.

Any approval must consider the public health risk and must ensure the individual is not showing symptoms of COVID-19 or may be released into an environment where a highly vulnerable person may be a close contact.

There is no blanket exemption approval.

Table 8: Key steps, roles and responsibilities for exemptions prior to commencing, and during, detention

Step	Roles and responsibilities	Mandatory obligation	Section (PHWA)
Request	1. covidquarantine@dhhs.vic.gov.au receives a request for exemption[4] 2. Person confirms flight details and arrival information before the matter is assessed.		
Assessment and decisions	3. Exemptions Team will consider the request and refer to the ECC Commander for decision 4. Exemptions case manager to: • inform the Deputy Commander AO operations if an exemption is granted so that relevant AO Airport Team Leader and AOs are informed (including correspondence) • Inform the EOC to arrange transport • Inform the CART team if required • arrange for compliance oversight with Victoria police • contact other jurisdictions (if transiting through Victoria) • Record all actions and supporting paperwork in the case management tool		
AO to issue Notice of Direction and Detention	5. The exemption team will provide guidance to the AO about issuing the exemption paperwork 6. AO will: • issue a Notice of Direction and Detention for those permitted to undertake detention at an alternative location • permit international transit for those issued a letter • record details in COVID-19 Compliance Application		200(2) and (4) 202(1)
International transit passenger process	7. To facilitate an exemption given to a person for international transit, the AO Team Leader will notify Airport AO and Australian Border Force (ABF) prior to their arrival at the airport via a specific email with a specific subject title to: • "map.border.clearance@abf.gov.au" with a cc to "NorthandWest.EOC@dhhs.vic.gov.au". A template email is below. • Email to be titled *Transit Passenger from Quarantine Hotel (DHHS)* and request assistance to collect released detainee for connecting transit flight to XXX. Email should include:		

[4] An onsite nurse or welfare staff can recommend the exemption for a person via covidquarantine email and outline why they believe an exemption should be considered. Unless impracticable the person on whose behalf the request has been made should be consulted

	○ full name (as per passport) ○ passport number ○ flight departure time ○ flight number ○ arrival time at T2 international departure.		

5.3 Unaccompanied minors

Unaccompanied minors will be considered on a case-by-case basis. If an unaccompanied minor is detained in a hotel without a parent or guardian, a specific process must apply.

There are three options:

i. Unaccompanied minor to undertake detention at an alternate location with parent or guardian
ii. Unaccompanied minor to undertake detention in hotel with parent. The parent or guardian will be required to agree to the mandatory detention arrangements
iii. Unaccompanied minor to undertake detention in hotel with welfare support provided by DHHS.

In general, there is a presumption that there are no exemptions granted to mandatory quarantine. The issues associated with mandatory quarantine of unaccompanied minors include:

1. where this occurs, and
2. with what adult supervision.

The State can issue a detention order to a person under 18 years who is unaccompanied outside the home (a person in the care of the state) if certain conditions are met. However, this is not preferred because of the intensive obligations imposed.

There is guidance for AOs on how to comply with the Charter of Human Rights in relation to unaccompanied minors at Appendix 5.

Table 9: Key steps, roles and responsibilities for managing unaccompanied minors

Step	Roles and responsibilities	Mandatory obligation	Section (PHWA)
When an unaccompanied minor normally resides outside Victoria			
AO to request approval if not already sought	1. If Exemptions team has not granted approval, AO to escalate to the Deputy Commander Policy and Exemptions and cc covidquarantine		
Assessment and decision	2. Exemptions case manager to: ○ inform the AO Operation Lead and AO Airport Team Leader of approval or rejection ○ contact other jurisdictions (if transiting to a location outside Victoria) ○ Advise requesting party of the risk management obligations on a domestic flight out of Victoria and seek confirmation it can be achieved.		
AO to issue Notice of Direction and Detention	3. AO will: ○ issue a Notice of Direction and Detention to undertake detention at an alternative location in Victoria in accordance with the instructions and templates provided by the Exemptions case manager		200(2),(4) and 202(1)

	○ permit transit to another state if minor normally resides outside Victoria ○ record details in COVID-19 Compliance Application.		
When minor resides in Victoria			
AO to request approval if not already sought	4. If Exemptions team has not granted approval, AO to escalate to Deputy Commander Policy and Exemptions and cc covidquarantine		
Assessment and decision	5. Exemptions case manager to: ○ inform the AO Operation Lead and AO Airport Team Leader of approval ○ arrange transport ○ arrange for compliance oversight with Victoria Police.		
AO to issue Notice of Direction and Detention	6. AO to issue direction and detention notice to child through their guardian for: ○ alternate location (home and / or parts of the home); or ○ Provide advice on minimising risk of transmission to others in the home where the minor is detained (equivalent to advice provided to close contacts in quarantine).		200(2), (4) and 202(1)

Escalation of issues

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

- contact the department's welfare teams immediately. Child Protection contact details for each Division are available from: https://services.dhhs.vic.gov.au/child-protection-contacts. West Division Intake covers the City of Melbourne LGA: REDACTED
- if it is after hours, contact the after-hours child protection team on 13 12 78 if the AO thinks a child may be harmed, and Victoria Police on 000 if the immediate safety of a child is at risk.

6 Permissions

6.1 Key points

- AOs can make decisions in consultation with their AO Team Leader or Deputy Commander AO Operations for simple requests.
- AO must complete a permission for temporary leave form and enter details in COVID-19 Compliance Application.

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

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

AOs should refer to the 'Permission for Temporary Leave from Detention' guide at **Appendix 3.**

6.2 AO to make decisions on certain permission requests on case-by-case basis

An AO in consultation with their AO Team Leader or Deputy Commander AO Operations can make certain straightforward decisions about the following scenarios on a case-by-case basis:

- attendance at a funeral
- medical treatment
- seeing family members who have a terminal illness
- smoke breaks where people are suffering extreme anxiety and where it is safe to do so from a public health/infection control perspective
- exercise breaks where it is safe to do so.

Not all leave requests can be accommodated and may be site and resource dependent. Any arrangement for leave would need to meet public health and human rights requirements and balance the needs of the person.

It is expected that those with medical needs, seeking to attend a funeral or with family members who are about to pass away are granted leave. The AO should confirm appropriate details before issuing permission to leave (refer to Table 10 for further details).

If medical care is deemed urgent by an on-site nurse or medical practitioner or attending AV paramedic, the AO should prioritise and approve leave immediately.

AOs are not responsible for transport arrangements. This is the responsibility of the DHHS Team Leader on-site. If a DHHS Team Leader is not on-site, please refer to EOC – DHHSOPSoteriaEOC@dhss.vic.gov.au and title the email "Referral to organise transport".

Table 10: Key steps, roles and responsibilities for temporary leave

Step	Roles and responsibilities	Mandatory obligation	Section (PHWA)
Assess site for suitability	1. AO Team Leader to assess site for suitability of exercise and fresh air breaks 2. AO to consider safety and security and obtain agreement from Security and DHHS Team Leader on suitable site 3. Site Map to be put on the Team Sharepoint site and attached as an attachment to this protocol following Deputy Commander AO Operations		

	approval.		
Request for temporary leave	4. Person may seek permission directly from the AO or may email covidquarantine@dhhs.vic.gov.au and explain the grounds for leave		
Referral to AO	5. Exemptions team to triage and forward to AO for decision 6. Exemptions team to assess complex cases and inform AO		
AO assessment and decision	7. AO to make decision and consider: • those that require exercise or fresh air break or those who may be at risk without these breaks (this is the most important consideration for fresh air and exercise breaks) • willingness and availability of security to oversee and facilitate exercise or other fresh air break (the number security will determine how many people can undertake temporary leave, as well as the ability to ensure small groups by room are distanced accordingly) • site layout, safety and capability to ensure persons are in a cordoned off area • maintaining infection control, such as ensuring persons do not touch door handles or lift buttons • adherence to exercise and smoking procedures 8. In considering a request for a person to visit a terminally ill family member in hospital, the AO will need to first check whether the medical facility will accept the person.		
Issue permission for temporary leave	9. AOs to: • instruct security on the dates and times permitted for leave • provide procedural guidance to security and the person in detention, such as exercising in a cordoned off area not accessed by members of the public • request the medical facility or hospital inform the AO prior to return (for medical temporary leave) • prepare a Permission for Temporary Leave from Detention form (see Appendix 2), and issue to the detainee and explain the leave obligations. For example: - a person attending a funeral must not attend the wake, must practice physical distancing and return immediately within stipulated timeframes - an exercise break is for a certain time and the person must return to their room following exercise or fresh air break • warn the person that failure to comply with these		s.203(1)

	directions is an offence • ensure the person checks back into the hotel at specified time • seek feedback on implementation of temporary leave and note any issued raised		
Record	10. If AO approves leave, the AO: • must keep original copies of the Permission for Temporary Leave from Detention form for the person, Appendix 2 and the Register of permissions granted under 4(1) of the Directions and Detention Notice, **Appendix 12**, and • enter details in COVID-19 Compliance Application.		

6.3 Emergency situations

Table : Key steps, roles and responsibilities for emergency leave

Step	Roles and responsibilities	Mandatory obligation	Section (PHWA)
Determine risk	1. AOs and Victoria Police officers may need to determine the severity of any emergency (such as a building fire, flood, natural disaster etc) and the health risk they pose to persons in detention.		
Evacuation	2. Assist with immediate evacuation to common assembly point 3. Contact Victoria police, emergency services and Deputy Commander AO Operations to support 4. Promote infection prevention and control and physical distancing principles if possible 5. Account for all persons being detained at the assembly point by way of the register of persons in detention		

6.4 Procedure for a person in detention / resident to leave their room for exercise or smoking

A person must be compliant and must not have symptoms before they could be allowed to have supervised exercise or a smoking break. Only well residents from the same room should be able to go out to exercise at the same time.

6.5 Guidance for safe movement associated with permissions

Guidance for person in detention

The steps that must be taken by the person in detention are:

- Confirm to the person who will escort them that they are well.
- Confirm to the person who will escort them that they have washed their hands immediately prior to leaving the room.

- Don a single-use facemask (surgical mask), to be supplied by the security escort prior to leaving the room.
- Perform hand hygiene with alcohol-based hand rub as they leave, this will require hand rub to be in the corridor in multiple locations.
- Be reminded to – and then not touch any surfaces or people within the hotel on the way out, and then not actually do it.
- Return immediately to their hotel room following the break.

Guidance for security escort

Security escort should:

- Don a single-use facemask (surgical mask) if a distance of >1.5 metres cannot be maintained when escorting the person;
- Perform hand hygiene with an alcohol-based hand rub or wash hands in soapy water before each break;
- Remind the person they are escorting to not touch any surfaces or people within the hotel on the way out or when coming back in
- Be the person who touches all surfaces if required such as the lift button or door handles (where possible using security passes and elbows rather than hands);
- Wherever possible, maintain a distance (1.5 metres or greater) from the person;
- Perform hand hygiene with an alcohol-based hand rub or wash hands in soapy water at the end of each break and when they go home
- Ensure exercise is only undertaken in a cordoned off area with no public access or interaction.

Infection control considerations

Points to remember when using a single-use facemask (surgical mask):

- Always perform hand hygiene before donning the mask.
- Mould the metal clip over the bridge of the nose and ensure the bottom of the mask fits snuggly under the chin.
- Avoid touching or adjusting the mask once it has been donned.
- Unless damp or soiled, masks may be worn for the duration of a shift for up to four hours.
- Masks must be removed and disposed of for breaks and then replaced if needed.
- Masks must never be partially removed (for example, top tie undone and left dangling around the neck) and then re-worn.
- Perform hand hygiene immediately before and after removal of the mask.

There is no requirement to wear gloves and this is not recommended, as many people forget to take them off and then contaminate surfaces. Hand hygiene is one of the most effective ways to prevent the spread of infection and gloves should not be seen as a substitute for hand hygiene. If gloves are worn, remove the gloves immediately after the person is back in their room and then wash your hands.

In addition:

Family groups may be taken out in a group provided it is only 2 adults and less than 5 in total.

They can be taken to an outside area with sunlight, for up to 15 minutes outside of the hotel.

Smokers can take up to 2 breaks per day if staffing permits.

Rostering to be initiated by the departmental staff/AO present.

7 Compliance

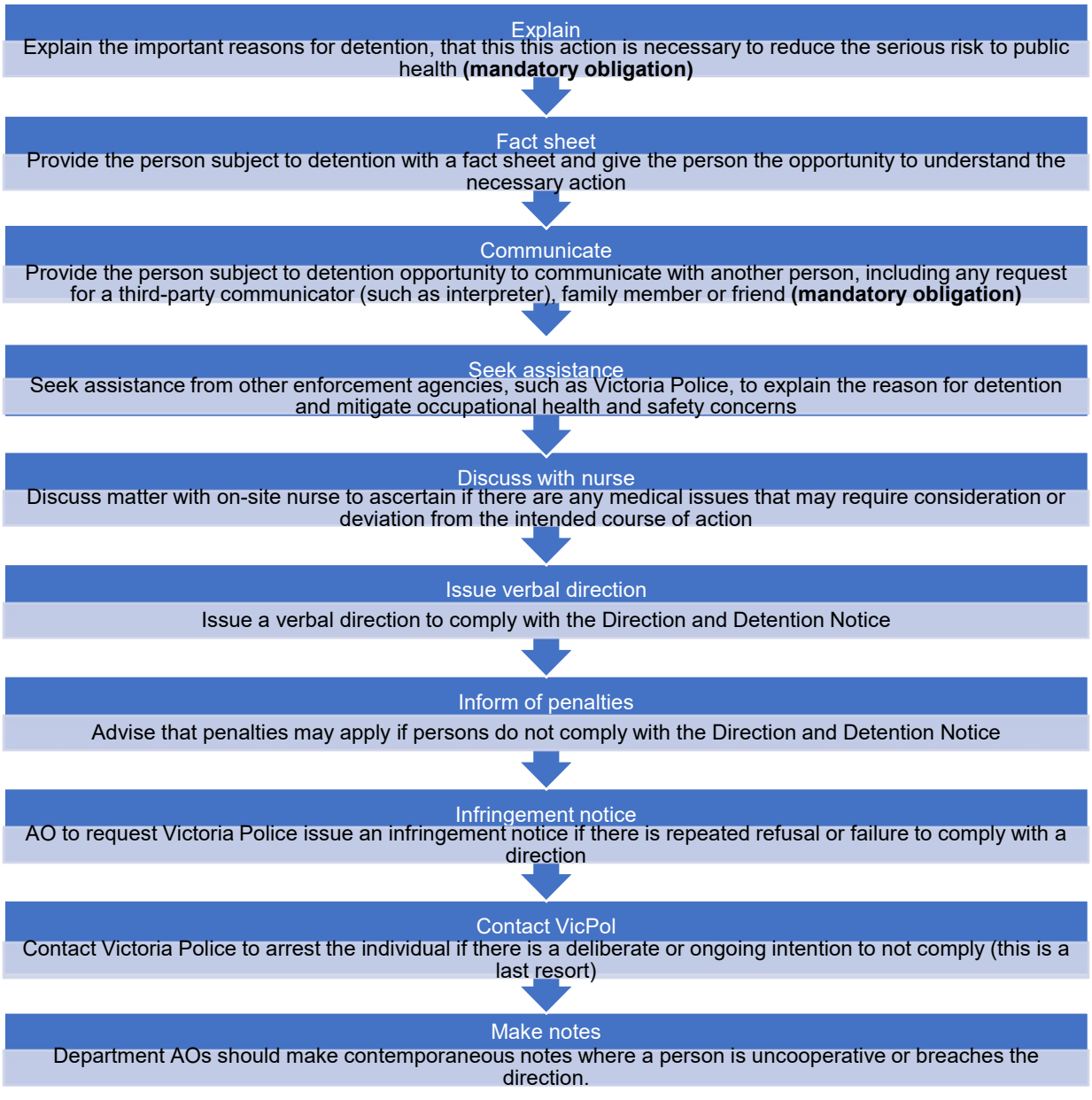
7.1 Key points

- AOs to apply a graduated approach to compliance.

7.2 Options to facilitate compliance

AOs should make every effort to inform the person of their obligations, facilitate communication if requested and explain the important rationale for the direction. Non-compliance could take the form of a person refusing to comply with the direction at the airport or hotel.

The following graduated approach should guide AOs:



7.2 Unauthorised departure from accommodation

Table 12: Key steps, roles and responsibilities for managing unauthorised departure from accommodation

Step	Roles and responsibilities	Mandatory obligation	Section (PHWA)
Notify and search	1. AO to notify AO Team Leader, on-site security and hotel management and request search.		
Contact Victoria police	2. AO to seek police assistance and notify the Deputy Commander AO operations if the person is not found.		
Identification and compliance	3. If the person is located, AO to: • seek security or Victoria Police assistance if it is determined the person poses a risk of trying to leave • provide an opportunity for the person to explain the reason why they left their room • assess the nature and extent of the breach, for example: - a walk to obtain fresh air - a deliberate intention to leave the hotel - mental health issues - escaping emotional or physical violence. • consider issuing an official warning or infringement through Victoria Police • reassess security arrangements.		s.203(1)

7.3 Infringements

There are four infringement offences applicable to detention arrangements. These are:

Table 13: List of infringements

Section (PHWA)	Description	Amount
s.183	Hinder or obstruct an authorised officer exercising a power without reasonable excuse (5 penalty units).	5 penalty units (PU)
s.188(2)	Refuse or fail to comply with a direction by CHO to provide information made under s.188(10 penalty units for a natural person and 30 penalty units for a body corporate without a reasonable excuse).	10 PU natural person, 30 PU body corporate
s.193(1)	Refuse or fail to comply with a direction given to, or a requirement made or, a person in the exercise of a public health risk powers (10 penalty units for natural person and 60 penalty units for body corporate).	10 PU natural person, 30 PU body corporate
s.203(1)	Refuse or fail to comply with a direction given to, or a requirement made or, a person in the exercise of a public health risk powers (10 penalty units for natural person and 60 penalty units for body corporate).	10 PU natural person, 30 PU body corporate

8 Occupational health and safety (OHS) for Authorised Officers

The purpose of this section is to provide an occupational health and safety procedure for AOs when attending off site locations during the current State of Emergency.

8.1 Key points

OHS is a shared responsibility of both the employer and the employee. AOs must raise hazards, concerns and incidents with the AO Team Leader of the Deputy Commander AO Operations.

AOs must take steps to protect themselves from transmission of COVID-19 and adhere to physical distancing protocols wherever possible

8.2 Health Emergency

Coronaviruses are a large family of viruses that cause respiratory infections. These can range from the common cold to more serious diseases. COVID-19 is the disease caused by a new coronavirus. It was first reported in December 2019 in Wuhan City in China.

Symptoms of COVID-19 can range from mild illness to pneumonia. Some people will recover easily, and others may get very sick very quickly which in some cases can COVID-19 can cause death.

8.3 OHS

OHS is a shared responsibility of both the employer and the employee. Officers must raise hazards, concerns and incidents with the rostered AO Team Leader.

One of the foremost issues associated with site attendance is the 'uncontrolled environment' that exists. AOs can be exposed to infectious diseases (such as COVID-19), confrontational and/or aggressive members of the public who may be drug affected, mentally ill or intellectually impaired. The very nature of this work is likely to be perceived as invasive and can provoke a defensive response.

Risks can be minimised by maintaining routine safe work practices and proper planning. Prior to any site visit, risks and hazards should be identified and assessed.

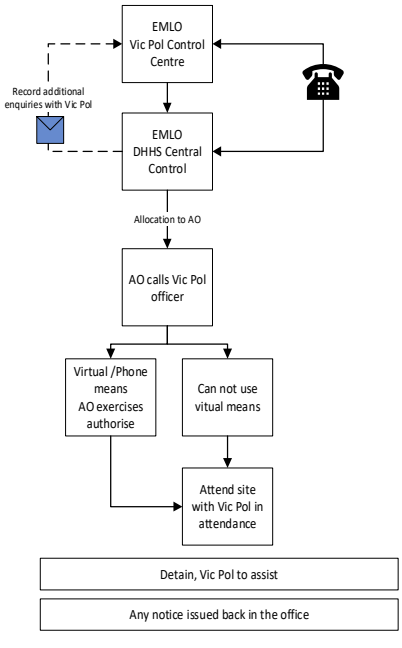
Officers and managers both have a shared responsibility for occupational health and safety. All employees have a responsibility to report and discuss hazards or perceived hazards, by bringing this to the managers attention.

8.4 Fatigue

AOs will be rostered on a rotating basis, with the aim of mitigating the risk of fatigue. Fatigue may impede decision making capability and when driving a motor vehicle to a location. When fatigue is identified please make this known to your AO Team Leader.

To mitigate the risk of fatigue, AOs should be aware of any fatigue they may have. A good tool to use to help officers identify their level of fatigue is to use the following calculator: http://www.vgate.net.au/fatigue.php

AOs are required to hold a valid motor vehicle licence and are required to adhere to the requirements of the department's driving policy. Information about this policy can be found on the DHHS intranet site.



8.5 Risk assessment before attendance | Personal Protection

In the first instance, officers are required to use technology (i.e: mobile phone, Facetime, Skype) to exercise their authority. This aims to protect officers from attending an uncontrolled environment, where the risk of harm is increased.

Before attending a site, whether an airport or a hotel, the officer should make themselves familiar with the recommendations produced by the Australian Government and the Department of Health and Human Services, in the protection against COVID-19.

Interventions are known as 'transmission reduction, or 'physical distancing' measures. Officers can take the following personal measures to reduce their risk of exposure to COVID-19. Officers with pre-existing medical conditions that put

them more at risk of COVID-19, should discuss this with their medical practitioner and manager.

8.6 Personal measures to reduce the risk of exposure to COVID-19

General

AOs must take steps to protect themselves from transmission of COVID-19 and adhere to physical distancing protocols wherever possible. For example,:

- Stay healthy with good nutrition, regular exercise, sensible drinking, sleep well, and if you are a smoker, quit.
- Wash your hands often with soap and water for at least 20 seconds, especially after you have been in a public place, or after blowing your nose, coughing, sneezing, or using the toilet. If soap and water are not readily available, use a hand sanitiser that contains at least 60 per cent alcohol.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Cover your nose and mouth with a tissue when you cough or sneeze. If you don't have a tissue, cough or sneeze into your upper sleeve or elbow.
- Stop shaking hands, hugging or kissing as a greeting.
- Ensure a **distance of 1.5 metres** is kept between yourself and others.
- Get vaccinated for flu (influenza) as soon as available. This could help reduce the risk of further problems. *Note: the department covers expenses for vaccines, speak to your manager for more details.*
- Clean and disinfect high touch surfaces regularly, for example: telephones, keyboards, door handles, light switches and, bench tops.

When an officer is called to attend the airport or a hotel to exercise powers in relation to the Direction and Detention notice they should take a **risk-based approach** and assess the most suitable way to reduce harm to themselves. Before attending, the officer must obtain information such as:

- Is the person being detained a positive case of COVID-19?
- Has the person being detained been recently in close contact with a positive case of COVID-19?

Officers are required to use their discretion and take into account their own personal safety. The Department of Health and Human Services has provided the following PPE:

- Single-use surgical mask
- Gloves
- Hand sanitizer.

AOs going onto floors of hotel

AOs going onto hotel floors with persons subject to detention must wear a surgical mask. There will be surgical masks for AO's at the hotels.

AO's should not enter the room in which a person is being detained. Communication should be from the corridor or outside the room.

Relocating COVID-19 positive person

While this process is led by the nurses/medical staff it must be authorised by the AO.

Before the person is moved, the AO must issue a new detention notice with the amended details. This must be served by the AO in PPE as advised by the health staff. The detention notice must clearly state it replaces the previous detention notice dated XXX. The AO is then to very briefly state that the patient was in room(x) and will be moved to room(y) as a result of their positive result. The AO WILL THEN LEAVE IN A SEAPARATE LIFT TO THE SECURITY/NURSING STAFF.

The room or location change must be recorded in the COVID-19 compliance app by the AO

Measures and guides to enhance occupational health and safety

PPE/measure	Guide
Single-use face mask (surgical mask)	When there is known case of COVID-19, or a person subject to detention has been recently exposed to COVID-19 and a distance of at least 1.5 metres cannot be maintained.
Gloves	If contact with the person or blood or body fluids is anticipated.
Hand hygiene / Hand Sanitizer Soap and water	Always
Physical distancing of at least 1.5 meters	Always

Known risks and hazards

Hazard	Risk	Mitigate
COVID-19 infection	Serious illness / death	Follow personal protective measures
Fatigue	Impaired decisions / driving to site	In the first instance use virtual technology to perform duties Use fatigue calculator http://www.vgate.net.au/fatigue.php
Physical Injury	Low / Medium	Only attend a site with Victoria Police or with security.
Other infectious agents		Follow personal protective measures

Appendix 1 – Script for plane/arrival

Required script before issuing a direction and detention notice

My Name is XXXX, I work for the Department of Health and Human Services Victoria and I am an Authorised Officer under the Public Health and Wellbeing Act. I am also authorised for the purposes of the emergency and public health risk powers in Victoria's current State of Emergency.

Because you have arrived in Victoria from overseas, when you disembark off this plane you will be issued with a direction and detention notice, which requires you to quarantine for a 14-day period at the hotel nominated on the notice.

Many of Victoria's cases of covid-19 originate from overseas and international travellers so this action is necessary to ensure we reduce the serious risk to public health posed by COVID 19.

Refusal or failure to comply without reasonable excuse is an offence. There are penalties for not complying with the notice.

Once you have been issued with the notice, please keep it with you at all times.

We greatly appreciate your co-operation and assistance in these challenging times. Thank you again.

Appendix 2 - Permission for temporary leave from detention

PERMISSION FOR TEMPORARY LEAVE FROM DETENTION

Public Health and Wellbeing Act 2008 (Vic)

Section 200

An Authorised Officer has granted you permission to leave your room based on one of the grounds set out below. This is temporary. You will be supervised when you leave your room. You must ensure you comply with all the conditions in this permission and any directions an Authorised Officer gives you. You must return to your room at the time specified to finish your detention. Speak to your supervising Authorised Officer if you require more information.

Temporary leave

(1) You have arrived in Victoria from overseas, on or after midnight [on 28 March 2020 or 13 April 2020] and have been placed in detention, pursuant to a Direction and Detention Notice that you were provided on your arrival in Victoria (**Notice**).

(2) This Permission for Temporary Leave From Detention (**Permission**) is made under paragraph 4(1) of the Notice.

Reason/s for, and terms of, permission granting temporary leave

(3) Permission for temporary leave has been granted to: _____ _____ [insert name] for the following reason/s [tick applicable]:

☐ (a) for the purpose of attending a medical facility to receive medical care:

Name of facility: _____

Time of admission/appointment:_____

Reason for medical appointment:_____

☐ (b) where it is reasonably necessary for physical or mental health:

Reason leave is necessary:_____

Proposed activity/solution:_____

☐ (c) on compassionate grounds:

Detail grounds:_____

(4) The temporary leave starts on _____

and ends on _____ [insert date and time].

_____ **Signature of Authorised Officer**

Name of Authorised Officer: _____

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

Conditions

(5) You must be supervised **at all times**/may be supervised *[delete as appropriate]* while you are out of your room. You are not permitted to leave your hotel room, even for the purpose contained in this Permission, unless you are accompanied by an Authorised Officer.

(6) While you are outside your room you must practice social distancing, and as far as possible, maintain a distance of 1.5 metres from all other people, including the Authorised Officer escorting you.

(7) When you are outside your room you must refrain from touching communal surfaces, as far as possible, such as door knobs, handrails, lift buttons etc.

(8) When you are outside your room you must, at all times, wear appropriate protective equipment to prevent the spread of COVID-19, if directed by the Authorised Officer escorting you.

(9) When you are outside your room you must, at all times, comply with any direction given to you by the Authorised Officer escorting you.

(10) At the end of your temporary leave, you will be escorted back to your room by the Authorised Officer escorting you. You must return to your room and remain there to complete the requirements under the Notice.

(11) Once you return to the hotel, you must proceed immediately to the room you have been allocated above in accordance with any instructions given to you.

(12) You must comply with any other conditions or directions the Authorised Officer considers appropriate.

(Insert additional conditions, if any, at Annexure 1)

Specific details

(13) Temporary leave is only permitted in limited circumstances, to the extent provided for in this Permission, and is subject to the strict conditions outlined at paragraph 3. You must comply with these conditions at all times while you are on temporary leave. These conditions are reasonably necessary to protect public health, in accordance with section 200(1)(d) of the Public Health and Wellbeing Act 2008 (Vic).

(14) Permission is only granted to the extent necessary to achieve the purpose of, and for the period of time noted at paragraph 2 of this Permission.

(15) Nothing in this Permission, invalidates, revokes or varies the circumstances, or period, of your detention, as contained in the Notice. The Notice continues to be in force during the period for which you are granted permission for temporary leave from detention. The Notice continues to be in force until it expires.

Offences and penalties

(16) It is an offence under section 203 of the Act if you refuse or fail to comply with the conditions set out in this Permission, unless you have a reasonable excuse for refusing or failing to comply.

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

Appendix 3 Guidance Note: Permission for Temporary Leave from Detention

How do you issue a Permission for Temporary Leave from Detention?

It is recommended that Authorised Officers take the following steps when issuing a Permission for Temporary Leave from Detention:

Before you provide the Permission for Temporary Leave from Detention

Carefully consider the request for permission and consider the grounds available under paragraph 4(1) of the Direction and Detention Notice – which include:

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

Complete all sections of the Permission, including clearly documenting the reasons for the Permission, date and time when the temporary leave is granted from and to, and whether the person will be supervised by the authorised officer during the temporary leave

Ensure the reference number is completed.

When you provide the Permission for Temporary Leave from Detention

You must warn the person that refusal or failure to comply without reasonable excuse, is an offence, and:

- explain the reason why it is necessary to provide the Permission and the conditions which apply to the temporary leave (including that the person is still subject to completing the remainder of the detention once the temporary leave expires, and the Permission is necessary to protect public health);
- provide a copy of the Permission to the person, provide them with time to read the Permission and keep the completed original for the department's records.

NB If it is not practicable to explain the reason why it is necessary to give the Permission, please do so as soon as practicable after Permission has been exercised.

What are the requirements when you are granting a permission to a person under the age of 18?

The same requirements set out above apply when issuing a Permission to an unaccompanied minor. However, the supervising Authorised Officer must have a Working With Children Check, have regard to the special conditions in the Direction and Detention Notice as well as the person's status as a child.

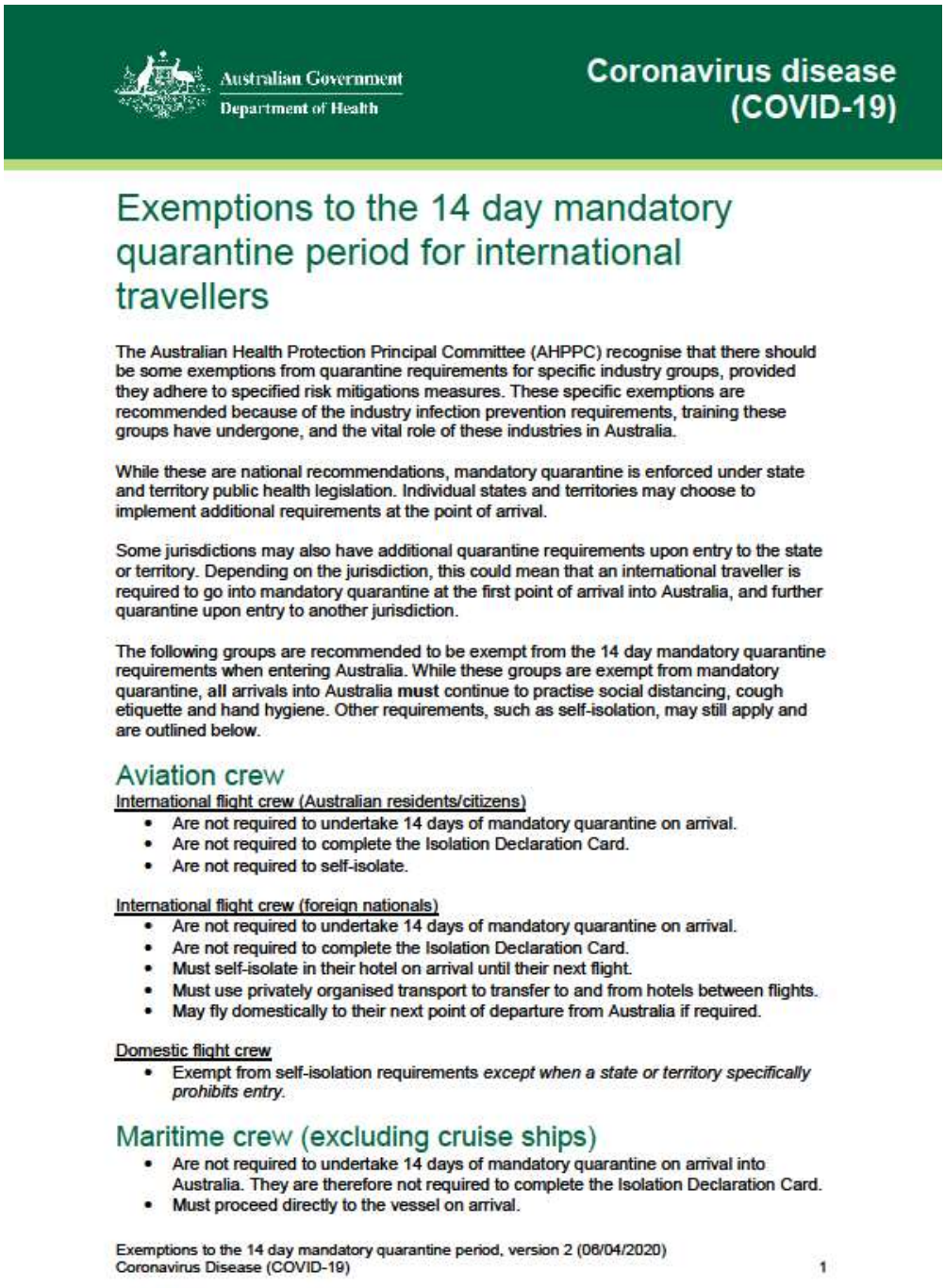
What other directions can you give?

Section 200(1)(d) of the PHWA sets out an emergency power that allows an authorised officer to give any other direction that the authorised officer considers is reasonably necessary to protect public health.

What are your obligations when you require compliance with a direction?

Exercising this power imposes several obligations on departmental authorised officers including that an authorised officer must, before exercising any emergency powers, warn the person that refusal or failure to comply without reasonable excuse, is an offence.

Appendix 4 Guidance: Exemptions under Commonwealth law



Australian Government
Department of Health

Coronavirus disease (COVID-19)

Exemptions to the 14 day mandatory quarantine period for international travellers

The Australian Health Protection Principal Committee (AHPPC) recognise that there should be some exemptions from quarantine requirements for specific industry groups, provided they adhere to specified risk mitigations measures. These specific exemptions are recommended because of the industry infection prevention requirements, training these groups have undergone, and the vital role of these industries in Australia.

While these are national recommendations, mandatory quarantine is enforced under state and territory public health legislation. Individual states and territories may choose to implement additional requirements at the point of arrival.

Some jurisdictions may also have additional quarantine requirements upon entry to the state or territory. Depending on the jurisdiction, this could mean that an international traveller is required to go into mandatory quarantine at the first point of arrival into Australia, and further quarantine upon entry to another jurisdiction.

The following groups are recommended to be exempt from the 14 day mandatory quarantine requirements when entering Australia. While these groups are exempt from mandatory quarantine, **all** arrivals into Australia **must** continue to practise social distancing, cough etiquette and hand hygiene. Other requirements, such as self-isolation, may still apply and are outlined below.

Aviation crew

International flight crew (Australian residents/citizens)

- Are not required to undertake 14 days of mandatory quarantine on arrival.
- Are not required to complete the Isolation Declaration Card.
- Are not required to self-isolate.

International flight crew (foreign nationals)

- Are not required to undertake 14 days of mandatory quarantine on arrival.
- Are not required to complete the Isolation Declaration Card.
- Must self-isolate in their hotel on arrival until their next flight.
- Must use privately organised transport to transfer to and from hotels between flights.
- May fly domestically to their next point of departure from Australia if required.

Domestic flight crew

- Exempt from self-isolation requirements *except when a state or territory specifically prohibits entry.*

Maritime crew (excluding cruise ships)

- Are not required to undertake 14 days of mandatory quarantine on arrival into Australia. They are therefore not required to complete the Isolation Declaration Card.
- Must proceed directly to the vessel on arrival.

Exemptions to the 14 day mandatory quarantine period, version 2 (06/04/2020)
Coronavirus Disease (COVID-19) 1

- If access to the vessel is not immediate, crew must self-isolate at their accommodation during any lay-over period.
- May travel domestically and/or take a domestic flight to meet their vessel at the next point of departure if required.
- At the completion of their shifts, they are not required to go into mandatory 14 days quarantine, but must undertake 14 days self-isolation.
- Time at sea counts towards the 14 days of self-isolation if no illness has been reported on-board. Therefore crew signing off commercial vessels that have spent greater than 14 days at sea, with no know illness on-board, do not need to self-isolate on arrival.

Unaccompanied minors

Unaccompanied minors will be allowed to travel domestically after entering Australia to self-quarantine with a parent or guardian at their home.

Transit passengers

- International transit passengers arriving into Australia are able to depart on another international flight if the following conditions are met:
  - If the individual has up to 8 hours until the departing international flight, they must remain at the airport and be permitted to onward travel, maintaining social distancing and hand hygiene.
  - If 8-72 hours before the departing flight, they must go to mandatory quarantine at the state designated facility until the time of the departing flight.
- No domestic onward travel is allowed, even if this is to meet a departing international flight. These people should go into mandatory quarantine at the state designated facility at the first point of arrival.

Diplomats

- Australia has legal obligations under the Vienna Convention to ensure diplomats freedom of movement and travel, and protection from detention. Diplomats are not required to undertake 14 days of mandatory quarantine on arrival into Australia. They are therefore not required to complete the Isolation Declaration Card.
- Diplomats should self-isolate at their mission or in their usual place of residence on arrival for 14 days.
- Diplomats must continue to practise social distancing, cough etiquette and hand hygiene.

Compassionate or medical grounds

Applications on medical or compassionate grounds should be submitted to the relevant state or territory who will consider requests on a case-by-case basis.

Contact details for state or territory public health agencies are available at www.health.gov.au/state-territory-contacts.

Where can I get more information?

For the latest advice, information and resources, go to www.health.gov.au.

Call the National Coronavirus Helpline on 1800 020 080. This line operates 24 hours a day, seven days a week. If you require translating or interpreting services, call 131 450.

Appendix 5 - Guidance note: Ensuring physical and mental welfare of international arrivals in individual detention (unaccompanied minors)

Introduction

You are an officer authorised by the Chief Health Officer under section 199(2)(a) of the *Public Health and Wellbeing Act 2008* (Vic) to exercise certain powers under that Act. You also have duties under the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**Charter**).

These Guidelines have been prepared to assist you to carry out your functions in relation to Victorian unaccompanied minors who have arrived in Victoria and are subject to detention notices, requiring them to self-quarantine in a designated hotel room for 14 days in order to limit the spread of Novel Coronavirus 2019 (**2019-nCoV**) where no parent, guardian or other carer (**parent**) has elected to join them in quarantine (a **Solo Child Detention Notice**).

As part of your functions, you will be required to make decisions as to whether a person who is subject to a Solo Child Detention Notice should be granted permission to leave their room:

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

Authorised Officers are also required to review the circumstances of each detained person at least once every 24 hours, in order to determine whether their detention continues to be reasonably necessary to eliminate or reduce a serious risk to public health.

Your obligations under the Charter of Human Rights and Responsibilities Act 2006

You are a public officer under the Charter. This means that, in providing services and performing functions in relation to persons subject to a Detention Notice you must, at all times:

- act compatibly with human rights; and
- give 'proper consideration' to the human rights of any person(s) affected by your decisions.

How to give 'proper consideration' to human rights

'Proper consideration' requires you to:

1. **first**, understand in general terms which human rights will be affected by your decisions (these rights are set out below under 'relevant human rights');
2. **second**, seriously turn your mind to the possible impact of your decisions on the relevant individual's human rights, and the implications for that person;
3. **third**, identify the countervailing interests (e.g. the important public objectives such as preventing the further spread of 2019-nCoV, which may weigh against a person's full enjoyment of their human rights for a period of time); and
4. **fourth**, balance the competing private and public interests to assess whether restricting a person's human rights (e.g. denying a person's request to leave their room) is justified in the circumstances.

Relevant human rights

The following human rights protected by the Charter are likely to be relevant to your functions when conducting daily wellbeing visits and when assessing what is reasonably necessary for the physical and mental health of children who are subject to Solo Child Detention Notices:

The right of children to such protection as is in their best interests (s 17(2)). As the Solo Child Detention Notices detain children in circumstances where no parent has elected to join them in quarantine, greater protection must be provided to these children in light of the vulnerability that this creates. Where possible the following additional protection should be provided:

You should undertake two hourly welfare checks while the child is awake and once overnight. You should ask the child to contact you when they wake each morning and let you know when they go to sleep so that this can be done.

You should ask the child if they have any concerns that they would like to raise with you at least once per day.

You should contact the child's parents once per day to identify whether the parent is having contact with the child and whether the parent or child have any concerns.

You should ensure that where the child does not already have the necessary equipment with them to do so (and their parent is not able to provide the necessary equipment) the child is provided with the use of equipment by the department to facilitate telephone and video calls with their parents. A child must not be detained without an adequate means of regularly communicating with their parents.

You should ensure that where the child does not already have the necessary equipment with them to do so (and their parent is not able to provide the necessary equipment) the child is provided with the use of equipment by the department to participate in remote education if that is occurring at the school they are attending. Within the confines of the quarantine you should obtain reasonable assistance for the child in setting up that computer equipment for use in remote education.

You should allow the child's parents to bring them lawful and safe items for recreation, study, amusement, sleep or exercise for their use during their detention. This should be allowed to occur at any time within business hours, and as many times as desired, during the detention.

The rights to liberty (s 21) and freedom of movement (s 12), and the right to humane treatment when deprived of liberty (s 22). As the Solo Child Detention Notices deprive children of liberty and restrict their movement, it is important that measures are put in place to ensure that the accommodation and conditions in which children are detained meet certain minimum standards (such as enabling parents to provide detained children with food, necessary medical care, and other necessities of living). It is also important that children are not detained for longer than is reasonably necessary.

Freedom of religion (s 14) and cultural rights (s 19). Solo Child Detention Notices may temporarily affect the ability of people who are detained to exercise their religious or cultural rights or perform cultural duties; however, they do not prevent detained persons form holding a religious belief, nor do they restrict engaging in their cultural or religious practices in other ways (for example, through private prayer, online tools or engaging in religious or cultural practices with other persons with whom they are co-isolated). Requests by children for additional items or means to exercise their religious or cultural practices will need to be considered and accommodated if reasonably practicable in all the circumstances.

The rights to recognition and equality before the law, and to enjoy human rights without discrimination (s 8). These rights will be relevant where the conditions of detention have a disproportionate impact on detained children who have a protected attribute (such as race or disability). Special measures may need to be taken in order to address the particular needs and vulnerabilities of, for example Aboriginal persons, or persons with a disability (including physical and mental conditions or disorders).

The rights to privacy, family and home (s 13), freedom of peaceful assembly and association (s 16) and the protection of families (s 17). Solo Child Detention Notices are likely to temporarily restrict the rights of persons to develop and maintain social relations, to freely assemble and associate, and will prohibit physical family unification for those with family members in Victoria. Children's rights may be particularly

affected, to the extent that a Solo Child Detention Notice results in the interference with a child's care and the broader family environment. It is important, therefore, to ensure children subject to Solo Child Detention Notices are not restricted from non-physical forms of communication with relatives and friends (such as by telephone or video call). Requests for additional items or services to facilitate such communication (e.g. internet access) will need to be considered and accommodated if reasonably practicable in all the circumstances.

Whether, following 'proper consideration', your decisions are compatible with each these human rights, will depend on whether they are reasonable and proportionate in all the circumstances (including whether you assessed any reasonably available alternatives).

General welfare considerations

All persons who are deprived of liberty must be treated with humanity and respect, and decisions made in respect of their welfare must take account of their circumstances and the particular impact that being detained will have on them. Mandatory isolation may, for some people, cause greater hardship than for others – when performing welfare visits you will need to be alert to whether that is the case for any particular person.

In particular, anxieties over the outbreak of 2019-nCoV in conjunction with being isolated may result in the emergence or exacerbation of mental health conditions amongst persons who are subject to Detention Notices.

If you have any concerns about the mental health of a detained person, you should immediately request an assessment of mental health be conducted and ensure appropriate support is facilitated. Hotel rooms are not normally used or designed for detention, so you should be aware that a person who is detained in a hotel room could have greater opportunity to harm themselves than would be the case in a normal place of detention.

Additional welfare considerations for children

Children differ from adults in their physical and psychological development, and in their emotional and educational needs. For these reasons, children who are subject to Solo Child Detention Notices may require different treatment or special measures.

In performing functions and making decisions with respect to a detained person who is a child, the best interests of the child should be a primary consideration. Children should be given the opportunity to conduct some form of physical exercise through daily indoor and outdoor recreational activities. They should also be provided with the ability to engage in age-appropriate activities tailored to their needs.

Each child's needs must be assessed on a case-by-case basis. Requests for items or services to meet the needs of individual children will need to be considered and accommodated if reasonably practicable in all the circumstances.

Where available, primary school age children should be allocated rooms that have an outside area where it is safe for active physical play to occur (not a balcony) and consideration should be given to allowing small children access to any larger outdoor areas that are available within the hotel, where possible within relevant transmission guidelines. Although each child’s needs must be assessed daily and individually, it can be assumed that it will have a negative effect on a child’s mental health to be kept in the same room or rooms for two weeks without access to an adequate outdoor area in which to play.

Balancing competing interests

However, the best interests of children and the rights of anyone who is subject to a Solo Child Detention Notice will need to be balanced against other demonstrably justifiable ends; for example, lawful, reasonable and proportionate measures taken to reduce the further spread of 2019-nCoV.

It is your role to undertake this balance in your welfare checks, based on the information and advice that you have from the department and on the information provided to you by the children that you are assessing.

Appendix 6 Direction and Detention Notice – Solo Children

DIRECTION AND DETENTION NOTICE

SOLO CHILDREN

Public Health and Wellbeing Act 2008 (Vic)
Section 200

Reason for this Notice

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

A state of emergency has been declared under section 198 of the *Public Health and Wellbeing Act 2008* (Vic) (the **Act**), because of the serious risk to public health posed by COVID-19.

In particular, there is a serious risk to public health as a result of people travelling to Victoria from overseas. People who have been overseas are at the highest risk of infection and are one of the biggest contributors to the spread of COVID-19 throughout Victoria.

You will be detained at the hotel specified in clause 2 below, in the room specified in clause 2 below, for a period of 14 days, because that is reasonably necessary for the purpose of eliminating or reducing a serious risk to public health, in accordance with section 200(1)(a) of the Act.

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

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

The Chief Health Officer will be notified that you have been detained. The Chief Health Officer must advise the Minister for Health of your detention.

Note: These steps are required by sections 200(7) and (9) of the Act.

Place and time of detention

You will be detained at:

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

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

You will be detained until: _____ on ____of _____2020.

Directions — transport to hotel

You must **proceed immediately to the vehicle** that has been provided to take you to the hotel, in accordance with any instructions given to you.

Once you arrive at the hotel, **you must proceed immediately to the room** you have been allocated above in accordance with any instructions given to you.

Conditions of your detention

You must not leave the room in any circumstances, unless:

you have been granted permission to do so:

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

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

on compassionate grounds; or

there is an emergency situation.

You must not permit any other person to enter your room, unless the person is authorised to be there for a specific purpose (for example, providing food or for medical reasons).

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

You are permitted to communicate with people who are not staying with you in your room, either by phone or other electronic means.

Note: An authorised officer must facilitate any reasonable request for communication made by you, in accordance with section 200(5) of the Act.

(18) If you are under 18 years of age your parent or guardian is permitted to stay with you, but only if they agree to submit to the same conditions of detention for the period that you are detained.

Review of your detention

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

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

Special conditions because you are a solo child

Because your parent or guardian is not with you in detention the following additional protections apply to you:

We will check on your welfare throughout the day and overnight.

We will ensure you get adequate food, either from your parents or elsewhere.

We will make sure you can communicate with your parents regularly.

We will try to facilitate remote education where it is being provided by your school.

We will communicate with your parents once a day.

Offence and penalty

It is an offence under section 203 of the Act if you refuse or fail to comply with the directions and requirements set out in this Notice, unless you have a reasonable excuse for refusing or failing to comply.

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

_____

Name of Authorised Officer: _____

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

Appendix 7: End of Detention Notice

Public Health and Wellbeing Act 2008 (Vic)

Section 200

Subject to the conditions below, this Notice is evidence that this detainee has completed their period of detention under a *Direction and Detention Notice* issued to reduce or eliminate the serious public health risk posed by COVID-19.

9 Detention Notice

You have arrived in Victoria from overseas, on or after midnight on 28 March 2020 or on or after midnight on 13 April 2020 and have been placed in detention, pursuant to a Direction and Detention Notice that you were provided on your arrival in Victoria (**Notice**).

10 Details of Detention Notice

Name of Detainee: **<<FIRST NAME>> <<LAST NAME>>**

Date of Detainment and Detention Notice: <<DETENTION START DATE>>

Place of Detention: <<HOTEL>> <<ROOM>>

11 End of Detention Notice

In accordance with section 200(6) of the *Public Health and Wellbeing Act 2008,* I have reviewed your continued detention.

On review of the Notice, I have made the following findings:

you will have served the required detention period by <<DETENTION END DATE>>; and

you have not started exhibiting any symptoms of COVID-19.

In consideration of the above circumstances, I have decided that your continued detention is not reasonably necessary to eliminate or reduce a serious risk to public health.

I advise that your detention pursuant to section 200(1)(a) of the *Public Health and Wellbeing Act 2008* (Vic) and the Notice will end on <<**DETENTION END DATE**>> at _____after you have been discharged by an Authorised Officer and have commenced transportation to your ordinary residence.

Although you are no longer to be detained pursuant to the Notice, you are required to comply with all directions currently in force in Victoria. This includes the Stay at Home Directions (No 4) (**Direction**), as amended from time to time. Pursuant to the Direction, if you live in Victoria you are required to travel directly to the premises where you ordinarily reside, and remain there unless you are leaving for one of the reasons listed in the Direction.

If you are a resident of another state arrangements will be made for you to return home. While you remain in the State of Victoria, you are required to comply with all Directions in operation in Victoria. Once you have returned home, you are required to comply with the Directions and/or Orders in place in your home jurisdiction, including any directions that may require you to isolate for a further 14 day period.

In the event that you start to experience symptoms of COVID-19, it is important that you self-isolate and, if necessary, contact your General Practitioner or local Public Health Unit.

12 End of Detention Instructions

You must not leave your hotel room until you have been collected by Security at which time you are permitted to travel to the hotel lobby to meet an Authorised Officer who will **sight your identification** and discharge you from detention. **Security will give you approximately an hour notice of when they will collect you.**

Your detention **does not end** until the time stated in paragraph 0 of this notice which will be filled in by an authorised officer when you are discharged from detention. Until that time you must continue to abide by the requirements of your detention, as contained in the Notice.

When leaving detention you **must** adhere to the following safeguards:

if provided to you, you **must** wear personal protective equipment;

you **must** refrain, as far as possible, from touching communal surfaces, such as handrails, elevator buttons and door handles;

you **must** where possible, engage in social distancing, maintaining a distance of 1.5 metres from other people; and

upon leaving your hotel room, you **must** go straight to the foyer for discharge and then immediately after travel to your transportation and travel directly to your ordinary residence.

These steps are to ensure your protection, and reduce the risk of you becoming infected with COVID-19 by any persons detained in the hotel, or in the community, who may have COVID-19.

Until your detention has concluded, you must follow instructions from Authorised Officer/s and any other conditions set out.

2 Offence and penalty

(1) It is an offence under section 203 of the Act if you refuse or fail to comply with the directions set out in this notice, unless you have a reasonable excuse for refusing or failing to comply.

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

_____ **Signature of Authorised Officer**

Name of Authorised Officer: _____

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

Appendix 8: End of Detention Notice (confirmed case or respiratory illness symptoms)

Public Health and Wellbeing Act 2008 (Vic)

Section 200

An Authorised Officer has decided to end your Direction and Detention Notice. This decision has been made following the mandatory review of your Direction and Detention Notice because you [*have returned a positive test for COVID-19*] *or* [*have started displaying symptoms of respiratory illness*].

1. Detention Notice

You have arrived in Victoria from overseas, on or after midnight on 28 March 2020 or on or after midnight on 13 April 2020 and have been placed in detention, pursuant to a Direction and Detention Notice that you were provided on your arrival in Victoria (**Notice**).

2. Details of End of Detention Notice

Name of Detainee:_____

Date Notice Made:_____

Date Notice Expires:_____

Place of Detention:_____

Medical Facility:_____
(if medical care is required)

COVID-19 Status or respiratory illness symptoms [tick applicable]:

COVID-19 confirmed*:* _____ *[insert date of test]*	☐	coughing	☐
fever or temperature in excess of 37.5 degrees	☐	sore throat	☐
congestion, in either the nasal sinuses or lungs	☐	body aches	☐
runny nose	☐	fatigue	☐

3. End of Detention Notice

In accordance with section 200(6) of the Public Health and Wellbeing Act 2008, I have reviewed your continued detention.

On review of the Notice, I have noticed that you [have been diagnosed with COVID-19] or [have exhibited the symptoms of respiratory illness, as outlined above at paragraph 2(8) *[delete as applicable*].

In consideration of the above, I do not believe that continued detention is reasonably necessary to eliminate or reduce a serious risk to public health because:

a) [*if applicable*] You have been confirmed to have COVID-19 and will be required to self-isolate in accordance with the Isolation (Diagnosis) Direction, in a premises that is

suitable for you to reside in, or a medical facility, until such a time you are notified that you no longer need to self-isolate and a clearance from isolation (self-isolation) is given;

b) [*if applicable*] You are showing symptoms of respiratory illness and will be required to self-isolate in accordance with the Stay at Home Direction (4) currently in force in Victoria and will need travel directly to your ordinary residence once you leave detention, and remain there unless you are permitted to leave for a reason specified in the Stay at Home Direction (4); and

c) You are ordinarily a resident in Victoria.

Compliance with Directions made by the Deputy Chief Health Officer is required to reduce or eliminate the serious risk to public health posed by COVID-19. It is essential that you [self-isolate in accordance with the Isolation (Diagnosis) Direction until such time as you are notified that you no longer need to self-isolate and a clearance from self-isolation is given] OR [return to your ordinary residence and remain there unless you are permitted to leave for a reason specified in the Stay at Home Direction (4). Please monitor your symptoms and seek appropriate medical care if required]. *[delete as applicable*].

The Notice is ended subject to the directions below under paragraph 4. Non-compliance with these directions is an offence.

4. Conditions

- You will be transited from the hotel where you have been detained to your ordinary residence / Premises for Isolation pursuant to Isolation (Diagnosis) Direction / medical facility [*delete as appropriate*] by an Authorised Officer. You may / will [*delete as appropriate*] be supervised during transit.
- While you are transiting to your ordinary residence / Premises for Isolation pursuant to Isolation (Diagnosis) Direction / medical facility [*delete as appropriate*], you must refrain from touching communal surfaces, as far as possible, such as door knobs, handrails, lift buttons etc.
- When you are transiting to your ordinary residence / Premises for Isolation pursuant to Isolation (Diagnosis) Direction / medical facility [*delete as appropriate*], you must, **at all times**, wear appropriate protective equipment to prevent the spread of COVID-19, if directed by the Authorised Officer.
- You must practice social distancing, and as far as possible, maintain a distance of 1.5 metres from all other people, including any Authorised Officer escorting you.
- When you are transiting to your ordinary residence / Premises for Isolation pursuant to Isolation (Diagnosis) Direction / medical facility [*delete as appropriate*], you must, **at all times**, comply with any direction given to you by any Authorised Officer escorting you.

5. Offence and penalty

It is an offence under section 203 of the Act if you refuse or fail to comply with the directions and requirements set out in this notice and/or the Isolation (Diagnosis) Direction *[if applicable*], unless you have a reasonable excuse for refusing or failing to comply.

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

_____ **Signature of Authorised Officer**

Name of Authorised Officer: _____

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

Appendix 9: Guidance Note – End of Detention

How to conclude a person's detainment under a *Direction and Detainment Notice* if they have served the required period of detainment, become a confirmed case of COVID-19 or have symptoms of respiratory illness

What do you have to do before you issue an End of Detention Notice?

If the person has served 14 days of detention you must decide how to administer the completion of that person's detention arrangements:

a) selecting a time for the person to attend a foyer after the 14 day period has concluded - it is recommended that this occur in small groups of people who are practicing appropriate social distancing and with sufficient time between groups to avoid crowds. This will ensure Authorised Officers can safely discharge each detainee

b) collecting a person from their hotel room after the 14 day period has concluded – this approach should be carefully administered to ensure Authorised Officers can safely discharge each person

c) if a person's detainment is concluding because they have a confirmed case of COVID-19 or symptoms of respiratory illness they must be discharged when it is safe to do so – e.g. when other detained people are in their rooms, under full supervision etc.

d) complete all sections of the Notice, including clearly documenting the reasons for the end of detention and the details recorded on the Direction and Detention Notice

e) update all the registers and relevant records about the person's detainment arrangements ensure the reference number is completed.

When should you issue an End of Detention Notice?

It is preferable that an End of Detention Notice be issued the day before a person's detainment is set to conclude – this will give the person adequate time to prepare (e.g. to pack their belongings) and ensure the orderly discharge of large groups of people.

A notice may be provided earlier but it creates a risk that a person may develop COVID-19 symptoms before the day the detainment period must end.

What do you have to do when you issue an End of Detention Notice?

When you issue an End of Detention Notice you must:

a) explain the reason why detention has ceased and is no longer necessary to eliminate or reduce a serious risk to public health

b) advise that person of the arrangements being made for their discharge from detention (e.g. at an allocated time at the foyer; when they are escorted from their room etc)

c) notify they person that although they are no longer subject to detention when they are discharged and leave the premises of their detention, they are still subject to the directions which are in force in Victoria, including

d) if they are ordinarily resident in Victoria, they are required to return immediately to their ordinary residence, where they must remain, in accordance with the Stay at Home Directions (No 2)

e) if they have a confirmed case of COVID-19, they must isolate at home in accordance with the Isolation (Diagnosis) Direction

Appendix 10 - Guidance Note — Exceptions to the General Quarantine Policy

Summary

You are [an officer authorised by the Chief Health Officer under section 199(2)(a) of the *Public Health and Wellbeing Act 2008* (Vic) (**PHW Act**) to exercise certain powers under that Act] [or a delegate of the Chief Health Officer under section 22 of the PHW Act] [**Note: however, only registered medical practitioners can be delegates under s 22**]. You also have duties under the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**Charter**).

This guidance note has been prepared to assist you to carry out your functions in determining whether individual persons arriving in Victoria from overseas should be exempt from being made subject to a detention notice requiring them to self-quarantine in a designated hotel room for 14 days in order to limit the spread of Novel Coronavirus 2019 (**2019-nCoV**) (the **general quarantine policy**). This policy is in place because people returning from overseas are at increased risk of infection from 2019-nCoV and may inadvertently transmit it to others upon their return and because the earlier requirement to isolate at home was not uniformly complied with.

As part of your functions, you are required to make decisions as to whether an exception to the general quarantine policy is warranted in particular cases that have been escalated to you by authorised officers. If you decide that an exception applies, you must subsequently decide whether the person in question should be:

released from quarantine in Victoria (because they are medically cleared or will be subject to another jurisdiction's regime); or

required to complete their quarantine in another location in Victoria (at home or in another facility), in which case they would be subject to the same conditions that apply to other international arrivals under the standard direction and detention notice, including monitoring and penalties for non-compliance.

This guidance note sets out the following **six categories of exceptions** to the general quarantine policy and provides a checklist of relevant factors to be considered when determining whether each exception applies:

1. International transit (for example, transit in Victoria from New Zealand en route to Europe or vice versa).

Interstate transit (with the approval of the receiving jurisdiction, usually for compassionate reasons or as an unaccompanied minor).

Unaccompanied minors whose legal guardians are unable to reside with them at the hotel (for example, due to other caring responsibilities).

Compassionate or medical grounds (for example, if the person suffers from anaphylaxis).

Previous confirmed cases with medical clearance who no longer require quarantine.

Key workers.

It also provides guidance on how to fulfil your obligations under the Charter for each exception. Those obligations are to act compatibly with human rights and to give 'proper consideration' to the relevant human rights of any person(s) affected by your decisions. The relevant factors and human rights considerations will differ depending on the applicable exception.

We note that, although it is important that the exceptions are reasonably transparent and communicated clearly to people arriving in Victoria from overseas, this must be balanced against the need to ensure that the categories of exceptions are appropriately circumscribed so as not to undermine the general quarantine policy. Further, although this guidance note has been developed in the interests of ensuring consistency and clarity in the application of the exceptions, you must determine each request on a case-by-case basis.

Your obligations under the Charter

You are a public officer under the Charter. This means that, in deciding whether an exception to the general quarantine policy is warranted in any particular case, you must give 'proper consideration' to the human rights of *any person* affected by the decision, including the person who would otherwise be subject to the detention notice, the person(s) who they may quarantine with if they were to quarantine at home, and members of the community.

'Proper consideration' requires you to:

- **first**, understand in general terms which human rights will be affected by your decision (these rights are set out below and differ depending on the exception);
- **second**, seriously turn your mind to the possible impact of your decision on the relevant individual's human rights, and the implications for that person;
- **third**, identify the countervailing interests (e.g. the important public objectives such as preventing the further spread of 2019-nCoV, which may weigh against a person's full enjoyment of their human rights for a period of time); and
- **fourth**, balance the competing private and public interests to assess whether restricting a person's human rights is justified in the circumstances.

Exceptions [*Ensure consistency with Australian Government policy re exceptions to mandatory quarantine*]

1. International transit

Description of category

Ref page 65

Relevant factors

[DHHS to please provide]

Relevant human rights

Ref page 67

2. Interstate transit

Description of category

[*Refer to letter to diplomat re exception to travel to Canberra*]

Relevant factors

[DHHS to please provide]

Relevant human rights

3. Unaccompanied minors whose legal guardians are unable to reside with them at the hotel

Description of category

Ref page 71

Relevant factors

[DHHS to please provide]

Relevant human rights

4. Compassionate or medical grounds

Description of category

[*Refer to previous assessments fo* REDACTED

Relevant factors

[DHHS to please provide]

Relevant human rights

5. Previous confirmed cases with medical clearance who no longer require quarantine

Description of category

Relevant factors

[DHHS to please provide]

Relevant human rights

6. Key workers

Description of category

[*Refer to letter from Minister Hunt re exception for key workers*]

Relevant factors

[DHHS to please provide]

Relevant human rights

[Note: do we possibly need a 'miscellaneous' / catch-all category, to capture cases that may warrant an exception but do not fall squarely into one of the above categories?]

Appendix 11: Charter of Human Rights obligations

Key points

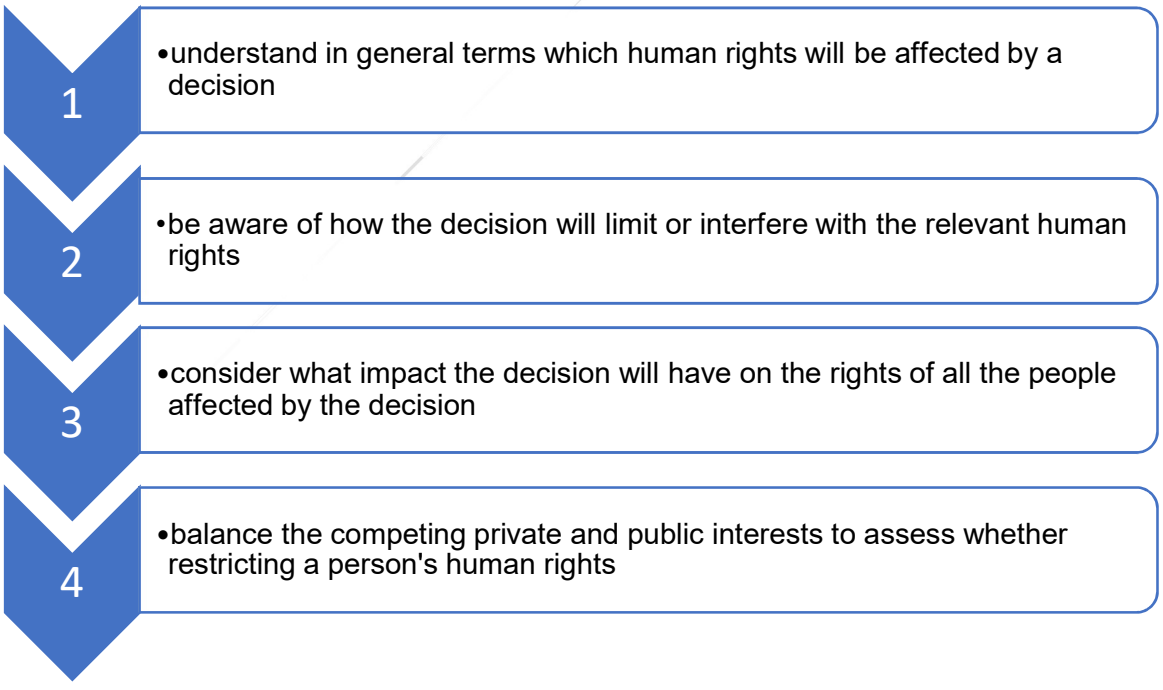
- AO must act compatibly with human rights.
- AO must give 'proper consideration' to the human rights of any person(s) affected by an AO's decision.

Department of Human Health and Services AO obligations under the *Charter of Human Rights and Responsibilities Act 2006*

Department AOs are public officials under the Charter of Human Rights. This means that, in providing services and performing functions in relation to persons subject to the Direction and Detention Notice, department AOs must, at all times:

- act compatibly with human rights; and
- give 'proper consideration' to the human rights of any person(s) affected by a department AO's decisions.

How to give 'proper consideration' to human rights



The relevant Charter Human Rights that departmental AOs need to be aware of that may be affected by a decision:

Charter Right	Obligation

Charter Right	Obligation
Right to life	This includes a duty to take appropriate steps to protect the right to life and steps to ensure that the person in detention is in a safe environment and has access to services that protect their right to life
Right to protection from torture and cruel, inhuman or degrading treatment	This includes protecting persons in detentions from humiliation and not subjecting persons in detention to medical treatments without their consent
Right to freedom of movement	while detention limits this right, it is done to minimise the serious risk to public health as a result of people travelling to Victoria from overseas
Right to privacy and reputation	this includes protecting the personal information of persons in detention and storing it securely
Right to protection of families and children	this includes taking steps to protect families and children and providing supports services to parents, children and those with a disability
Property Rights	this includes ensuring the property of a person in detention is protected
Right to liberty and security of person	this includes only be detained in accordance with the PHWA and ensuring steps are taken to ensure physical safety of people, such as threats from violence
Rights to humane treatment when deprived of liberty	this includes treating persons in detention humanely.

Appendix 12 Register of permissions granted under 4(1) of the *Direction and Detention Notice*

Authorised officer:_____

Ref No.	Date	Name of detained person	Reason	Time-Out	Time-In

Appendix 13 - Enforcement and Compliance roles and responsibilities

Enforcement and Compliance Command

Role	Responsibilities
Enforcement and Compliance Commander	• Lead and provide oversight to compliance matters under all Public Health Directions • Provide advice and input into complex compliance matters. • Provide advice and support to the Chief Health Officer and their delegate on compliance • Approves exemptions
Deputy Command – AO Operations	• Executive oversight of Authorised officer operations in the hotels. Ensures planning arrangements allow for safe operations of AO decisions and escalation point for complex AO decisions across all AO operations across the airport and hotel environments. Ensure AOs understand protocols and follow protocols to ensure detention arrangements are legal • Ensure VicPol have appropriate AO guidance and support.
AO Operation support	• Undertake rostering, recruiting and onboarding of AOs. (rostering transitioning to EOC) • Manage the release process for detention and 24 hour legal review process
AO Team Leader*	• Provide management oversight of AOs • First point of escalation of permissions • Report on daily review of people being detained. (Transition to Review and release team)

AO	• Primary responsible for:
	  ○ administration of, and ensuring compliance with, the Direction and Detention Notices (27 March 2020 and 13 April 2020)
	  ○ meeting obligations under the PHWA

Deputy Command Policy and Exemptions	• Executive oversight of development of operational protocols, exemptions and review process. Ensures connections with other relevant areas to ensure processes are connected and complex issues resolved.
Operational Policy and Protocols Leader	• Develop operational policy and protocols to support Directions • Coordinates the training of AOs

Exemptions Leader	• Manage the COVID Quarantine inbox[5].and case management process – ensure cases are allocated and resolved in a timely manner

Contacts for each role are as per daily roster.

Other non-ECC roles involved in compliance

Role	Responsibility
DHHS Hotel site lead	• Supports the health and well-being of staff • Liaises with airport command and staff from other departments and agencies represented at the hotel • Provides situational awareness and intelligence to inform transport providers, state-level emergency management arrangements and airport operations • Provides a point of reference to all site-staff to help resolve operations, logistics or site-related issues and / or escalations required • Ensures appropriate records management processes are in place.
DJPR	• Manage contracts with accommodation providers
Medical, Nursing and welfare staff	• Provide 24 hour on-call medical support subject to demand • Provide welfare to detainees through a daily welfare check — welfare officers email COVIDQuarantine@dhhs.vic.gov.au and phone the site AO individually to alert AO of medical and welfare issues • Capture client personal needs, e.g. dietary, medication, allergies, personal hygiene needs • Provide a satisfaction survey for residents to complete each week.
Department and hotel staff	• Deliver hyper-care (concierge) services onsite • Manage transport arrangements from the airport and other locations detainees may be permissioned to go • Manage material needs including food and drink.
Security	• To assist AOs in ensuring detainees comply with notices and permissions. This includes ensuring detainees do not leave hotel rooms, assisting with movement of detainees where they have permission to leave rooms, and assisting with release

[5] COVIDquarantine@dhhs.vic.gov.au

Annex 2 – Health & Wellbeing

Annex approver: Public Health Commander

Last version date: v2.0 1 June 2020

Standards for healthcare and welfare provision

Standard 1. Rights of people in mandatory quarantine

Criterion 1.1 Charter of Human Rights and Responsibilities

Policies and practices guiding decisions made about people in mandatory quarantine under Operation Soteria must consider the Victorian Charter of Human Rights and Responsibilities.

The Victorian Charter of Human Rights and Responsibilities Act 2006 (the Charter) contains twenty basic rights that promote and protect the values of freedom, respect, equality and dignity. The Charter requires the Victorian Government (state and local) to consider human rights when they make decisions about people. While some of these rights may be restricted for quarantined people, consideration of these rights must underlie all decisions made by Operation Soteria staff in relation to people in mandatory detention.

- Relevant Charter of Human Rights that must be considered by Operation Soteria staff when making decisions in relation to people in mandatory detention include:

  - Right to life
  - Right to protection from torture and cruel, inhumane or degrading treatment
  - Freedom from forced work
  - Right to freedom of movement
  - Right to privacy and reputation
  - Freedom of thought, conscience, religion and belief
  - Freedom of expression
  - Right to protection of families and children
  - Cultural rights
  - Property rights
  - Right to liberty and security of the person
  - Right to humane treatment when deprived of liberty

  Noting section 19(2) outlines the distinct cultural rights of Aboriginal persons.

- Quarantined persons should be provided with a notice of detention, information on the terms and nature of the mandatory quarantine period and opportunity to seek exemption or review of the current detention order

Criterion 1.2 Diverse groups

- All persons in mandatory quarantine should be treated with dignity and respect.
- Providers of health and welfare services must meet the care needs of quarantined persons on an individual basis.
- Consideration should be given to the special needs of Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse (CALD) backgrounds; lesbian, gay, bisexual, trans, gender diverse and intersex people; people with disabilities, and others.
- Quarantined persons should be screened on arrival to identify those persons who are of Aboriginal or Torres Strait Islander heritage

- The care provided to Aboriginal and Torres Strait Islander peoples should fulfil the six actions of the National Safety and Quality Health Service Standards that focus specifically on meeting the needs of Aboriginal and Torres Strait Islander people (for further details see https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Safety-and-Quality-Health-Service-Standards-User-Guide-for-Aboriginal-and-Torres-Strait-Islander-Health.pdf).
- Quarantined persons should be screened on arrival to identify those with physical, sensory, psychosocial or intellectual disabilities.
- Quarantined persons with a disability should be provided with the services and supports they require. Australia is a signatory to the United Nations Convention on the Rights of Persons with Disabilities, which sets out human rights for people with disabilities which include accessibility, personal mobility and access to healthcare.

Criterion 1.3 Use of interpreters

- Quarantined persons should be screened on arrival to identify those who require interpreters
- Interpreters must be used for quarantined persons where English is not their first language and translation would normally be required for interaction with the health or welfare systems
- Language requirements should be recorded in the quarantined person's record and hotel staff advised.

Criterion 1.4 Feedback and complaints process

A feedback and complaints process can provide unique information about quarantined persons needs and the quality of care provided by Operation Soteria. Openly discussing feedback and concerns helps staff to understand strengths in their service, potential problems, and how to make improvements.

- Processes for assessing satisfaction and receiving and addressing complaints should be established.

Potential indicators

Program delivery

- Number of people seeking exemptions from mandatory quarantine
- Number of Aboriginal and Torres Strait Islander peoples in quarantine
- Number of people with a disability in quarantine
- Number of people in quarantine requiring interpreter services
- Number of adverse events arising from failure to address the needs of a person with disability
- Nature of adverse events (de-identified) arising from failure to address the needs of a person with disability
- Number of adverse events arising from failure to use an interpreter
- Nature of adverse events (de-identified) arising from failure to use an interpreter
- Number of complaints related to detention, health and welfare services
- Nature of complaints (de-identified) related to detention, health and welfare services

Outcomes

- Number of people receiving exemptions from mandatory quarantine
- Reasons for exemptions granted (de-identified)
- Outcomes of adverse events (de-identified) arising from failure to use an interpreter
- Outcomes of adverse events (de-identified) arising from failure to address the needs of a person with disability
- Resolution of complaints related to on-site staff, mandatory detention processes and health and welfare services

Reporting frequency

- Significant adverse events (major incidents): as soon as possible after occurrence
- All other adverse events: daily
- Formal complaints: weekly

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

As part of the duty of care towards people in mandatory detention under Operation Soteria, it is essential that appropriately qualified staff screen quarantined individuals for health and welfare risk factors, so that appropriate services are made available to those who require them.

Criterion 2.1 Health and welfare risk factors

Returned travellers will be screened for risk factors related to the following:

- current or potential infection with COVID-19 including:
  - temperature
  - symptoms including fever, cough, shortness of breath, chills, body aches, sore throat, headache, runny nose, muscle pain or diarrhoea
- potential complications or adverse events arising from
  - current or previous physical health conditions
  - current or previous mental health conditions
  - current or previous disabilities
- allergies and food sensitivities, with particular note of anaphylaxis
- need for ongoing medication, contact with usual treating health professionals, and other support services
- family violence or child abuse
- drug and alcohol use and/or dependence
- current stressors or factors that will make quarantine particularly difficult, such as small children, bereavement, etc
- needs or fears expressed by the quarantined person
- vulnerability due to age (children or people over 65) or pregnancy

Criterion 2.2 Schedule for screening

- Returned travellers should be screened for COVID-19 at the following times:

  On arrival at airport: screening to include temperature and symptoms of COVID-19

  Day 3 and Day 11: voluntary routine testing
- Returned travellers will be screened for other health and welfare concerns at the following times:

  On day of arrival using the initial welfare self-reported survey XXX hyperlink to document

  Nurse health assessment within the first 24 hours, documented in the nurse health record

  Regularly throughout detention as determined by risk factors (Criterion 2.5), including welfare checks and checks by nurses or other appropriate staff.

Criterion 2.3 Methods of screening

- Screening tools (online or paper-based surveys, interview questions and prompts) that have been validated to assess health and welfare risk factors should be used where available.
- If appropriate validated tools are unavailable, any tools created for this purpose should be developed by professionals with expertise in survey development.
- It is essential that the initial screening assessment includes identification of Aboriginal and/or Torres Strait Islander status.

Criterion 2.4 Staff undertaking screening

- Staff undertaking health screening should have appropriate qualifications to conduct the tasks they are allocated, including understanding of Aboriginal cultural safety.
- Assessment of current or potential infection with COVID-19 should be undertaken by medical or nursing staff

- Assessment of all other risk factors should be undertaken by staff who have:
- an understanding of the issues likely to be raised and their implications
- knowledge of the circumstances that would require escalation or referral to health or mental health professionals
- training and experience in handling conversations:
    - on sensitive topics, such as family violence
    - with disturbed or fearful people
- It should be noted that health, education and other professional groups have mandatory requirements to report suspected child abuse. CART should be notified, and the individual practitioners are required to make a notification through child protection intake.
- Health or welfare phone calls to Aboriginal or Torres Strait Islander people should be undertaken by people who have undertaken Aboriginal cultural safety training.

Criterion 2.5 Risk assessment and follow up of persons 'at risk'

The self-screening survey and health assessment needs to identify any of the following risk factors to allocate an appropriate risk Tier. This must be completed in the first 24 hours and documented in the nurse health record and/or welfare application. Each quarantined person could be triaged into three tiers of risk based on identified risk factors as per the example table below.

Risk Tier	**Risk factors**	**Follow up by appropriate health or welfare professionals**
Tier 1	• Persons with suspected or confirmed COVID-19 • Families with children < 18 years • Persons aged > 65 years • Aboriginal and Torres Strait Islander peoples • Persons with underlying physical comorbidities (e.g. respiratory or cardiac conditions) • Persons with a disability • Persons with a history of mental illness • Allergies and food sensitivities, with particular note of anaphylaxis • History of family violence or child abuse • Drug and alcohol use and/or dependence • Current stressors or factors that will make quarantine particularly difficult, such as small children, bereavement, etc. • Those with needs or fears expressed by the quarantined person • Pregnant women	Phone call daily
Tier 2	• Persons who indicate they require a phone call but do not have any other risk factors. • Persons who are by themselves.	Phone call every second day
Tier 3	• Persons with none of the factors above	Tailored contact

- Relevant plans for follow up of identified risks should be developed

- Protocols for communicating follow up plans to relevant health and welfare staff should be documented
- At the discretion of the on-site clinical staff, quarantined persons with currently active physical or mental health issues should be:
    - managed on-site if within the capacity, capability and credentialing of attending medical and nursing staff
    - referred to the appropriate health services (e.g. mental health services, specialist medical services, hospital, etc) or other support services as required.

- Notification to the DHHS team leader and escalation to Emergency Operation Centre as appropriate.

Potential indicators

Program delivery

- Number of returning passengers arriving in Victoria
- Number and percentage of returning passengers screened for COVID-19 at the airport
- Reasons for COVID-19 screening not completed at the airport (e.g. passenger refused screening, insufficient staff, etc)
- Number and percentage of quarantined persons receiving health assessment (including risk assessment) in the first 24 hours of arrival
- Reasons for initial health assessment not completed on day of arrival (passenger refused screening, insufficient staff, etc)
- Number and percentage of quarantined persons receiving initial health assessment (including risk factors) after the first 24 hours (e.g. 20% on Day 2)
- Number and percentage of quarantined persons receiving subsequent screen for risk factors during detention period (i.e. screening survey or interview, follow up of identified risk factors)

Outcomes

- Number and percentage of screened passengers with known COVID-19 based on documentary evidence
- Number and percentage of screened passengers with known COVID-19 based on self-report
- Number and percentage of screened passengers with suspected COVID-19 based on signs and symptoms
- Number and percentage of quarantined persons with identified risk factors at initial health assessment
- Number and percentage of quarantined persons with identified risk factors at subsequent health assessment
- Nature of risk factors (de-identified)
- Number and percentage of quarantined persons referred to Operation Soteria health or support services by service (e.g. 10 [2%] referred to on-site doctor, 5 [1%] referred to NorthWestern Mental Health Services)
- Number and percentage of quarantined persons with identified risk factors referred to external services (e.g. one referred to Aboriginal community-controlled health services)

Reporting frequency

- All: Daily
- A daily report will be collated from the AO database, nurse health record and welfare application.

Standard 3. Provision of health and welfare services

The needs of quarantined individuals vary widely and Operation Soteria must have a flexible on-site system for the provision of health and welfare services that can accommodate urgent, non-urgent, complex, planned chronic care and preventive health needs.

Criterion 3.1 Meeting the needs of people in mandatory quarantine

The following principles should be followed in meeting the health and welfare needs of quarantined persons:

- All reasonable requests for medical care from quarantined persons should be facilitated within an appropriate timeframe depending on the acuity of the issue or request, and in a culturally appropriate manner.
- Provision of health or welfare services should not be deferred or delayed because a person is in quarantine.
- Any request for medical review should be carefully considered to determine whether telemedicine or in-person consultation is the most appropriate approach. Telemedicine should not be used if an in-person review or physical examination is clinically indicated. However, if an in-person review is not required, telemedicine is appropriate to reduce risk of infection to health providers and quarantined persons.
- Quarantined persons should be supported in accessing care through their usual general practitioner (GP), medical specialist, Aboriginal community-controlled health organisation, or other health professional via telehealth arrangements where possible. They should also be asked to request that the health professional consulted provides information regarding any ongoing health or welfare issues to the on-site clinical team if appropriate.

Criterion 3.2 Provision of on-site clinical services

- Safeguarding of the health and welfare of quarantined persons is paramount.
- Medical, nursing and other clinical services should be engaged at each hotel/facility to enable ADEQUATE, APPROPRIATE and TIMELY and culturally safe delivery of regular health assessment, acute clinical and support services. This should be determined by those commissioning/operating the health and welfare services in consultation with the Clinical Lead. It should correspond to the workload and burden of illness/needs of the population in mandatory quarantine at any time.
- Given the risk of mental health issues for people in isolation, mental health primary care services should also be available at a ratio proportionate to the burden of disease emerging from the quarantined cohort. Linking Aboriginal and Torres Strait Islander clients to culturally safe and trauma informed mental health and wellbeing services is essential.
- Medical, nursing and other clinical staff should practice within the requirements of their professional registrations, level of experience, codes of conduct and professional standards.
- Medical and nursing clinical practices, record-keeping and correspondence with other health professionals should meet the expectations and usual standards of high-quality primary care.
- Medical and nursing staff should have appropriate training, experience and credentials to:
    - identify physical and mental health emergencies
    - manage acute physical and mental health conditions by providing treatment or arranging appropriate referrals/ escalate care appropriately
    - provide support to quarantined persons who are distressed.
- Clinical governance arrangements should be in place to ensure that:
    - staff have appropriate training, experience and credentials
    - clinical practice is consistent with the best available evidence and follows applicable professional standards
    - clear and consistent escalation pathways are clearly communicated to all clinical staff
    - adequate, appropriate, well-maintained and calibrated clinical equipment is available to deliver primary care services
    - suitable arrangements are in place to enable comprehensive and secure medical record keeping.
- Provision should be made for both on-site in-person clinical consultations and telehealth consultations
- On-site clinical staff should be provided with mobile phones to facilitate rapid access by quarantined persons, operational and administrative staff, and external healthcare providers
- Processes for ensuring continuity of care through accurate and comprehensive medical record keeping and communication of medical information between providers engaged to provide on-site health care should be established.
- It is the responsibility of the doctor who orders any test (COVID-19 or otherwise) to follow up on the result and notify the patient in a timely manner. If they are not able to do so, they must handover this task to the next doctor on-call, inform the nurse, and record this in the medical record.

- Requests for medical care must be actioned in keeping with the acuity of the issue. Where staffing allows, the doctor may see patients before the nurse, particularly if the request is deemed urgent. An example of appropriate response times is included below.

Acuity of issue	Time frame for response
Emergency/life-threatening issue	Immediate – any person present to call 000 ASAP without waiting for nurse or doctor to attend
Urgent physical health concerns	Nurse to review ASAP (within 30 minutes) Doctor to review within 1 hour
Urgent mental health issue	Doctor or nurse to review within 1 hour
Urgent mental health issue accompanied by suicidal intent	Doctor to review ASAP (within 30 minutes)
Minor health issue (physical or mental) requiring review, non-urgent	Nurse to review within 4 hours Doctor to review (if required) within 12 hours
Prescription requests (urgent)	Doctor to action within 8 hours
Prescription requests (non-urgent)	Doctor to action within 24 hours

- At the discretion of the on-site clinical staff, quarantined persons with currently active physical or mental health issues should be:
    - managed on-site if within the capacity, capability and credentialing of attending medical and nursing staff
    - referred to the appropriate health services (e.g. mental health services, specialist medical services, hospital, Aboriginal community-controlled health organisation, etc.) or other support services as required.
- In the case of a physical health emergency in a quarantined person (e.g. heart attack, stroke, anaphylaxis, etc.) an ambulance should be called immediately by any person in attendance. There is no need to wait for attendance of medical or nursing staff in this situation, but they should be called for review as soon as practical after an ambulance has been called.
- In the case of a mental health emergency in a quarantined person (e.g. acute suicidal ideation, thoughts of self-harm, psychosis, etc.) the quarantined individual should be reviewed by the doctor on call as a matter of urgency, particularly if suicidal intent is present. The doctor should then determine if transfer to hospital via ambulance is required for urgent psychiatric assessment or if psychiatric advice or assessment can be appropriately obtained over the phone. If the quarantined individual is deemed as needing urgent psychiatric review and is not willing to be transferred for assessment, the doctor on call will need to decide if enacting provisions within the Mental Health Act 2014 is required.
- Documented protocols related to provision of on-site health services should include:

  Processes for follow up of physical and mental health risk factors identified through screening

  Clear instructions for:
    - quarantined persons on how to contact medical and nursing staff
    - clinical staff on responsibilities for first point of contact, triage, escalation and referral pathways
    - clinical staff on actions to be taken in response to acute physical and mental health emergencies
    - clinical staff on continuity of care and handover of outstanding tasks and concerns
    - agreed method of documentation of outstanding tasks/ physical or mental health issues needing follow up.
- Documentation should also include contact numbers for:
    - Hotels and other facilities being used for quarantine
    - Medical and nursing contacts at each facility

- Health service emergency departments, mental health services, Aboriginal community-controlled health services, liaison officers related to this operation (including Aboriginal hospital liaison officers)
- Other resources including, but not limited to, local health and welfare services, psychiatric triage team (1300 TRIAGE), Crisis Assessment and Treatment Teams (CATT), DHHS Complex Assessment and Referral Team (CART), telephone advice lines, online services, etc.
- Emergency operations centre and DHHS teams.

Prescribing benzodiazepines/anxiolytics

When considering initiating prescription of benzodiazepines for short term management of anxiety or other mental health issues (such as claustrophobia, panic attacks, PTSD etc) in mandatory detention, doctors should exercise a high degree of caution, and implement other strategies to manage these conditions where possible. Doctors initiating prescriptions for benzodiazepines, opioids, anxiolytics and antipsychotics should only do so after a careful history and risk assessment has been conducted. Psychiatric input should be sought where necessary. Care should be taken to ensure that benzodiazepines are not prescribed to individuals who are consuming alcohol, or who have other contraindications to these medications. Prescriptions should also be limited to small quantities of tablets at a time, with appropriate follow up review arranged to assess response and re-evaluate need for medication.

Initiation of sleeping tablets (including benzodiazepines, zolpidem, zopiclone etc.) in mandatory quarantine should only be considered after a thorough assessment by a healthcare professional. Those on sleeping tablets regularly should have their dose confirmed with their usual GP prior to prescriptions being provided in mandatory quarantine. Care should be taken to ensure sleeping tablets are not prescribed to individuals who are consuming alcohol, or who have other contraindications to these medications.

Further information on the safe keeping of prescription medications such as Benzodiazepines can be found at Annex 3, section 10 and through the Commander COVID-19 Accommodation.

- On-site doctors should be informed of these specific considerations for prescribing benzodiazepines and anxiolytics to quarantined persons.

Criterion 3.3 Provision of welfare services

- Safeguarding of the health and welfare of quarantined persons is paramount
- All quarantined persons should have access to communication services such as phone (local calls) internet and wi-fi so that they can stay in regular contact with family and friends.
- All quarantined persons should have access to entertainment and news services such as television and radio.
- Arrangements for quarantined persons to receive care packages of personal items from family and friends should be established.
- Appropriate professionals should be engaged at a ratio proportionate to the number of quarantined persons at each hotel/facility to enable ADEQUATE, APPROPRIATE, culturally safe and TIMELY delivery of welfare services. This should be determined by those commissioning/operating the health and welfare services. It should correspond to the workload and burden of illness/needs of the population in mandatory quarantine at any time.
- Welfare professionals should practice within the requirements of their professional registrations, level of experience, codes of conduct and professional standards.
- Welfare practices, record-keeping and correspondence with other health and welfare professionals should meet the expectations of high-quality welfare services.
- Welfare staff should have appropriate training, experience and credentials (including Aboriginal cultural safety) to:
    - identify and deal with significant welfare issues by providing advice or arranging appropriate referrals
    - provide support to quarantined persons who are distressed.
- Governance arrangements should be in place to ensure that welfare staff have appropriate training, experience and credentials.
- Provision should be made for both on-site in-person welfare consultations and telehealth consultations.

- Welfare staff should be provided with mobile phones to facilitate rapid access by quarantined persons, operational and administrative staff, and external healthcare providers.
- Regular welfare checks should be conducted, at a minimum, based on the three risk tiers noted above or more frequently to meet the needs of quarantined individuals as determined by clinical or welfare staff.
- Requests for welfare assistance from quarantined persons or clinical staff should be actioned in keeping with the urgency and significance of the issue (usually within 24 hours).
- Processes for managing, escalating and referring incidents of family violence or child abuse should be established, including provision of safe accommodation and referral to Victoria Police where appropriate.
- Processes for assessing satisfaction and receiving and addressing complaints should be established
- Documented protocols related to provision of welfare services should include, but not be limited to:

  Processes for follow up of risk factors related to welfare issues identified through screening

  Clear instructions for:
    - quarantined persons on how to contact welfare staff
    - quarantined persons on the arrangements for care packages
    - on-site clinical staff on how to contact welfare staff
    - welfare staff on responsibilities for first point of contact, triage, escalation and referral pathways
    - welfare staff on continuity of care and handover of outstanding tasks and concerns
    - welfare staff on management, escalation and referral of reports of family violence or child abuse

- Documentation should also include, but not be limited to contact numbers for:
    - Welfare staff
    - Welfare agencies for referral
    - Family violence and child abuse services
    - Services and programs for Aboriginal and/or Torres Strait Islander people
    - Appropriate Victoria Police departments

Criterion 3.4 Provision of pharmacy and pathology services

- Pharmacy services should be provided to allow for
    - prompt procurement of necessary medications (prescriptions or over-the-counter products) and equipment for quarantined persons
    - delivery to the relevant hotel/facility
    - prescriptions to be emailed to the pharmacy by the quarantined person's usual doctor or the on-site doctor
- Processes for COVID-19 swabs should follow the COVID 19 instructions for testing. (hyperlink) Pathology tests required by the treating clinician (on-site doctor or person's own GP) should be undertaken by the on-site medical or nursing staff. Equipment for taking bloods should be available at (or available to be transported to) the hotel/facility. These specimens should be labelled as per the protocol for labelling COVID-19 swabs (same requirement for identifiers)
- Routine pathology tests should be deferred until after the quarantine period if possible.

Criterion 3.5 Public health policy for COVID-19 in mandatory quarantine

- All staff should follow the COVID-19 policy for mandatory quarantine detailed in Annex 3 (hyperlink).

Potential indicators

Program delivery

- Number of quarantined persons followed up as per their risk screening follow up plan
- Number of Aboriginal and Torres Strait Islander people followed up as per their risk screening follow-up plan
- Number of referrals to external health and welfare providers
- Number of adverse events arising from absent or inadequate protocols for health and welfare or failure to follow relevant protocols
- Nature of adverse events (de-identified) arising from absent or inadequate protocols for health and welfare or failure to follow relevant protocols
- Number of serious physical or mental health incidents not related to protocols for health and welfare
- Nature of serious physical or mental health incidents (de-identified) not related to protocols for health and welfare
- Number of COVID-19 swabs
- Number of calls related to family violence or child abuse
- Number of emergencies requiring 000 calls
- Number of emergency transfers to hospital
- Number of non-emergency transfers to hospital
- Nature of emergency and non-emergency transfers to hospital (de-identified)

Outcomes

- Outcomes of adverse events (de-identified) arising from absent or inadequate protocols for health and welfare or failure to follow relevant protocols
- Outcomes of serious physical or mental health incidents (de-identified) not related to protocols for health and welfare
- Outcomes of emergency transfers to hospital
- Outcomes of non-emergency transfers to hospital
- Number of COVID-19 swabs with positive results
- Action taken as a result of positive COVID-19 swab
- Action taken as a result of response to calls related to family violence or child abuse

Reporting frequency

- Adverse events, serious incidents and COVID-19 positive swabs: as soon as possible after occurrence
- All others: daily

Standard 4. Health promotion and preventive care

While in mandatory quarantine, health promotion and preventative care should be made available to all quarantined individuals. This includes access to fresh air and promotion of exercise where possible.

Criterion 4.1 Smoking

- Smoking is not permitted in most hotels
- Quarantined persons who are smokers should be provided with information and actively encouraged to quit using validated methods such as:
    - Nicotine Replacement Therapy
    - Quitline telephone counselling (phone 13 78 48)
    - Contacting their regular GP via telehealth

- Where feasible, smoking breaks may be permitted in some circumstances for individuals who do not have access to a smoking area or balcony, where it can be safely and practically implemented at the hotel (weather permitting), taking into account infection control and physical distancing precautions.

Criterion 4.2 Fresh air

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

Criterion 4.3 Exercise

- Exercise is important for physical and mental health, particularly in the mandatory quarantine environment
- In-room exercises should be encouraged and resources to support this should be facilitated if possible

Criterion 4.4 Alcohol and drugs

- Alcohol is permitted within hotels
- Excessive alcohol consumption should be discouraged.
- Alcohol should not be provided to persons under 18 years of age (including in the hotel room minibar)
- If there are concerns about potential alcohol or other substance abuse or withdrawal:
    - Request nurse or medical review.
    - Provide numbers for support services.
- If there are concerns about acute alcohol withdrawal, confusion, deteriorating mental state, or mental illness:

Escalate for urgent medical review

Consider calling 000

Potential indicators

- Number of incidents related to nicotine, alcohol or other drugs (withdrawal or intoxication)
- Number of people taking fresh air breaks

Standard 5. Infection control

Infection control procedures in the mandatory quarantine hotels are essential to protect on-site staff and quarantined individuals from COVID-19 and other pathogens. The foundation of good infection control is to assume everyone is potentially infectious, and therefore proper procedures have to be followed at all times.

Criterion 5.1 Personal protective equipment (PPE)

- Appropriate personal protective equipment (single-use face masks, P2/N95 masks, gowns and eye protection) should be available to all staff and quarantined individuals for use when indicated
- PPE stocks should be maintained at each hotel/facility, monitored through regular stocktake and a mechanism to rapidly obtain additional stock in place. Hotels should not run out of stock
- Biohazard bags for waste disposal, hand sanitizer, paper towels, and other necessities for hand hygiene stations should also be available in hotels
- PPE, hand hygiene stations, and waste disposal facilities should be situated at the donning/doffing areas in each hotel

- Appropriate PPE protocols (for droplet and contact precautions) should be available to all staff working in the hotels with clear instruction on what type of PPE to wear in what circumstances, how to don and doff it, and how to dispose of it (see the department's website for further information on PPE usage: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19#personal)
- Additional training and educational resources should be made available to staff who require it.

Criterion 5.2 Cleaning and waste disposal

- Quarantined individuals should have safe and clean rooms
- Housekeeping services should not be provided routinely in the interest of infection control
- Fresh linen, towels and additional amenities should be left outside rooms for quarantined individuals to collect
- Terminal cleaning is required on vacation of each room. This should follow the processes outlined in the DHHS document 'Cleaning and disinfecting to reduce COVID-19 transmission'
- Rooms that have been vacated should not be repurposed during the quarantine period
- Quarantined individuals may not be able to upkeep their rooms for various reasons, which may affect their physical and mental health. Efforts should be made to assist a quarantined person with cleaning their room if they are not capable of doing so themselves. Any persons for whom there is a concern about room hygiene and safety should be flagged to the team leader.

Criterion 5.3 Laundry

- Quarantined individuals should place dirty linen in biohazard bags which are left outside rooms for collection
- Hotel staff should wear appropriate PPE when handling dirty laundry
- Handling of dirty linen should be minimised; it should be put straight into the washing machines if possible
- Laundry should be washed on the highest possible temperature setting and thoroughly dried before use
- Staff should follow hand hygiene protocols after handling dirty linen.

Criterion 5.4 Isolation protocols

- All staff should follow the 'Public health policy for COVID-19 in mandatory quarantine' (bearing in mind a trauma informed approach is essential for Aboriginal people in isolation).
- Suspected cases of COVID-19 should be separated/isolated from people they share a room with as soon as they become symptomatic if consent is given.
- If this has not already occurred, confirmed cases should be isolated from people they share a room with as soon as the positive result is known. All people who are COVID-19 positive are to be moved the designated COVID-19 hotel unless due to exit mandatory quarantine within 24 hours in which the need for transfer may be assessed on a case by case basis. Appropriate signage, PPE and other consumables should be available at the entrance to this area of the hotel.
- Where there are large numbers of confirmed cases arriving on a flight, a COVID-19 hotel is a more appropriate arrangement. Where the infrastructure allows, suspected cases should also be moved to an area of the hotel away from well individuals.

Potential indicators

Program delivery

- Number of adverse events arising from absent or inadequate protocols for infection control or failure to follow relevant protocols
- Nature of adverse events (de-identified) arising from absent or inadequate protocols for infection control or failure to follow relevant protocols.

Outcomes

- Outcomes of adverse events (de-identified) arising from absent or inadequate protocols for infection control or failure to follow relevant protocols

Reporting frequency

- Significant adverse events: as soon as possible after occurrence
- All others: daily

Standard 6. Allergies and dietary requirements

As part of the duty of care towards people in mandatory detention, it is essential that appropriately qualified staff document and have processes for managing quarantined individuals' allergy and dietary requirements, as failure to do this can have life-threatening consequences.

- Information on allergies should be collected from all quarantined individuals.

  Allergen (e.g. name of medication, type of food, etc)

  Allergic reaction (e.g. rash, gastrointestinal disturbance, etc)

  History of severe allergic reactions or anaphylaxis

  Use of antihistamines, corticosteroids or EpiPens

  Clinical staff should ensure that quarantined persons have adequate supplies of allergy medications. If required, urgent prescriptions should be filled and delivered to the hotel/facility
- Mechanisms should be put in place to avoid/limit quarantined individual's contact with allergens
- Dietary requirements should be collected from all quarantined individuals

  Food allergy (as above, e.g. cow's milk allergy)

  Food intolerance (e.g. lactose intolerance)

  Clinical diet (e.g. low salt diet for kidney disease)
- Screening tools that have been validated to collect details of allergies and dietary requirements should be used. If appropriate validated tools are unavailable, any tools created for this purpose should be developed by professionals with methodological expertise in survey development and content knowledge of allergy and dietary requirements
- Clinical staff identifying allergies and dietary requirements should escalate this information to appropriate operations staff to ensure that details are provided to catering providers:
- An ambulance should be called for anyone who develops a severe allergy whilst in mandatory quarantine, without needing approval from clinical staff, authorised officers or hotel staff etc. On arrival, paramedics should be given clear access to the person for whom the ambulance was called
- Documented protocols related to provision of appropriate services to meet allergy and dietary requirements should include, but not be limited to:

  Processes for dealing with food allergies, intolerances and other requirements

  Clear instructions for:

  - clinical and operations staff on how to communicate allergy and dietary requirements to catering providers
  - catering providers on how to address allergy and dietary requirements
  - quarantined persons on how their allergy and dietary requirements will be met
- Documentation should also include, but not be limited to contact numbers for next of kin of the person with an allergy
- As a safeguard, some form of door marking or sign should be used to indicate that a person in the hotel room has a significant allergy or specific dietary requirements.

Potential indicators

Program delivery

- Number of adverse events arising from absent or inadequate protocols for allergies and dietary requirements or failure to follow relevant protocols

- Nature of adverse events (de-identified) arising from absent or inadequate protocols for allergies and dietary requirements or failure to follow relevant protocols.

Outcomes

- Outcomes of adverse events (de-identified) arising from absent or inadequate protocols for allergies and dietary requirements or failure to follow relevant protocols

Reporting frequency

- Significant adverse events: as soon as possible after occurrence
- All others: daily

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

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

Operation Soteria has a systematic approach to maintaining the confidentiality and privacy of a quarantined person's personal and health information.

The *Privacy Act 2001 (Cth)* states that a patient's personal health information includes a person's name, address, account details and any health information (including medical or personal opinion) about the person.

Medical, nursing, clinical and allied heath staff have requirements relating to confidentiality in their professional registration and codes of conduct.

- Quarantined persons should be informed that their health information will be treated as private and confidential and will only be released to third parties with their consent or in compelling circumstances (e.g. concern for the patient's safety or the safety of others) as required by law
- Mechanisms should be in place to ensure that information is shared between on-site staff when necessary but within the bounds of the law. Any transfer of information to a third party without the consent of the quarantined person needs to be documented in their medical record
- Patient information in hotels/facilities should not be stored or left visible in areas where non-health services staff have unrestricted access, or where constant staff supervision is not easily provided
- Devices used to access the information management systems are only accessible to authorised clinical staff
- Screensavers or other automated privacy protection devices are enabled
- Documented protocols related to the confidentiality and privacy of personal and health information of quarantined persons should include, but not be limited to:

  Informing newly quarantined people about the information collected about them, the use of that information, the range of people (e.g. doctors, nurses, psychologists) who may have access to their medical records and the scope of that access, privacy arrangements and how they can gain access to their personal and health information

  Gaining consent from quarantined people before disclosing personal and health information to third parties

  Providing health information to another health professional if requested by the quarantined person

  Maintaining the security of information held at the hotel/facility, on private external servers or on government servers

  Retaining medical records as required by law.

- Documentation should also include, but not be limited to:

the type of personal health information that may need to be relayed to DHHS when assessing special needs of a quarantined person

how confidentiality can be maximised if a third party is present in the consultation without the consent of on-site clinical staff or patient.

Criterion 7.2 Information security (including medical records)

It is paramount that the security of confidential data on quarantined persons is maintained.

- The security of patient information (including medical records) in electronic or paper formats should be maintained through the use of secure-access information management systems
- A minimum number of secure databases should be used to prevent fragmentation of records management and reduce the risk of critical information not being available to DHHS, health or welfare staff providing for the health and welfare needs of quarantined persons
- Different staff members should have different levels of access to quarantined person's information (for example, administrative staff should not have access to the patient's medical records). In relation to medical records, the principles of patient confidentiality should be maintained unless required by law
- These records should not be accessed by anyone not providing care for the person. Specifically, these medical records must only be accessed or viewed by an AHPRA-registered health practitioner employed by DHHS to provide services to people in detention.
- On-site staff have personal passwords to authorise appropriate levels of access to health or other personal information.
- If medical notes are recorded on paper, these should be stored securely and uploaded to the information management system as soon as is practicable and within 72 hours at most
- If an on-site doctor completes an assessment, they must provide a written record of this to the on-site nursing staff, either on paper or via email, if an electronic medical record system is not available. This must be securely stored as soon as possible
- Inactive records must also be also be kept and stored securely. An inactive record is generally considered to be a record of a person who is no longer detained in mandatory detention
- An information disaster recovery plan for use in an emergency such as device failure or power failure should be established.

Back-ups of electronic information are performed at an appropriate frequency

Back-ups of electronic information are stored in a secure offsite environment

Antivirus software is installed and updated

- All internet connected devices have firewalls installed
- Documented protocols related to information security should include, but not be limited to processes for:

Collection, storage and transfer to electronic storage

Back-up and recovery of digital information

- Documentation should also include, but not be limited to:

Record of which staff are authorised to access different levels of information about a quarantined person (e.g. Personal details, contact details, medical record, COVID-19 status, etc).

Criterion 7.3 Transfer of personal information (including medical records)

On request from a quarantined individual, in an emergency, or to support a referral for health or welfare reasons, a summary or a copy of personal information (including the patient health record) may be transferred to the patient, another medical practitioner, health service provider or health service.

- Transfer of patient information in these situations should be facilitated

- Consent of the quarantined person should be obtained before transferring information, except in an emergency when they are unable to give consent and failure to transfer the information will prevent optimal care. Consent may be given for the release of some information beyond an individual consultation
- On-site staff record any requests by quarantined individuals or other reasons for transfer of health information in the medical record. This note should include details of where the information was sent and who authorised the transfer
- Any electronic data transmission of patient information over a public network must be encrypted.

Criterion 7.4 Retention of personal information (including medical records)

The *Privacy Act 1988 (Cth)* requires personal health information to be destroyed or permanently de-identified once it is no longer needed for any authorised use or for disclosure under the legislation.

The *Health Records Act 2001 (Vic)* recommends that individual patient health records be retained for a minimum of 7 years from the date of last contact, or until the patient has reached the age of 25 years, whichever is the longer. In the case of patient health information collected for the purpose of providing medical advice or treatment, it may be appropriate to retain this information indefinitely so that it is available, if necessary, to assist with the patient's future diagnosis and treatment.

- A protocol for the retention and destruction of personal health information for people in mandatory quarantine consistent with the *Privacy Act 1988 (Cth)* and *Health Records Act 2001 (Vic)* should be established and communicated to all relevant staff

Potential indicators

Program delivery

- Incidents of breach of privacy related to medical information
- Incidents related to failure to maintain adequate medical records

Outcomes

- Adverse events arising from breach of privacy or failure to maintain adequate medical records

Reporting frequency

- Significant adverse events: as soon as possible after occurrence
- All others: daily

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

A series of potential indicators to measure program delivery and outcomes are presented for each Standard and a suggested reporting frequency is provided. These indicators were developed systematically to address all the issues contained within these Standards. However, it may not be feasible, or even desirable, to collect and report on them all. They remain as a comprehensive list in this document to inform current decision-making for Operation Soteria and potential measures that may be taken to address future public health emergencies.

- Final decisions on the reporting structure; content, format and frequency of reports; and methods of data collection and analysis should be determined through deliberations with all stakeholders including, but not limited to, Public Health, Compliance, Intelligence and Operations.
- Decision-making criteria should include, but not be limited to:
    - information priorities of each stakeholder group
    - risk assessment and mitigation strategies
    - program monitoring and evaluation questions

    - feasibility of, and resources required for, data collection, analysis and reporting
- Data should be assessed for accuracy (reliability and validity) and completeness. Appropriate measures should be instigated to enable and facilitate easy and accurate capture, entry and transmission of data.
- Minimum datasets for urgent, daily and weekly reporting should be established.

Public Health Policy for COVID-19 in Mandatory Quarantine

Summary

This document outlines the Department of Health and Human Services (DHHS) public health policy for COVID-19 in mandatory quarantine (Operation Soteria).

Identification and management of COVID-19 is undertaken in two scenarios – diagnostic testing of symptomatic individuals and routine testing by invitation to all persons in mandatory quarantine on Day 3 and Day 11 of the quarantine period.

Policy quick reference guide

Table 1. Management based on outcomes of diagnostic testing or Day 3 routine testing

Negative result	Asymptomatic	• Must complete 14 days of mandatory quarantine • Should still be offered testing on Day 11 and if they become symptomatic
	Symptomatic	• Remain in current location to complete 14 days of mandatory quarantine • May require repeat testing if symptoms do not improve (repeat testing should be directed by the on-site GP) • If requiring transport, they should go by Non-Emergency Patient Transport (NEPT) and should wear personal protective equipment (PPE) while in transit
Positive result	All cases	• Transfer to the COVID-19 hotel for the remainder of the quarantine period • Transport of positive cases (to home or to the COVID-19 hotel) should be by NEPT and cases should wear PPE while in transit • Close contacts sharing a room with positive cases should be encouraged to move to a separate room • When the 14-day mandatory quarantine period is complete individuals who have not yet met the department's criteria for release from isolation of a confirmed case should be managed as per confirmed cases from Day 11 testing (see box below)
	Asymptomatic	• If a person is currently asymptomatic and has no history of symptoms in the past 14 days, then the test date will be taken as a proxy for a symptom onset date (Day 0) and they will be required to isolate for 10 days from this date
	Symptomatic	• If a person is symptomatic, the isolation period will be determined as per the department's criteria for release from isolation of a confirmed case • Release from isolation will be actively considered when **ALL** the following criteria are met: – the person has been afebrile for the previous 72 hours, **AND** – at least **10 days** have elapsed after the onset of the acute illness, **AND** – there has been a noted improvement in symptoms, **AND** – a risk assessment has been conducted by the department and deemed no further criteria are needed
Not tested	Asymptomatic	• Must complete 14 days of mandatory quarantine • Should still be offered testing on Day 11 and if they become symptomatic

(declined testing or other reason)	Symptomatic	• Remain in current location to complete 14 days of mandatory quarantine • Strongly advise to be tested • Document that they are symptomatic, and that they have been offered and refused testing • If requiring transport, they should go by NEPT and should wear PPE while in transit

Table 2. Management based on outcomes of Day 11 routine testing

		Staying in Victoria on exit	**Leaving Victoria on exit (interstate or international)**
Negative result	Asymptomatic	• **Subject to the Stay at Home Directions** • Issue End of Detention Notice (standard) • Allow to exit detention	• **Subject to the Stay at Home Directions until they leave Victoria** • Issue End of Detention Notice (standard) • Allow to exit detention
	Symptomatic	• **Subject to the Stay at Home Directions** • Issue End of Detention Notice (standard) • Allow to exit detention • Advise to stay at home until symptoms have resolved for 72 hours	• **Subject to the Stay at Home Directions until they leave Victoria** • Allow to exit detention • Issue End of Detention Notice (standard) • Allow to travel interstate • Advise to stay at home until symptoms have resolved for 72 hours
Positive result	All cases	• **Subject to the Diagnosed Persons and Close Contacts Direction** • Issue End of Detention Notice (confirmed case) • If the person has more than 24 hours left in mandatory quarantine before they are due to exit, they should be transferred to the COVID-19 hotel for the remainder of the quarantine period • If the person is due to exit to home within 24 hours of receiving the positive test result, the decision to transfer to the COVID-19 hotel should be made on a case-by-case basis, and exiting from their current hotel to home on Day 14 may be the more appropriate arrangement. • When the 14-day mandatory quarantine period is complete: – Victorians who are still infectious (who have not yet met the department's criteria for release from isolation of a confirmed case) are permitted to isolate at home, if they	• **Subject to the Diagnosed Persons and Close Contacts Direction** • Issue End of Detention Notice (confirmed case) • **Must not travel interstate** • When the 14-day mandatory quarantine period is complete: – Individuals from interstate who are still infectious (who have not yet met the department's criteria for release from isolation of a confirmed case) are permitted to isolate at an identified residence in Victoria, if they can do so safely and appropriately – Individuals from interstate who cannot safely isolate at an alternative residence in Victoria may continue to isolate at the COVID-19 hotel until they meet the department's criteria for release from isolation of a

		can do so safely and appropriately – Victorians who cannot safely isolate at home may continue to isolate at the COVID-19 hotel until they meet the department's criteria for release from isolation of a confirmed case • Transport of positive cases (to home or to the COVID-19 hotel) should be by Non-Emergency Patient Transport (NEPT) • Positive cases should wear PPE while in transit	confirmed case • Transport of positive cases (to the COVID-19 hotel or to other appropriate accommodation in Victoria) should be by NEPT • Positive cases should wear PPE while in transit • If there are concerns that the person will not safely isolate in Victoria, a further Direction and Detention Notice should be considered, in consultation with the Public Health Commander and DHHS Legal
	Asymptomatic	• If a person is currently asymptomatic and has no history of symptoms in the past 14 days, then the test date will be taken as a proxy for a symptom onset date (day 0) and they will be required to isolate for 10 days from this date.	• If a person is currently asymptomatic and has no history of symptoms in the past 14 days, then the test date will be taken as a proxy for a symptom onset date (day 0) and they will be required to isolate for 10 days from this date.
	Symptomatic	• If a person is symptomatic, the isolation period will be determined as per the department's criteria for release from isolation of a confirmed case • Release from isolation will be actively considered when **ALL** the following criteria are met: – the person has been afebrile for the previous 72 hours, **AND** – at least **ten days** have elapsed after the onset of the acute illness, **AND** – there has been a noted improvement in symptoms, **AND** – a risk assessment has been conducted by the department and deemed no further criteria are needed	• If a person is symptomatic, the isolation period will be determined as per the department's criteria for release from isolation of a confirmed case • Release from isolation will be actively considered when **ALL** the following criteria are met: – the person has been afebrile for the previous 72 hours, **AND** – at least **ten days** have elapsed after the onset of the acute illness, **AND** – there has been a noted improvement in symptoms, **AND** – a risk assessment has been conducted by the department and deemed no further criteria are needed
Results pending	Asymptomatic	• **Subject to the Stay at Home Directions** • Issue End of Detention Notice (standard) • Allow to exit detention • All persons exiting mandatory quarantine who have COVID-19 test results pending should be advised to isolate until the test result is known • DHHS should ensure the test result, positive or negative, is provided to the person	• **Subject to the Stay at Home Directions until they leave Victoria** • Issue End of Detention Notice (standard) • Allow to exit detention • All persons exiting mandatory quarantine who have COVID-19 test results pending should be advised to isolate until the test result is known • DHHS should ensure the test result, positive or negative, is provided to the person and, if positive, to the relevant

			state/territory public health department
	Symptomatic	• **Subject to the Stay at Home Directions** • Issue End of Detention Notice (respiratory symptoms) • Allow to exit detention • Victorians who can safely isolate at home must do so until the test result is known • Transport by NEPT, should wear PPE while in transit • Victorians who cannot safely isolate at home or other appropriate accommodation may continue to isolate at the quarantine hotel until the test result is known • DHHS should ensure the test result, positive or negative, is provided to the person	• **Subject to the Stay at Home Directions until they leave Victoria** • Issue End of Detention Notice (respiratory symptoms) • **Must not travel interstate**, must stay in Victoria until test result is known • If there is concern that they will not follow this advice, a further Direction and Detention Notice may be issued in consultation with the Public Health Commander and DHHS Legal • DHHS will accommodate in quarantine hotel until test result is known, if they have no other appropriate/safe accommodation to isolate in Victoria • If required, transport by NEPT and wear PPE while in transit • DHHS should ensure the test result, positive or negative, is provided to the person and, if positive, to the relevant state/territory public health department
Newly symptomatic after Day 11 test		• Where a person develops symptoms after the Day 11 testing, and the Day 11 test result is negative, repeat testing should be undertaken • Management should be as per the relevant category described above	• Where a person develops symptoms after the Day 11 testing, and the Day 11 test result is negative, repeat testing should be undertaken • Management should be as per the relevant category described above
Not tested (declined testing or other reason)	Asymptomatic	• **Subject to the Stay at Home Directions** • Issue End of Detention Notice (standard) • Allow to exit detention	• **Subject to the Stay at Home Directions until they leave Victoria** • Issue End of Detention Notice (standard) • Allow to exit detention
	Symptomatic	• **Subject to the Stay at Home Directions** • Issue End of Detention Notice (respiratory symptoms) • Allow to exit detention • Strongly advise to be tested • Document that they are symptomatic, and that they have been offered and refused testing • If requiring transport, they should go by NEPT and should wear PPE while in transit	• **Subject to the Stay at Home Directions until they leave Victoria** • Issue End of Detention Notice (respiratory symptoms) • Strongly advise to be tested • Document that they are symptomatic, and that they have been offered and refused testing • Each instance must be discussed with the Deputy Public Health Commander for a risk assessment, a further

			Direction and Detention Notice may be considered, in consultation with the Public Health Commander and DHHS Legal • DHHS will accommodate in quarantine hotel until test is agreed and result known, if they have no other appropriate/safe accommodation to isolate in in Victoria • If required, transport by NEPT and wear PPE while in transit
Close contact (not tested)	All close contacts	• **Subject to the Diagnosed Persons and Close Contacts Direction** • Issue End of Detention Notice (standard) • Close contacts of confirmed cases must isolate for 14 days since last contact with the confirmed case during their infectious period • All close contacts of confirmed cases should be encouraged to separate from the confirmed case so that their new quarantine period can commence • Close contacts from Victoria are permitted to isolate at home, if they can do so safely and appropriately • DHHS will accommodate in hotel if they have no other appropriate/safe accommodation to isolate in in Victoria • If required, transport by NEPT and wear PPE while in transit	• **Subject to the Diagnosed Persons and Close Contacts Direction** • Issue End of Detention Notice (standard) • Close contacts of confirmed cases must isolate for 14 days since last contact with the confirmed case during their infectious period • All close contacts of confirmed cases should be encouraged to separate from the confirmed case so that their new quarantine period can commence • **Must not travel interstate** • If there is a concern that they will not follow this advice (i.e. if refusing to isolate in Victoria and planning to travel interstate), a new Direction and Detention Notice should be considered, in consultation with the Public Health Commander and DHHS Legal • DHHS will accommodate in hotel if they have no other appropriate/safe accommodation to isolate in in Victoria • If required, transport by NEPT and wear PPE while in transit

COVID-19 testing

Indications for testing

Symptomatic testing should occur whenever clinically indicated (i.e. if the person is symptomatic).

If a person screens positive for symptoms or a temperature at the airport, the on-call Human Biosecurity Officer (HBO) should be contacted. The HBO should arrange for ambulance transfer to the Royal Melbourne Hospital for clinical assessment and testing. Please see the current *Border Health Measures Protocol* for further information.

Routine testing for COVID-19 is recommended for all individuals in mandatory quarantine on Day 3 and Day 11 of the quarantine period.

General testing process

COVID-19 testing is voluntary. Quarantined individuals cannot be forcibly tested.

Testing should be carried out as early as possible on the day of testing (unless otherwise indicated), to ensure tests are processed and results reported in a timely manner.

Informed consent

- Information on the testing process must be provided to individuals at the beginning of the quarantine period and again before testing is carried out.
- Consideration must be given to persons from non-English speaking backgrounds who may require interpreters to give their consent.
- Informed consent must be sought and documented in the nursing health record; if a test is declined, this should also be documented.
- Refusal of testing by symptomatic persons should be escalated to the appropriate lead and included in the daily report to the Public Health Commander.

Temperature and symptom check

- A temperature and symptom check should be performed and documented each time COVID-19 testing is offered.
- If a temperature or symptoms are present, the person should be treated as a suspected case, and advised to isolate separate from other persons until the test result is known.

Personal protective equipment

Personal protective equipment (PPE) should be used as per current department recommendations (available here: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19).

Diagnostic testing for symptomatic individuals

Individuals who are symptomatic should be tested for COVID-19 as soon as is practicable.

A returned traveller who has signs or symptoms consistent with COVID-19 should be considered a **suspected case**. Suspected cases should be given the option to isolate separate from their travel companions until the test result is known.

Of note, persons may happen to develop symptoms on Day 3 or Day 11. They should still be tested as part of the Day 3 and Day 11 testing process, but it should be clearly marked on the pathology request that they are symptomatic.

Diagnostic testing for symptomatic individuals should be coordinated by the doctors and nurses working in the hotels. In this instance, the requesting medical practitioner should be the doctor looking after that particular hotel on that date. The requesting medical practitioner is responsible for provision of the result to the quarantined individual, in addition to notifying the department if there is a confirmed case.

Routine testing on Day 3 and Day 11

The purpose of Day 3 testing is to detect cases of COVID-19 early in the quarantine period, so that appropriate isolation arrangements can be made both for the case and their close contacts, but also to reduce the possibility of an extended quarantine (and possibly detention) period.

The purpose of Day 11 testing is to detect cases of COVID-19 before they are due to exit mandatory quarantine, so that appropriate isolation arrangements can be put in place, and to reduce the risk of transmission in the community.

Tailored information on the Day 3 and Day 11 testing process must be provided to individuals at the beginning of the quarantine period and again before testing is carried out. Consent should be sought and documented as per the above procedure.

Day 3 and Day 11 testing will **NOT** be requested of the following groups:

- persons who are confirmed cases of COVID-19 (unless specifically indicated (e.g. if there is a specific clinical or public health indication, as determined by the treating medical practitioner and the department's CCOM)).
- persons who already have a COVID-19 test result pending.
- approved transit passengers who are generally in transit for less than 72 hours.

It should be noted that close contacts of confirmed cases who are residing at the COVID-19 designated hotel **should** be offered Day 3 and Day 11 testing, as per standard practice.

Where it is identified in advance that individuals are observing Ramadan and are unable to have a swab taken on the morning of Day 11, the test may be conducted on the evening of Day 10.

Confirmed cases should not be tested again unless specifically indicated (e.g. if there is a specific clinical or public health indication, as determined by the treating medical practitioner and the department).

Provision of results

Results should be provided by the medical practitioner who requested the test (currently Dr Garrow of Medi7 or a delegate general practitioner from Medi7).

Results of routine COVID-19 tests should be provided to individuals as soon as is practicable, with priority given to the communication of positive results before negative results, and Day 11 results before Day 3 results.

For positive results:

- Notification to be made personally via phone to explain the results.
- Interpreters to be used as required.
- Consultation to be documented in the medical record.
- On site nurses should be notified when guests have been informed of their positive results to facilitate timely relocation arrangement, where required.
- Positive cases should be notified of their result before they are contacted by the Case and Contact team.

All results:

Nurses on site at each hotel are responsible for delivering written test results to all guests.

- Nurses receive printed copies of results (positive and negative) from VIDRL by VCS.
- On-site nurses deliver printed copy of results to each individual in their hotel room along with either:
  - 'Information for people with positive results from routine testing' letter
  - 'Information for people with negative results from routine testing' letter
- Translation and interpreters to be used as required.

Notifications to DHHS

Notification of confirmed cases to the department must be carried out by the nominated medical practitioner described above, in addition to the testing laboratory.

Repeat swabbing

Repeat testing should not be carried out for confirmed cases, unless recommended by the department or required for a specific purpose (e.g. to return to work in high risk settings, to enable visitor access to hospital, etc).

Clearance testing is not currently required for release from isolation, nor for release from mandatory quarantine.

Case and contact management

Confirmed cases

Nurses should temperature check and review symptoms of confirmed cases daily. This should be documented in the nursing record, along with the date of the acute illness onset.

Diagnosed in mandatory quarantine

Confirmed case management is provided by a Case and Contact Officer (CCO) from the department.

Positive cases (regardless of symptom status) should be transferred to the COVID-19 hotel for the remainder of the mandatory quarantine period.

Isolation periods will be determined as follows:

- If a person is currently asymptomatic and has no history of symptoms in the last 14 days, then the test date will be taken as a proxy for a symptom onset date (Day 0) and they will be required to isolate for 10 days from this date.
- If a person is symptomatic, their isolation period will be determined as per the department's release from isolation criteria.

When the 14-day mandatory quarantine period is complete:

- Individuals from Victoria who are still infectious (who have not yet met the department's criteria for release from isolation of a confirmed case) may return home to complete their isolation, if they can do so safely and appropriately at home.
- Individuals from interstate, and Victorians who cannot safely isolate at home, may continue to isolate at the COVID-19 hotel until they meet the department's criteria for release from isolation of a confirmed case.

Positive cases requiring transport should be transported by Non-Emergency Patient Transport (NEPT) and should wear PPE whilst in transit.

Entering mandatory quarantine

Confirmed cases (currently infectious or recovered) entering mandatory quarantine should be accommodated in the COVID-19 hotel.

The required isolation period will be determined by the Case and Contact team on a case-by-case basis.

COVID-19 hotel

If a confirmed cases is due to exit mandatory quarantine within 24 hours to isolate at home in Victoria, the need for transfer to the COVID-19 hotel can be assessed on a case by case basis (taking into account the duration of time the person will need to say at the COVID-19 hotel, and the risks associated with transfer between sites).

If a confirmed case (and potentially their family members or close contacts) are being transferred to the COVID-19 hotel, these transfers should take place during the day where possible.

Close contacts

Close contact management is provided by a Case and Contact Officer (CCO) from the department.

Close contacts of confirmed cases (whether symptomatic or asymptomatic):

- Must isolate for 14 days since last contact with the confirmed case.
- Should be encouraged to separate from the confirmed case so that their new quarantine period can commence.

Close contacts from Victoria who have completed the mandatory quarantine period but not the close contact quarantine period will be permitted to isolate at home (if safe and appropriate isolation arrangements can be made), otherwise they will be accommodated by DHHS in appropriate accommodation.

Isolation and exit arrangements

Isolation arrangements

Persons sharing a room must be informed that this may have implications for the amount of time they are required to quarantine (although not their mandatory detention period) should one of them become a confirmed case.

Where one person in a room becomes symptomatic or a confirmed case, the persons in the room should be advised to isolate in separate rooms.

Release from isolation

Symptomatic cases

Confirmed cases of COVID-19 will be considered for release from isolation and early release from mandatory quarantine, once they meet **ALL** the department's criteria for release from isolation of a confirmed case:

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

Clearance testing is not required for release from isolation, either in the home or in mandatory quarantine.

Asymptomatic cases

Asymptomatic cases of COVID-19 will be considered for release from isolation and early release from mandatory quarantine once they have been asymptomatic for 10 days since the test result.

Process for release from isolation

As per the DHHS guidelines for health services and general practitioners (see https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19), the department will determine when a confirmed case no longer requires to be isolated in mandatory quarantine, hospital or in their own home.

- Every confirmed case that is diagnosed in Victoria is notified to the department and assigned a case and contact officer (CCO), regardless of whether they are diagnosed in detention or outside of detention. Every confirmed case receives daily contact from the case and contact team.
- The CCO will advise when it is appropriate for consideration for release from isolation, and will issue a clearance certificate (via email) to COVIDquarantine@dhhs.vic.gov.au for the case when they meet the criteria for release from isolation.

Exit arrangements

Appropriate transport, accommodation and isolation/quarantine arrangements should be planned and in place for close contacts, confirmed and suspected cases about to exit mandatory quarantine. These arrangements should be in keeping with DHHS policy as per Table 2 above.

Any deviations from the agreed policy must be escalated to and approved by the Compliance and Enforcement Lead, and the Deputy Public Health Commander for Physical Distancing.

Transport arrangements

All quarantined individuals requiring transport during the mandatory quarantine period should wear PPE whilst in transit. Non-emergency transfers of individuals where relevant (e.g. to the COVID-19 hotel) should be by Non-Emergency Patient Transport (NEPT). In the case of an emergency, transfer should be by emergency ambulance by calling 000.

Annex 3 – COVID–19 Operational guidelines for mandatory quarantine

Annex approver: DHHS Commander COVID-19 Accommodation

Last version date: v2.0 1 June 2020

Purpose

The purpose of this Annex is to provide operational guidance in order to manage each stage of the mandatory quarantine process. This Annex outlines the activities required to provide safe, efficient and effective hotel operations for the management of passengers arriving at Victorian ports who are subject to mandatory quarantine within Victoria.

Permission to access this document or any links contained, can be requested by emailing DHHSOpSoteriaEOC@dhhs.vic.gov.au.

Scope

This document addresses the public health operational requirements for managing mandatory quarantine.

Audience

This document is intended for use by DHHS staff, other agencies, health care workers and other people involved in the care of individuals in mandatory quarantine (detention).

Standard Operating Procedures (SOPs) have been developed for all cells of operation and outline the roles and responsibilities of staff in transitioning new arriving passengers through the **Ports of Entry (in draft),** **Mandatory Quarantine Hotels** and the **Emergency Operations Centre.**

1. Emergency Operations Centre (EOC)

The Operation Soteria Emergency Operations Centre is located in Fitzroy. The EOC is organised around an AIIMS structure with four leadership roles (Commander, and three Deputy Commanders) and three core functional sections, Operations, Planning and Logistics. The Standard Operating Procedures for the EOC are currently under development.

2. Ports of Entry (airports and maritime).

Priorities for DHHS operation staff include:

- Supporting the health and wellbeing of incoming passengers, DHHS staff, and staff from other agencies contracted for airport and maritime operations.
- Liaison with ports command (including both airport and maritime) and staff from all agencies to ensure the safe and appropriate movement of arriving passengers, deemed by compliance for transfer to the mandatory quarantine hotels, or for those passengers requiring immediate health and wellbeing attention to appropriate hospitals care. This includes transport and accommodation needs.
- Providing situational awareness and intelligence to inform transport providers, hotel operations and State – level emergency management of the current number and requirements for newly arriving passengers and/or crew as required.
- Provide a point of reference to all site and virtual staff to resolve issues for resolution, including logistics, compliance and escalation to command.
- Ensure appropriate records management processes adhered to.

- Conduct operational priorities in a manner that align to Standard 1: *Rights of people in mandatory quarantine* as outlined in Annex 2 of this document.
- Provision of welcome pack to all arriving passengers, assess. liaise and coordinate the immediate needs of arriving passengers and provide advice as required. EOC command will be provided intelligence on the high-risk immediate needs of arriving passengers.

2.1 Airport screening and assessment of immediate health and wellbeing risk factors

In accordance with Annex 2, Standard 2; *Screening and follow up of health and welfare risk factors* DHHS nurses and Department of Agriculture, Water and the Environment (DAWE) biosecurity officers will screen all passengers arriving from overseas for symptoms of COVID-19. This symptom check includes questions about cough, sore throat, breathing difficulties, headaches and other symptoms of unwellness (as per the health screening protocol for Melbourne airport). Nurses will perform a temperature check on each passenger. If a person screens positive on the symptom check, or on the temperature check (temperature >37.8 ˚C), the Human Biosecurity Officer (HBO) will be contacted by the DAWE biosecurity officer to arrange for testing as outlined in Section 2.3 of this document.

2.2 Airport arrival and hotel documentation

Guests receive information when they arrive at the airport. They are required to complete a Welfare questionnaire and a food safety questionnaire to provide at arrival at the hotel.

Upon arrival at the hotel, and throughout their stay, guests will also receive various factsheets and newsletters to provide information that supports them during their stay. All current information being provided to guests is available at current information for hotel guests.

Annex 1 *COVID-19 Compliance Policy and procedures – Detention authorisation* outlines the responsibilities of Authorised Officers at ports of arrival and hotels.

2.3 Management of an unwell person (Suspected or positive COVID-19)

2.3.1 Airports

The lead for this situation is the HBO on behalf of the Deputy Chief Health Officer (Communicable Diseases). Any passengers who screen positive on the airport health check will trigger the DAWE biosecurity officer to contact the HBO on-call for the department via 1300 651 160. After discussion with the HBO, if it is determined that the person meets the criteria for a suspected case of COVID-19, the following actions should be taken.

The HBO should organise an ambulance transfer to the appropriate health service Royal Melbourne Hospital (or Royal Children's Hospital) for testing and assessment.

The DHHS authorised officer (AO) at the airport should:

- Issue the person their detention notice.
- Log the person as requiring mandatory quarantine at a specified hotel.
- Provide an information sheet to travel with the person to provide to the hospital advising that the person is being detained in mandatory quarantine. This includes the phone number for the hospital to call when the person is ready for discharge so that transport can be organised by the hotel team leader (patient transfer/ambulance/maxi taxi etc.) to return the person to the hotel.

Provide a permission to enable the person to be transported to the hospital and, following medical release, be transported back to the hotel.

- Follow-up with the hospital to update on the person's situation.

The person must remain at the hospital until the result of their COVID-19 test is known if they are showing symptoms of COVID-19.

After the test result is known, if they are well enough to be discharged from the hospital, transfer (by patient transfer/ambulance/maxi taxi etc.) can be organised to bring the person to the assigned hotel.

- If the person has a positive test result (i.e. they are a confirmed case), they should be transported to the COVID-19 hotel.
- If the person has a negative test result, they can be situated in a general part of the hotel.
- The AO must ensure the room number is included on the detention notice.

If the person is unwell and requires admission to hospital, the Compliance / AO Lead should be informed and the EOC.

2.3.2 Seaports

All international vessels and goods become subject to biosecurity control on entering Australian territorial seas. Vessels subject to biosecurity control must only enter Australia at ports that have been determined as first points of entry under *The Biosecurity Act 2015 (C'th),* unless permission has been granted to enter a non-first point of entry.

All aircraft and maritime vessels are required to obtain permission (pratique) before docking or landing at Victorian ports and complete a pre-arrival-report (PAR). The PAR for maritime vessels is submitted through the Maritime Arrivals Reporting System and is sent through 12-96 hours in advance of arrival. This information goes to the Maritime National Coordination Centre (MNCC).

If conditions change after the issue of a PAR, the operator of the vessel must notify the port or the MNCC as it may change whether pratique is automatically granted or if the vessel needs to obtain negative pratique from a Biosecurity Officer (BO).

All travellers arriving at seaports who are subject to mandatory quarantine will undergo health screening on arrival at the port of entry (NOTE: individual arrangements may be put in place at seaports depending on the circumstances).

2.3.2.1 Advanced notification of an unwell crew member on a maritime vessel

If there has been advanced notice of a passenger or crew member with COVID-19 symptoms

If a passenger or crew member meets the current criteria for COVID-19 testing in Victoria (https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19), the passenger or crew member will be required to be tested. The BO (or the MPL on behalf of the BO) notifies the HBO and the HBO will either:

- Arrange for testing to be done by the vessel's doctor or a DHHS contracted nurse at the port; OR
- Where testing cannot be done by the vessel's doctor or DHHS contracted nurse, the HBO will arrange ambulance transfer to hospital for testing.

If an onshore healthcare worker is required to board the vessel e.g. to conduct testing, they will not board a vessel at anchorage, it must be berthed.

No one will be allowed on or off the vessel until the results are known except at the discretion of the BO or HBO.

If all testing for COVID-19 is negative, and there are no concerns about other Listed Human Diseases, the HBO will contact the BO and grant pratique.

If any test for COVID-19 is positive, the HBO in conjunction with the DPHC: Physical Distancing will determine appropriate management of cases, and handover to the Case and Contact Management Team (DHHS) for ongoing public health management.

Classification of contacts with confirmed cases of COVID-19 will be made on a case-by-case basis via a risk assessment coordinated by the DPHC: Physical Distancing, with appropriate management of contacts and other people on the vessel depending on the outcome of the assessment.

If the crew member needs non-urgent medical attention and the Biosecurity Officer deems the complaint is not related to one of the Listed Human Diseases (i.e. they do not need to activate the HBO), they may allow the crew member to disembark the vessel to seek medical attention without HBO approval.

2.3.2.2 No previous notification of an unwell crew member on a maritime vessel

If the BO is alerted to an **unwell crew member** (and there has been no previous notification), they will meet and board the vessel to administer a TIC.

- If a person is identified as positive on the TIC form, the BO will contact the HBO, who will undertake further assessment as detailed above

Additional information is outlined in *Border Health Measures at Victorian International Ports (Air and Sea)* (currently in draft and is awaiting approval).

2.4 Refusal of testing

2.4.1 At the airport

If a person refuses to be transported from the airport to hospital for COVID-19 testing, and they are only mildly symptomatic (as per assessment made by the DHHS nurse and the HBO):

- They should be transported to the hotel
- They should be treated as a suspected case of COVID-19 and offered testing again at the hotel
- If they refuse testing at the hotel they should be treated as if they are COVID-19 – they must be situated at the COVID-19 hotel
- They should be encouraged to comply with testing, but they cannot be forcibly tested.

2.4.2 At the hospital

If a person refuses testing for COVID-19 at a hospital and they are well enough to return to the hotel:

- Every effort should be made to encourage them to get tested before leaving hospital to allow for the most appropriate quarantine location at the COVID-19 hotel, they cannot be forcibly tested.
- If they continue to refuse testing, they should be transported back to the hotel and treated as if they are COVID-19 positive - they must be situated the COVID-19 hotel.

If a person refuses testing and treatment at a hospital and is too unwell to be released from hospital, a Human Biosecurity Control Order (HBCO) may need to be considered.

2.5 Management of an unwell person (not COVID-19) related

Incoming passengers may present to the ports of entry with non-COVID-19 related health or wellbeing concerns. These passengers must be reviewed by the nursing staff and assessment and management facilitated through the most appropriate hospital as per the hospital transfer plan.

3. Quarantine and isolation arrangements

3.1 Accommodation options to promote effective quarantine

There are a number of accommodation options for people – such a couple or family – to promote effective quarantine. Request for accommodation preference is requested at the airport by DHHS contracted staff to allow rooms to be allocated on arrival to the hotel. If a person at this time is known to be positive for COVID –19 the companions should be advised of the risk of the options of staying together.

In instances where two or more well people (who are not suspected or confirmed cases of COVID-19) wish to share a room in advance of check-in at the hotel, this should be facilitated. However, they should be informed that sharing a room may have implications for the amount of time they are required to quarantine (although not their mandatory detention period) should their roommate become a confirmed case.

When a person within a party or group is identified as positive for COVID-19 in the hotel, the Doctor is responsible for the notification to the person and the Departments Case and Contact Management team. The case and contact management team will contact the positive person and do a review to identify close contacts, including other family members or friends who have been cohabiting. They will provide advice to the close contact regarding their need to commence a further 14 days of quarantine from the date of last contact with the infectious person (explained further below), including recommendation of the option to separate people – if they consent – at various points in the quarantine journey.

Option 1 – Parties stay together

A couple or family stay together and share a suite or room. If a person becomes positive, an extension of quarantine will be required on a tailored basis for the other persons.

Option 2 – Parties separate from arrival at the hotel

A couple or family are separated from the outset. If a person becomes positive, the other parties do not need to recommence 14 days of quarantine.

Option 3 – Parties are separated once one person becomes positive

A couple or family separate into different rooms (with no contact thereafter) after a person becomes positive for COVID-19.

The non-infected persons then start a new 14-day quarantine period, which is served at home once they complete the mandatory 14-day period in the hotel.

Option 4 – Parties stay together after one person becomes positive

The parties stay together. At the end of the 14-day period, they both leave to home isolation, and the non-infected persons commence a further 14-day quarantine period, as long as they separate in the house to which they go.

It should be noted that returning passengers who reside in states other than Victoria may be unable to travel home to their home state if they become positive or a close contact of an infected individual.

3.2 Communication of these options to people in mandatory quarantine

The DHHS Team Leader will coordinate the movement of guest and their companions to the COVID –19 hotel and the Authorised Officer will manage the change in detention notice. Once movements have occurred the EOC and Public Health will be notified of the locations of affected people.

4. Mandatory Quarantine Hotels

4.1 Team Leaders

Team Leaders are employed by DHHS to provide a safe environment for people who are required to enter a period of compulsory quarantine at a hotel after returning from overseas. They are also responsible for managing all aspects of the passengers stay in accordance with all extant policies and procedures. The Team Leaders' Pack has been developed to provide a summary of all policy and procedures and contains hyperlinks to source documents. The Team Leaders' Pack is a live document and all updates are communicated from the EOC to Team Leaders in daily briefs.

4.2 On arrival

Upon arrival at the quarantine hotels, passengers receive information packs. Current information provided to passengers can be accessed via Current information for hotel guests. Passengers will also receive additional Newsletters. to provide information that supports them during their stay.

The process for passengers arriving at hotels and the documentation they are required to provide is detailed in the Team Leaders' Pack.

4.3 COVID-19 positive hotels

Any person who is confirmed as having COVID-19 as a result of a positive test, should be relocated to the COVID-19 hotel. Appropriate signage, PPE and other consumables should be available at the entrance to this hotel. Further information regarding procedures for managing accommodation for COVID-19 positive guests and their close contacts can be found in Positive Hotels Guidance (draft awaiting approval).

5. Confirmed cases entering detention

5.1 Current infectious cases

In the situation that an arriving passenger is a current infectious case of COVID-19:

- They will still be handed the detention notice and placed in mandatory quarantine.
- They will be given a single-use face mask to wear and will be kept separated from the other passengers where possible.
- At the hotel, they will be asked to provide confirmation of their diagnosis.
- If there is any doubt surrounding the certainty of the diagnosis of COVID-19, they will be offered additional testing.

5.2 Recovered cases

In the situation where an individual self-reports they were a confirmed case of COVID-19 and have recovered from the infection:

- They will still be handed the detention notice and placed in mandatory quarantine.
- The onus is on the individual to provide the evidence that they had a confirmed case of COVID-19 and the required amount of time has passed such that they are no longer considered infectious.
- The department will decide on a case-by-case basis whether evidence from other sources (from testing done overseas) can be considered sufficient proof to inform clinical and public health decision-making.
- If they meet the criteria for release from isolation (see below) and the testing and medical reports provided are considered sufficient by the department; they may be considered for release from detention.

- They will still be handed the detention notice until this can be verified, and the request has been approved.

Note – there are no automatic exemptions for persons who are recovered cases. These requests need to be assessed on a case-by-case situation.

6. Provision of health and welfare services

As per Annex 2, Standard 3 *Provision of health and welfare services*, Operation Soteria has a flexible on-site system for the provision of health and welfare services that can accommodate urgent, non-urgent, complex, planned chronic care and preventive health needs The excerpts below outline these practical procedures.

6.1 Clinical assessment and testing for COVID-19

The objective of this testing program is to identify potential cases of COVID-19 amongst returned travellers who have a higher likelihood of being positive than the Australian population. The SOP for COVID-19 testing containing information on required schedules, PPE, and procedures is found in **Enhanced Testing Programme for COVID-19 In Mandatory Quarantine**.

6.1.1 Indications for testing

If a quarantined individual has any signs or symptoms consistent with COVID-19 infection at any time during the mandatory quarantine period, they must be offered testing that day (or the following morning if overnight).

Indications for testing include:

Signs of symptoms of COVID-19 (e.g. fever, chills, cough, shortness of breath, sore throat, fatigue, runny nose, anosmia).

- A nurse or doctor recommends testing.

The person had a positive test result overseas and the overseas laboratory result does not meet the required reporting standards in Victoria.

- It is requested by Public Health (DHHS) as part of a specific testing initiative.

Nurses and doctors working across the hotels must familiarise themselves with the clinical presentation of COVID-19 and should be familiar with the department's guidance which is available in Health services and general practice - coronavirus disease (COVID-19).

It should be noted that a lower clinical threshold for COVID-19 testing should apply in mandatory quarantine due to the high-risk nature of the setting and the population.

6.1.2 Timing of testing

Individuals in mandatory quarantine should be tested for COVID-19 at the following times:

- If they screen positive on the health screen (temperature and symptom check) at the airport.
- If they report symptoms during a nurse check or welfare check or at any other time during quarantine.
- On day 3 and/or day of 11 of the mandatory quarantine period, regardless of symptoms, persons in quarantine will be offered a voluntary testing.

When testing is indicated, it should be performed that day so that results are returned as soon as possible (which will inform quarantine arrangements). If symptoms occur over night, the testing should occur no later than the following morning.

Failure to offer COVID-19 testing to an individual in mandatory quarantine who is symptomatic should be considered a risk which needs to be reported to the EOC and investigated accordingly.

6.1.3 Refusal of testing

If a quarantined individual has signs or symptoms consistent with COVID-19 (i.e. testing is indicated) is offered testing, but refuses to be tested, this should be documented in detail in the nursing record. The importance of testing should be explained to the person. Any refusal of testing by symptomatic persons should be escalated to the team leader and command at EOC and should be included in the daily report to the Public Health Commander.

6.1.4 Communication of results

It is the responsibility of the medical practitioner who ordered the test to follow-up the result of the test and ensure arrangements are in place to advise the patient of the result, whether negative or positive. If they are not able to do so, they must handover this task to the next doctor on-call, inform the nurse, and record this in the medical record. If the result is positive, the requesting medical practitioner must notify the department on REDACTED

6.2 Case management

6.2.1 Management of suspected cases

The following actions should be taken once a quarantined individual is a suspected case:

- Suspected cases should be isolated in a separate room away from other quarantined individuals if feasible.
- If this is not possible and they are sharing a room with another person or persons, they should be given a single use face mask and advised to physically distance themselves (> 1.5m) from other persons in the room, practise hand hygiene and cough and sneeze etiquette, open a window(if possible), and clean/sanitise surfaces and common areas.
- If they have been isolated in a separate room, when the result of the test is known they can either return to their original room, sharing with other quarantined individuals (if negative), or relocated to the COVID-19 hotel (if positive).

6.2.2 Management of confirmed cases

The following actions should be taken once a quarantined individual is a confirmed case:

They should be accommodated / cohorted at the COVID 19 hotel

- The medical practitioner who requests the COVID-19 test is responsible for notifying the department of a positive result and notifying the patient (or handing this over to the doctor on call)
- A case and contact officer (CCO) from the department will then contact the case and perform a case interview
- The case's roommates will be listed as close contacts and will also be contacted and monitored by the department. They will be given the opportunity to isolate in separate rooms for the remainder of their time at the hotel. They will be required to quarantine 14 days post the last contact with the positive roommate.
- The CCO will have daily contact with the case until they are ready to be released from isolation (and therefore detention)
- Appropriate PPE (droplet and contact precautions) should be worn by all persons having contact with the confirmed case.

Further guidance relating to passengers who receive a confirmed diagnosis of COVID-19 during the 14-day detention period can be found here.

6.2.2.1 Quarantined individual becomes a confirmed case

If a hotel detainee becomes a confirmed case, they are followed up by the New Cases team.

An interview is conducted to identify possible acquisition and close contacts. The difference between the 14-day mandatory hotel quarantine period and the isolation requirements during their infectious period are explicitly explained. The case will have been told this information on arrival and relocated to the COVID-19 hotel.

The EOC is informed via email of the confirmed case. If it is identified that people wish to separate, an additional room is requested in the email.

A confirmed case is contacted daily by the Existing Cases team for a risk assessment of symptoms

Nurses should review confirmed cases daily for symptoms and take their temperature. This should be recorded in the nursing record, and may be used to inform clinical decision-making regarding release from isolation.

If a confirmed case meets the release from isolation criteria within the 14-day mandatory quarantine period, the PH Ops emails COVID quarantine and the EOC and provides a standardised letter informing the case they have met their release from isolation criteria

The case is informed of the release process, and to expect contact by the Hotel Team Leader

If a confirmed case meets the release from isolation criteria after the 14-day mandatory quarantine period is completed and is not a Victorian resident or is a Victorian resident and cannot return to an appropriate location, PH Ops emails the EOC and requests extended accommodation to be arranged. The outcome must be provided back to PH Ops

If a confirmed case meets the release from isolation criteria after the 14-day mandatory quarantine period is completed and is a Victorian resident that can continue to quarantine within their home, the PH Ops emails the EOC to request arrangement of transport. The outcome must be provided back to PH Ops.

6.2.2.2 Quarantined individual becomes a close contact

Close contacts are followed up by the New Close Contact team:

The difference between 14-day mandatory hotel quarantine period and the 14-day quarantine period from last contact with a confirmed case is explicitly explained. If currently sharing a room, they are advised that their quarantine period will be extended and are advised to separate

If they wish to separate, the PH Ops emails EOC and request an additional room be organised for the close contact at the COVID-19 hotel

A close contact is contacted daily by the Existing Contacts team to assess if they have developed symptoms and assess if they are still sharing a room. If still sharing, the Existing Contacts team again recommend separating and explicitly explain that their 14-day quarantine period will be extended. If it is identified that people wish to separate, the PH Ops will email the EOC and request an additional room be organised

If a close contact develops symptoms and requires testing, the Existing Contacts team emails the EOC to arrange testing

If a close contact (Victorian resident) has completed their 14-day mandatory quarantine period but is still within their 14-day quarantine period, the PH Ops emails EOC to request transport be arranged for them to return home for the remainder of their quarantine period. The outcome must be provided back to PH Ops

If a close contact (non-Victorian resident or Victorian resident that cannot return to an appropriate location) has completed their 14-day mandatory quarantine period but is still within their 14-day quarantine period, the PH Ops emails EOC and requests extended accommodation to be arranged. The **outcome must be provided back to PH Ops**

If an interstate resident wishes to return to their home state for the remainder of their quarantine period, this may be considered on a case by case basis

Appropriate hygiene precautions must be taken if travelling by air (i.e. face masks) and people must return straight home. The home jurisdiction must be informed so they can be followed up as close contacts by their home jurisdiction.

The *Operation Soteria Clinical Governance Framework* is currently in draft and awaiting approval from *SaferCare Victoria.*

7. Transport of COVID-19 positive,close contact and other guests

A SOP has been developed to provide guidance on transporting confirmed COVID-19 cases and their close contacts in a way that minimises the risk of further spread of the disease. This document can be found in Transport Guideline, COVID-19 Cases and Close Contacts. It also sets out transport arrangements for presenting to hospital for medical care, and transport arrangements at the end of quarantine. This guide applies to hospitals, health services, mandatory quarantine sites, transport providers, and others needing to coordinate the movement of individuals.

For all medical emergencies call Ambulance Victoria '000'. If 000 is called, the reference number is to be recorded in the Incident Report.

For all non-emergency patient transport (NEPT).

The Ambulance Emergency Operations Centre (AEOC) will coordinate all non-urgent transfers, including St John Ambulance. This service is available seven days a week. As much as possible, these arrangements should be utilised between 08:00 am and 4:00 pm.

Complete the Operation Soteria Patient Transport Request Form

Contact the AEOC on 1300 851 121 between 8:00 am – 8:00 pm.

Commercial taxis

Bookings can be made through 13cabs (03) 9277 3877. Wheelchair accessible commercial passenger vehicles (WAVs) may be used to transport COVI-19 positive passengers where non-emergency patient transport services are not available.

Refer to the current 'Guidelines for health services and general practitioners' (see https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19).

8. Welfare Check Team and Complex Assessment and Response Team

8.1 Welfare Check team

The Welfare Check Team is located offsite from the hotel and their primary role is to conduct two phone surveys with guests on day 3 and 9 of their hotel quarantine period.

On day 3 the Welfare Check Team will undertake a comprehensive health, wellbeing and safety assessment. This will including verifying health information provided by guests upon hotel arrival to ensure essential information about medications, allergies or health issues have been identified and are being managed appropriately.

The team will seek to understand if there is anything that makes the guest feel unsafe, such as family violence and drug and alcohol dependencies and refer for escalation of risks as required. Identify what wellbeing strategies they can utilise to help them cope with hotel quarantine such as exercise, keeping in

contact with loved ones etc. In addition, guests will also be asked to think about their exit strategy, in preparation for their exit from hotel quarantine.

On day 9, a shorter assessment is undertaken with guests to identify whether their needs are being met and to capture any feedback about their experience.

8.2 Complex Assessment and Response Team

Complex Assessment and Response Team is located offsite from the hotel and take referrals from all services supporting the hotel detention including nurses, the hotel team leader, the Welfare Check Team, DJPR and AOs. CART are responsible for undertaking assessments where an individual and/or family is identified as having complex needs and requires support. CART can develop safety plans and risk management plans, which are informed by specialist, and work with professionals to ensure these plans are implemented at the hotel. In addition, they can assist an individual and/or family with an application for financial hardship assistance relating to accommodation stays. Please refer to the Returned Traveller Hardship Policy for further information.

For more information on the specific roles and responsibilities of each team, please refer to Welfare Cell at a glance.

9. Exercise area implementation plan

Quarantined guests will be provided with access to fresh air in line with the endorsed Exercise and Fresh Air Implementation Plan. Team leaders are to ensure that PPE is available, and procedures are followed in accordance with the PPE guidelines pertaining to healthcare workers and hotel security and AOs.

10. Food ordering information

Operation Soteria will endeavour to ensure all passengers dietary requirements will be met. Specific guidance concerning processes for people with food allergies or dietary requirement, including information on reimbursements of meal from external suppliers, is found here.

Passengers that don't have dietary requirements are able to order from any food delivery platform however it will be at their own expense.

Further details on ordering food is located in sections three and four of the Food Management Policy.

11. Hotel delivery policy and acceptance

11.1 Care package delivery

Passengers can arrange to have items picked up from your family and friends in Victoria and delivered to the hotel through the Government Support Service. This service is provided at no charge and can be used twice during their 14-day quarantine. If passengers live interstate, they will need to arrange a Melbourne collection point for their care parcel.

11.2 Supermarket Delivery

Supermarket delivery is available to all passengers. As with home delivery perishable and cooked food, alcohol, and cigarettes will be destroyed if delivered in any care parcel. Illicit drugs will be handed to Victorian Police.

Further information on hotel deliveries are located in sections 4.3 of the Food Management Policy.

12. Medication Policy

All medicines and poisons located and utilised in hotels where passengers are undertaking mandatory quarantine, shall be stored in accordance with the Operation Soteria Medicines and Poisons Storage Policy. The doctor / general practitioner on-duty will determine what pharmaceuticals need to be ordered.

Pharmaceuticals can include:

- Prescription and over the counter (OTC) medications
- Cleaning wipes
- Hand sanitiser
- Batteries for medical equipment
- Covers for medical equipment
- Garbage bags

Additional information on ordering pharmaceuticals can be found in the Team Leader Pack.

13. Infection control and hygiene

Information on infection control and use of PPE can be found of the Department of health and Human Services Website via the following links:

Information for healthcare Workers can be found at:

https://www.dhhs.vic.gov.au/coronavirus-covid-19-guide-conventional-use-personal-protective-equipment-ppe

Information for Community Service Providers can be found:

https://www.dhhs.vic.gov.au/ppe-community-service-providers-prevention-covid-19

14. Escalation Process

Wherever possible, the principle of local resolution should be applied. Team Leaders should utilise resources at their disposal (the hotel, Authorised Officer, nurses and other medical staff) to try and resolve issues directly.

If the hotel team is unable to resolve the complaint, escalate to the EOC Operations Lead via email to dhhsopsoteriaEOC@dhhs.vic.gov.au direct the guest to the DHHS complaints process at https://www.dhhs.vic.gov.au/making-complaint. Available on this website is a fact sheet on how to make a complaint (available in easy-English format and multiple other languages), along with the current DHHS Feedback management policy.

Complaints can be registered online (eform), via email or over the phone. The DHHS Feedback team will register the complaint and refer to the appropriate team for resolution.

HR / staff complaints are to be emailed to the EOC via dhhsopsoteriaEOC@dhhs.vic.gov.au and will be managed by the Deputy Commander Hotels.

Further information with regard to the management of major incidents or alleged major incidents is contained within Quarantine incident Reporting (draft, awaiting approval).

15. Interpreter booking process

For all interpreter requirements ‘Language Loop’ is the provider that is used. The contact number for this service is 03 9280 1955 (For calls greater that 90 minutes use 03 9280 1900 to make a booking). The detailed process for interpreter bookings is located in the Team Leader Pack.

16. Other Logistics

16.1 PPE

Hotels are required to hold a minimum supply of PPE to last three business days. All PPE requests are processed by the EOC logistics team using the PPE Request Form. The completed PPE request form with subject line **PPE Order <hotel name>** is sent from the hotel to the EOC via email to**:** dhhsopssteriaeoc@dhhs.vic.gov.au

16.2 Ordering other stores

Hotels have a limited capacity to order stores directly. All other stores requests (medical, stationary etc) are emailed directly to dhhsopssteriaeoc@dhhs.vic.gov.au and processed through the appropriate channels.

Additional information on ordering stores, and minimum requirement of logistical stores to operate. can be found in the Team Leader Pack.

16.3 Clinical waste

The collection of clinical waste and sharps containers is undertaken by external contractors. The complete process can be found in the Team Leader Pack.

17. Departure – release from mandatory detention

17.1. Departure - Criteria for release from detention

Further information with regard to the criteria for release from detention can be found in Annex 1 *Chapter 5.8 Departure - Release from mandatory detention.*

Clearance testing is **not** required for release from isolation, either in the home or in mandatory quarantine.

Prior to release, health checks will, be undertaken by nursing staff on the second last day prior to the 14-day period ending, this is not mandatory.

If people being detained have a temperature or other symptoms of COVID-19 before leaving or at the health check in, this will not affect the completion of their detention. They will not be detained longer than their 14-day detention period. The policy for exiting processes can be found here Exit of accommodation arrangements.

17.2 Process for release from detention of a confirmed case

The department will determine when a confirmed case no longer requires to be isolated in mandatory quarantine, hospital or in their own home.

Every confirmed case that is diagnosed in Victoria is notified to the department and assigned a case and contact officer (CCO), regardless of whether they are diagnosed in detention or outside of detention. Every confirmed case receives daily contact from the case and contact team.

The CCO will advise when it is appropriate for consideration for release from isolation, and will issue a clearance certificate (via email) to COVID.quarantine@dhhs.vic.gov.au for the case when they meet the criteria for release from isolation.

Nurses looking after confirmed cases in detention should temperature check and review symptoms of confirmed cases daily. The date of acute illness onset should be clearly documented in their records.

Everyone is to be offered a voluntary temperature and symptom check by a nurse 24 hours before release.

17.2.1 Release from detention of a confirmed case

Confirmed cases who leave detention but have not yet met the department's criteria for release from isolation are subject to the *End of Detention Notice (confirmed case not cleared infection)*.

They will not be detained longer than the 14-day quarantine period.

They will be released from detention at the agreed time, but will be subject to an *End of Detention Notice (confirmed case not cleared infection)*.

They should be assisted to self-isolate at home or in another suitable premises in Victoria until they meet the required criteria.

A premises is considered suitable if it has a facility/room where the person can be isolated so as not to cause undue a risk for another householder (i.e. not a hostel or dormitory accommodation).

They will be given a single-use face mask to wear when checking-out from the hotel and in transit to their next destination.

They will be provided with a 'confirmed case' information sheet.

Further information with regard to this process can be found in Annex 1 *Chapter 5.8 Departure - Release from mandatory detention.*

Should a guest not have an appropriate location to travel to or is unable to return to their home state alternative directions may be used on a case by case basis as directed by the Compliance team.

17.2.1.1 Non-emergency ambulance transport

When a confirmed case of COVID-19 who is considered still infectious (but is stable) is assessed as appropriate for transition to isolation in their home and is nearing the end of the 14-day quarantine period, Ambulance Victoria (AV) will be requested by the DHHS Team Leader to provide non-emergency patient transport (NEPT) for that person to a destination in Victoria that is the assessed appropriate home isolation location.

If there are multiple persons to be transitioned to home isolation on the same day, subject to compliance-related logistics and any privacy considerations being met, it is permissible for two or more potentially infectious confirmed cases of COVID-19 to be transported together in one NEPT, i.e. to cohort confirmed cases.

17.2.2 Suspected cases

Any suspected case of COVID-19 who is in mandatory quarantine who has reached 14 days from the start of their mandatory quarantine period (midnight) may leave and should be assisted to safely isolate in an appropriate environment until COVID-19 is excluded. Any suspected case of COVID-19 who is in mandatory quarantine who has NOT reached 14 days from the start of their mandatory quarantine period (midnight) needs to remain in mandatory quarantine.

Any suspected case who has reached the end of their 14-days mandatory quarantine will be issued with an *End of Detention Notice (symptoms of respiratory illness)*

Further information with regard to this process can be found in Annex 1 *Chapter 5.8 Departure - Release from mandatory detention.*

17.2.3 Care after release from mandatory quarantine

It is important that when a quarantined person has health concerns that need ongoing medical care, transfer of care to another healthcare practitioner, including appropriate documentation and/or copy of the medical record, is arranged when the person is released from mandatory detention.

17.3 Quarantine domestic travel checklist

The following is a checklist of what is required for a person to travel domestically whilst they should still be in quarantine (i.e. if they have been released from mandatory quarantine (detention)):

- The requirements for onward travel (e.g. funeral, sick relative).
- Reassessment that the person remains well (afebrile, asymptomatic).
- Person has a supply of single use face masks and hand sanitiser.
- The two rows around the person on the flight are kept empty.

17.4 Other measures

To ensure all parties are kept informed of current residents and cases/contacts:

- Accommodation team to provide daily updates of all residents arriving in detention to PH Ops.
- PH Ops to provide daily updates of all cases and contacts currently in detention.

To ensure all returned travellers seeking assistance on the grounds of hardship are able to access support in accordance with the Returned Traveller Hardship Policy.

These processes will be reviewed as operational needs dictate.

BEHAVIOURAL INSIGHTS UNIT

Promoting effective use of COVID-19 PPE in quarantine hotels

Advice

Last update: 23 June 2020

VICTORIA State Government | Premier and Cabinet

The challenge

The BIU visited the Grand Chancellor and Stamford hotel on 22/06/20

Getting hotel quarantine staff to consistently and appropriately using PPE

PPE requirements	Barriers	Desired behaviours	Existing incentives/levers
• Masks • Gloves • How frequent use? • Barriers + friction costs to use PPE? • Variability across people (nurses vs. security contractors) hotels? • Summarised in a policy → tailored for nurses/security etc.	• **Comprehension** seems to be a barrier to correct use of PPE • Making policy materials easier to absorb and comply with • When in a hotel environment, may not be so straightforward (esp if English isn't first language) • **Opportunities: colour code** • Resistance (e.g. not using hand sanitisers for religious concerns) or not knowing how to use PPE	• Limit potential contacts between staff and quarantined (personal and surfaces) → delivering meals • Wash/sanitise hands • Use PPE correctly (masks covering nose and mouth) • Bin PPE after use • Don't reuse PPE • Don't overuse PPE • Take gloves off after contact • Wash hands/sanitise after removing PPE	• Existing prompts to wash hands • Organic audits/controls by team leaders and supervisors • Gender implications: the vast majority of security guards are males, nurses mostly females • Mistaken beliefs (e.g. don't want to use hand sanitizers for health concerns)

The people

The BIU visited the Grand Chancellor and Stamford hotel on 22/06/20

Who is the target?

- Nurses
- GPs
- Hotel staff
- DHHS staff (contractors?)
- Security staff contractors (note: having less experience on how to properly use PPE)
- Gender gap + hierarchy: male security contractors don't want to take orders by female nurses
- Riskiest cohort: security guards (mostly men, most frequent contacts)
- Health-care workers: not always compliant (some want more PPE)
- Almost behavioural "factions" (security guards vs. nurses vs. cleaners)
- 8 security guards and one mental health nurse tested positive (mental health people are higher risk because they spend more time with patients)

Security guards

- Contractors and sub-contractors
- Mostly men
- Potentially needing more training on how to use PPE + hygiene
- Told not to wear gloves
- Maintain 1.5.m all time
- Normally stay in the corridor
- Not required to wear mask when in corridor
- Potential contact <1.5m with guests
- when guests arrive at hotel
  - when they go out for fresh air - lifts
  - When guest exit
  - When delivering meals outside the room door
- Pick up rubbish
- **They don't get paid for sick leave**
- **They spend a lot of time together socialising**

Cleaners

- contractors - third parties managed by DJPR
- Cleaning companies already having their H&S procedures
- Typically cleaners disinfect but refuse to clean first
- They tend to take instructions from their own company
- No regular auditing but cleaning policies in place
- Potential change in contract with cleaning/security companies in July

Nurses

- Well trained to use PPE
- Mostly women
- Typically do not get in touch with patients with exception of emergencies and swabs
- Leave medications at the room door for guests
- Team leader as main supervisor/coordinator

- ❖ Behavioural science is not able to change behaviour when there are strong contrary financial incentives.
- ❖ Note the Hardship Fund announced (23 June) for people who cannot go to work. Providing clarity on how to apply may be an intervention avenue to explore.

Top 6 behavioural change principles for Health and Safety

1 Reduce information overload

- It can be easier to achieve complex goals if they are broken down into more manageable chunks. Another strategy is to have people identify any barriers they are likely to encounter, and then plan how to overcome them.

2 Reduce the 'hassle factor' of wearing PPE

- Even small effort to perform an action can put people off. Reducing the effort required to follow a procedure safely can increase how many people do so (and vice versa to discourage unsafe behaviour).

3 Design for safety with defaults and prompts

- Design hotel spaces and procedures so that safe behaviour is the default, with no additional action required.
- Prompt people when they are likely to be receptive. The same information can have drastically different success.

4 Leverage social norms

- Show that most people perform the desired behaviour. Describing what most people do in a particular situation encourages others to do the same.

5 Simplify procedures and written messages

- Making the message or procedure clear and simple often results in a significant increase in compliance. Useful to think about how procedures can be shortened and simplified.

6 Provide feedback to encourage change

- Feedback is central to how we learn. Giving employees feedback on their behaviour can help them understand how they are performing (which is not always obvious) and gives them an opportunity to adjust their behaviour

Existing policies – Advice after field visit

Advice on existing policies

- Update/Change the *PPE policy advice documents* to make them more informative and for key messages to reach their recipients (see specific comments to the existing documents in slides 6-9).

- Building on the system of zones currently organically in use in hotels (*green, orange, and red zones*), we suggest expanding the number of zones according to the level of protection needed. e.g. lobby when receiving guests. The lobby could be yellow and turn orange when guests arrive. The signalling must change when this occurs.
- Associate each colour (zone) with a protection standard (from distancing to maximum protection standard)
- Demarcate zones (currently green, orange, red. Not all are demarcated).
- Design sheets for each zone (with PPE allowed and behaviours to adopt).
- At the border between zones there must be stations with the materials required in the next zone, and bins to dispose of what has already been used.

Communication between groups:

- To improve on-site communication, a daily / weekly debrief can be made with team leaders of the different cohorts (security, nurses, hotel workers, cleaners, VPS).
- Each venue has established (formally or informally) an internal code and good practices e.g. colour coding areas, intersperse rounds of guards and cleaning to avoid agglomerations. We suggest documenting those good practices and consider their implementation in different hotels.

BEHAVIOURAL INSIGHTS UNIT

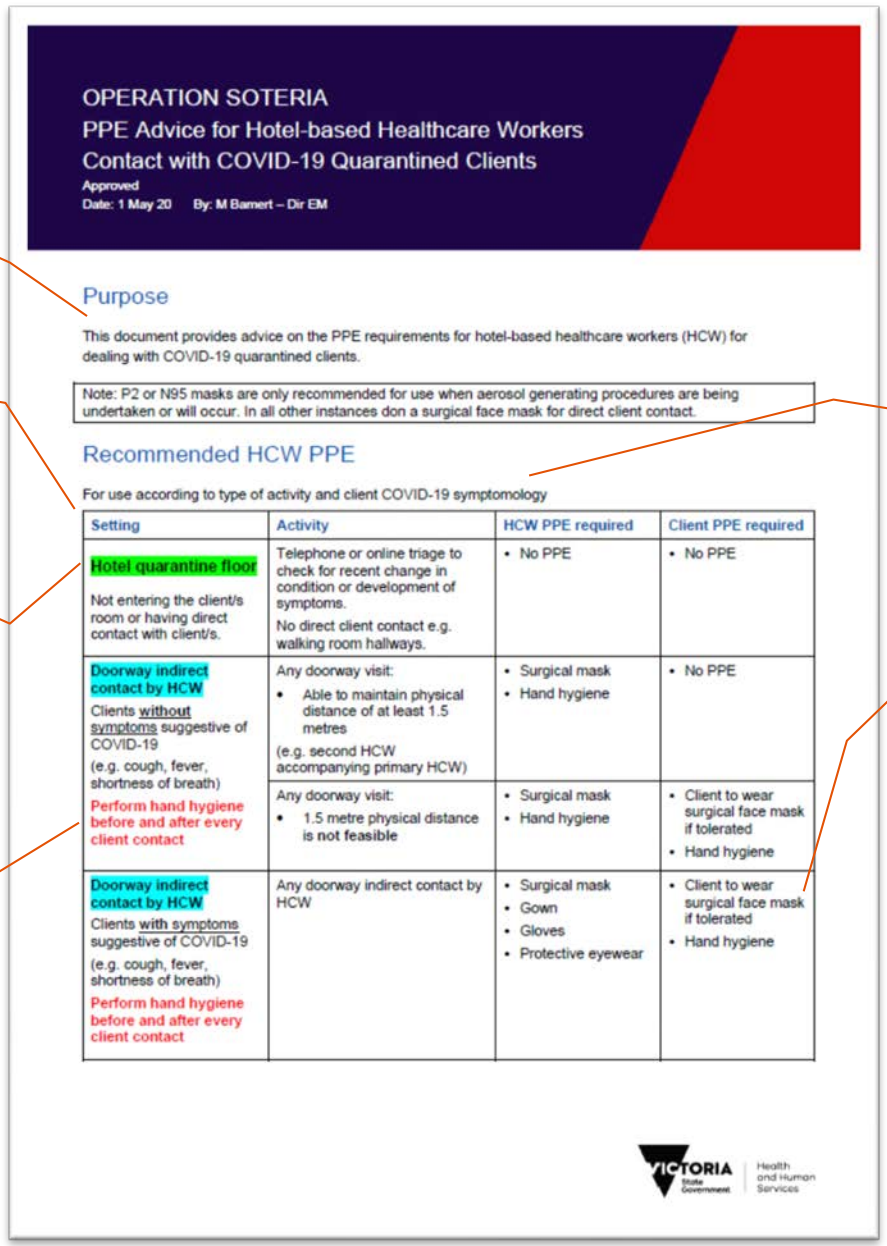
Existing policies

Suggest making specific policies for every cohort (security guards, nurses, cleaners)

Suggest renaming the "setting" to "Interaction point" or "client interaction"

Suggest making the "Setting" clearer (e.g. When in the hotel without any contact with clients

Suggest not mentioning behaviours in the "Setting" section to avoid confusion



OPERATION SOTERIA
PPE Advice for Hotel-based Healthcare Workers
Contact with COVID-19 Quarantined Clients
Approved
Date: 1 May 20 By: M Barnett – Dir EM

Purpose

This document provides advice on the PPE requirements for hotel-based healthcare workers (HCW) for dealing with COVID-19 quarantined clients.

Note: P2 or N95 masks are only recommended for use when aerosol generating procedures are being undertaken or will occur. In all other instances don a surgical face mask for direct client contact.

Recommended HCW PPE

For use according to type of activity and client COVID-19 symptomology

Setting	Activity	HCW PPE required	Client PPE required
Hotel quarantine floor Not entering the client/s room or having direct contact with client/s.	Telephone or online triage to check for recent change in condition or development of symptoms. No direct client contact e.g. walking room hallways.	• No PPE	• No PPE
Doorway indirect contact by HCW Clients without symptoms suggestive of COVID-19 (e.g. cough, fever, shortness of breath) Perform hand hygiene before and after every client contact	Any doorway visit: • Able to maintain physical distance of at least 1.5 metres (e.g. second HCW accompanying primary HCW)	• Surgical mask • Hand hygiene	• No PPE
	Any doorway visit: • 1.5 metre physical distance is not feasible	• Surgical mask • Hand hygiene	• Client to wear surgical face mask if tolerated • Hand hygiene
Doorway indirect contact by HCW Clients with symptoms suggestive of COVID-19 (e.g. cough, fever, shortness of breath) Perform hand hygiene before and after every client contact	Any doorway indirect contact by HCW	• Surgical mask • Gown • Gloves • Protective eyewear	• Client to wear surgical face mask if tolerated • Hand hygiene

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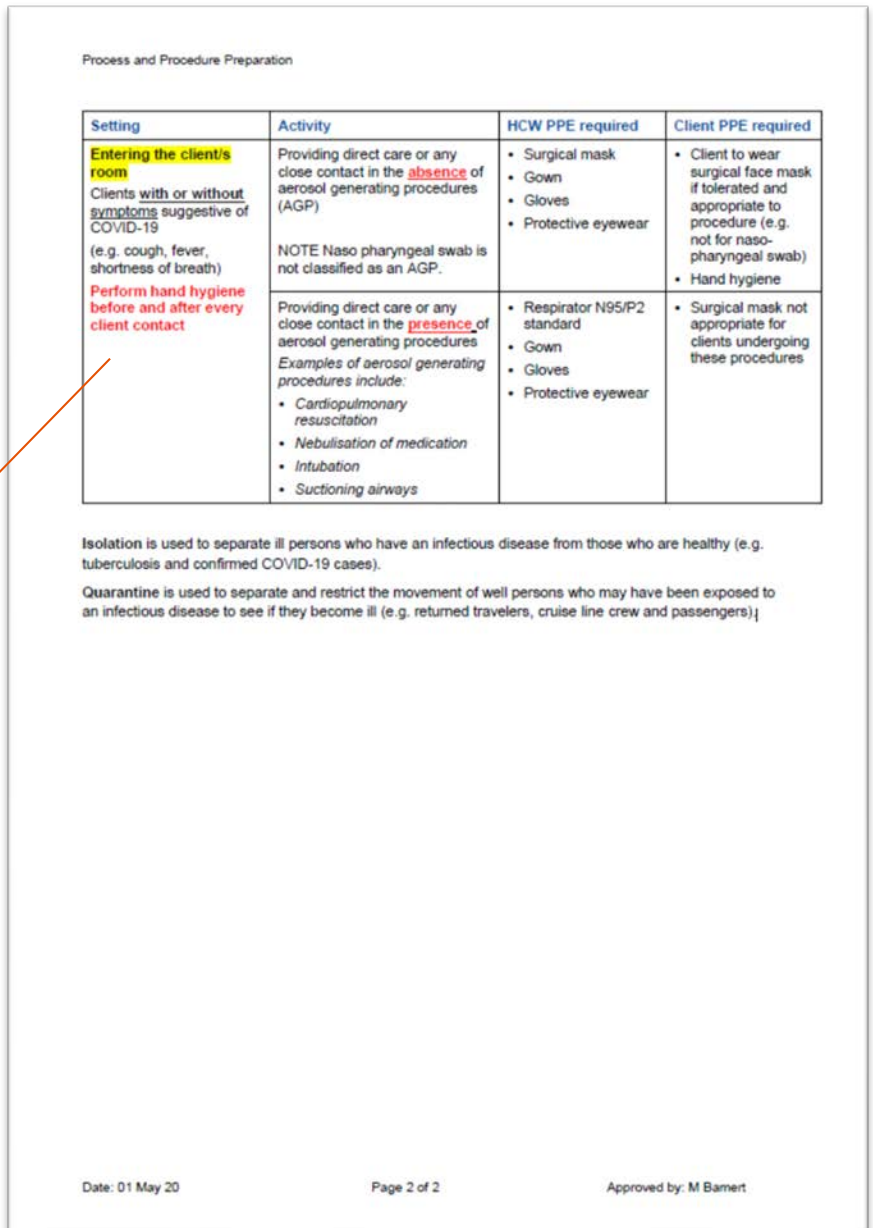
Suggest separating tables out based on Symptomology. E.g. Three tables "Regardless of presentation of symptoms or not" / "Without symptoms" / "With symptoms". Make headings on tables very clear

Suggest making the expected behaviours explicit per cohort:
- Wear mask to cover nose and mouth
- Wash hands or use hand sanitiser before and after

BEHAVIOURAL INSIGHTS UNIT

Existing policies

Suggest making behaviours stated in this column consistent in the PPE column if relevant. E.g. Hand hygiene suggested here but not in the PPE column.



Process and Procedure Preparation

Setting	Activity	HCW PPE required	Client PPE required
Entering the client/s room Clients with or without symptoms suggestive of COVID-19 (e.g. cough, fever, shortness of breath) Perform hand hygiene before and after every client contact	Providing direct care or any close contact in the absence of aerosol generating procedures (AGP) NOTE Naso pharyngeal swab is not classified as an AGP.	• Surgical mask • Gown • Gloves • Protective eyewear	• Client to wear surgical face mask if tolerated and appropriate to procedure (e.g. not for naso-pharyngeal swab) • Hand hygiene
	Providing direct care or any close contact in the presence of aerosol generating procedures *Examples of aerosol generating procedures include:* • *Cardiopulmonary resuscitation* • *Nebulisation of medication* • *Intubation* • *Suctioning airways*	• Respirator N95/P2 standard • Gown • Gloves • Protective eyewear	• Surgical mask not appropriate for clients undergoing these procedures

Isolation is used to separate ill persons who have an infectious disease from those who are healthy (e.g. tuberculosis and confirmed COVID-19 cases).

Quarantine is used to separate and restrict the movement of well persons who may have been exposed to an infectious disease to see if they become ill (e.g. returned travelers, cruise line crew and passengers).

Date: 01 May 20 Page 2 of 2 Approved by: M Barnett

Existing policies

Each zone should have its own visible instructions on what to do and what not to do (e.g. no mask zones). Use visuals where possible

Clearly indicate on site which zone you are in (green, orange, red)

Suggest making this "single most important strategy" more salient by including hand hygiene in a box on the top of the page

Suggest making this strategy much more salient and behaviourally focussed – e.g. "wash your hands or use hand sanitiser" rather than "hand hygiene". Use visuals where possible.

COVID-19 Mandatory quarantine

PPE Advice for Hotel Security Staff and AO's in Contact with Quarantined Individuals

Version 2.1

Recommended PPE use According to Type of Activity

Setting	Activity	Security Staff	Client PPE required
Hotel Lobby Perform hand hygiene before and after every client contact	Able to maintain physical distance of at least 1.5 metres	No PPE Hand hygiene	No PPE
	When accompanying clients for fresh air/exercise breaks from room to outside and able to maintain 1.5 metres	No PPE Hand hygiene	Client to wear surgical face mask if tolerated Hand hygiene Advised not to touch anything on the way out/down
	1.5 metre physical distance is **not feasible**	Surgical mask Hand hygiene	
Hotel Lobby **When new guests are arriving for the commencement of their quarantine** Perform hand hygiene before and after every client contact	Able to maintain physical distance of at least 1.5 metres	No PPE Hand hygiene	Client to wear surgical face mask if tolerated Hand hygiene Advised not to touch anything on the way in/up
	1.5 metre physical distance is **not feasible**	Surgical mask Hand hygiene	
Hotel quarantine floor Not entering the client's room or having direct contact with client/s.	No direct client contact e.g. walking room hallways or stationed in room corridors	No PPE Hand hygiene	No PPE
Doorway indirect contact by security Perform hand hygiene before and after every client contact	Any doorway visit: Able to maintain physical distance of at least 1.5 metres	No PPE Hand hygiene	No PPE
	Any doorway visit: 1.5 metre physical distance is **not feasible**	Surgical mask Hand hygiene	Client to wear surgical face mask if tolerated Hand hygiene

Hand Hygiene

Effective hand hygiene is the single most important strategy in preventing infection.

Hands should be washed with soap and water if they are visibly soiled, otherwise alcohol-based hand rub can be used continuously.

Hand hygiene should be frequently performed, including

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Suggest reducing information and focusing on the two main decisions (for security guards):

- No surgical mask vs surgical mask
- When to sanitise or wash hands

Other key messages: Examples of masks being misused and its consequences. These messages should be located in mask-areas.
In no mask needed areas, disposal bins should be available to discourage reuse of PPE. Preferably locate these at the exit from a mask zone to a non-mask zone (e.g. like quarantine bins in airport arrival passageways)

BEHAVIOURAL INSIGHTS UNIT

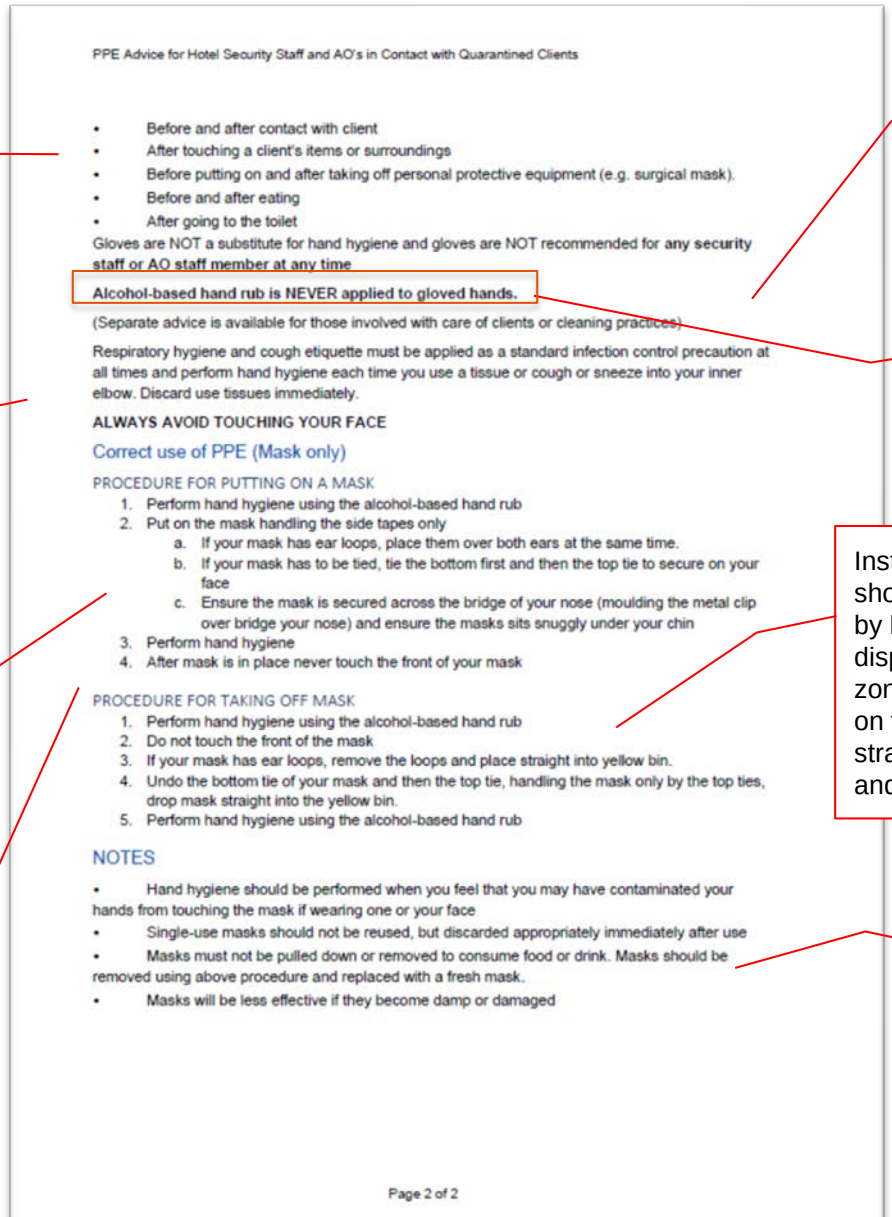
Existing policies

Consider establishing a no-gloves policy in certain areas and limiting its supply due that they are not recommended for all situations and are creating unwanted behaviours

Suggest introducing a feedback sheet from supervisor to employee at the end of shift, so that employees can be aware of compliance with rules

The section on how to put on PPE correctly could be a sheet in itself. In addition to training, sheet must be available in areas where it is to be used.

Suggest using of visual steps on how to put on / dispose of a mask, similar to visual steps to wash hands.



PPE Advice for Hotel Security Staff and AO's in Contact with Quarantined Clients

- Before and after contact with client
- After touching a client's items or surroundings
- Before putting on and after taking off personal protective equipment (e.g. surgical mask).
- Before and after eating
- After going to the toilet

Gloves are NOT a substitute for hand hygiene and gloves are NOT recommended for **any security staff or AO staff member at any time**

Alcohol-based hand rub is NEVER applied to gloved hands.

(Separate advice is available for those involved with care of clients or cleaning practices)

Respiratory hygiene and cough etiquette must be applied as a standard infection control precaution at all times and perform hand hygiene each time you use a tissue or cough or sneeze into your inner elbow. Discard use tissues immediately.

ALWAYS AVOID TOUCHING YOUR FACE

Correct use of PPE (Mask only)

PROCEDURE FOR PUTTING ON A MASK

1. Perform hand hygiene using the alcohol-based hand rub
2. Put on the mask handling the side tapes only
   a. If your mask has ear loops, place them over both ears at the same time.
   b. If your mask has to be tied, tie the bottom first and then the top tie to secure on your face
   c. Ensure the mask is secured across the bridge of your nose (moulding the metal clip over bridge your nose) and ensure the masks sits snuggly under your chin
3. Perform hand hygiene
4. After mask is in place never touch the front of your mask

PROCEDURE FOR TAKING OFF MASK

1. Perform hand hygiene using the alcohol-based hand rub
2. Do not touch the front of the mask
3. If your mask has ear loops, remove the loops and place straight into yellow bin.
4. Undo the bottom tie of your mask and then the top tie, handling the mask only by the top ties, drop mask straight into the yellow bin.
5. Perform hand hygiene using the alcohol-based hand rub

NOTES

- Hand hygiene should be performed when you feel that you may have contaminated your hands from touching the mask if wearing one or your face
- Single-use masks should not be reused, but discarded appropriately immediately after use
- Masks must not be pulled down or removed to consume food or drink. Masks should be removed using above procedure and replaced with a fresh mask.
- Masks will be less effective if they become damp or damaged

Page 2 of 2

Suggest using a trusted Messenger (e.g. team leaders/security guards supervisors)

Use active language throughout. E.g. “Never apply alcohol-based sanitiser to gloved hands”

Instructions on discarding used masks should be specific and easy to do (e.g. by locating hand sanitiser at the disposal bin at the edge of the mask zone, and providing clear instructions on the bin itself such as “Using only the straps, remove mask from your face and dispose in yellow bin”)

Consider policy of no-eating (even drinking water) in areas or moments that need masks. Furthermore, establish designated areas for breaks and food and label them explicitly no-mask zone.